

## QPP Year 4: 2020 Cost Category

Under the Merit-Based Incentive Payment System (MIPS), Cost is one of four categories on which Eligible Clinicians (ECs) are evaluated. Unlike the three other categories, the Cost category is evaluated via claim submissions and does not require ECs to submit data to CMS. Feedback on performance will be provided through the annual feedback report that is released each year in the summer. The Cost category is reweighted to zero for MIPS APMS/ APMS. Performance year 2020 has significant changes to the category elements as defined below.

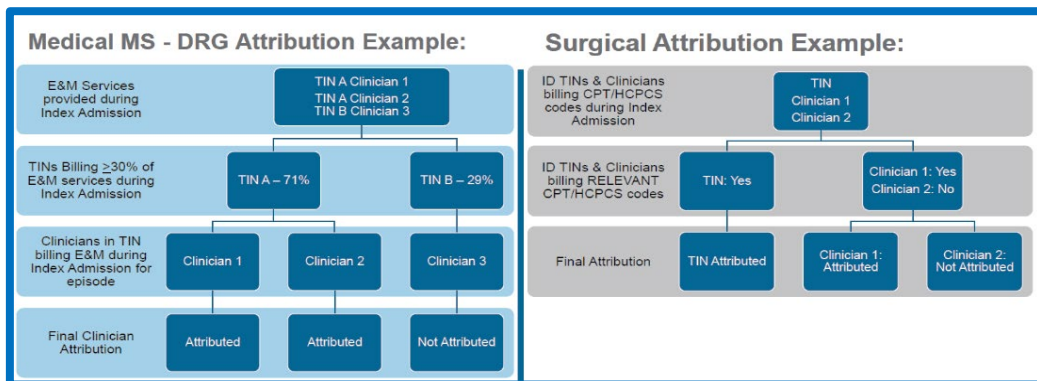
### Changes to the Cost Category

- Updated attribution method for all measures
- New terminology
  - MSPB-Clinician
  - Candidate Event
- 10 additional episode-based measures
- Cost evaluated monthly
- Beneficiaries can be assigned to multiple providers
- Scoring calculated at TIN and NPI level
- MPSB Medical vs Surgical Episode

### Attribution

Attribution occurs at the TIN and NPI levels with each measure having its own methodology. Some measures have specialty exclusions. Each measure is risk-adjusted and specialty adjusted as needed. Each measure has its own Measure Information sheet, as well as a Code Measure list for reference. These provide extensive information regarding the measure and it's applicability to your organization. They can be found at the Quality Payment Program website, [Explore Cost Measures](#).

Examples of Attribution for MSPB-C and TPCC are provided here.



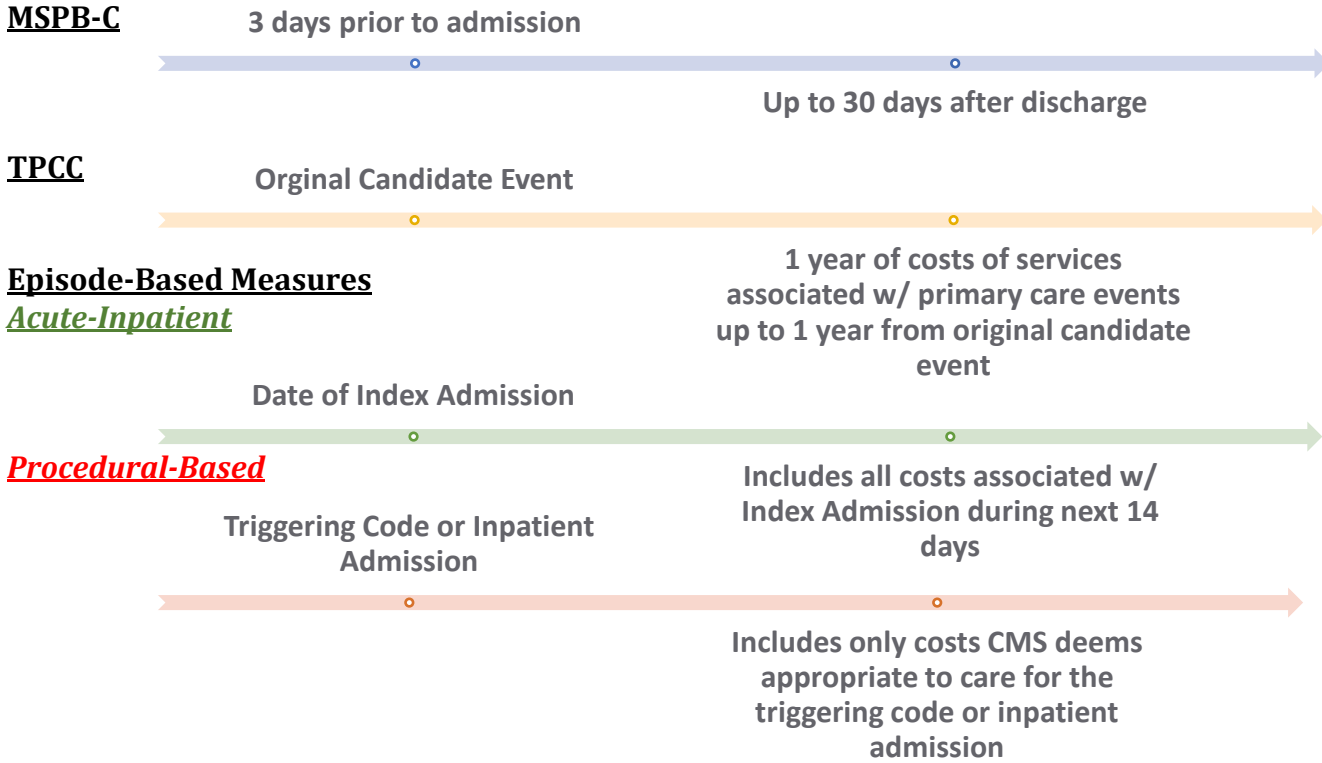
**MSPB Medical versus Surgical -** The TIN billing more than 30% of the Evaluation and Management services will be attributed to the beneficiary. Each clinician within the TIN who bills an E&M service will be attributed to the beneficiary. The same process applies for the surgical episodes, except that attribution is based on CPT/HCPCS codes.

**TPCC -** Attribution is centered on the plurality of primary care services within a risk window. The risk window begins with a candidate event. The TIN is attributed to the beneficiary if a second primary care service is billed within 3 days by another PCP, or within 90 days if billed by another clinician in the original TIN.

Clinician: Specialty	Candidate Events	Exclusions	TIN-NPI Attribution
A: Cardiology	Candidate Event 1 Candidate Event 2	Excluded From Global Surgery Service	Clinicians A & B will not be Attributed
B: Optometry	Candidate Event 3 Candidate Event 4	Excluded From Due Optometry Specialty	Clinician C will be Attributed Event 5
C: Family Practice	Candidate Event 5	No Exclusions Apply	Clinician D will be Attributed Event 6-7
D: Geriatric Medicine	Candidate Event 6 Candidate Event 7	No Exclusions Apply	

## Risk Windows

Costs for each measure are based on all Medicare Parts A & B during the risk window for each measure.



## Scoring Methodology

Measure	Points Earned	Total Possible Points
Medicare Spending Per Beneficiary Clinician (MSPBC)	8.1	10
Total Per Capita Cost (TPCC)	6.8	10
Elective Outpatient PCI	3.2	10
Knee Arthroplasty	Not Scored	N/A
Revascularization for LE Chronic Critical Limb Ischemia	Not Scored	N/A
Routine Cataract Removal w/ IOL Implantation	Not Scored	N/A
Screening/Surveillance Colonoscopy	4.2	10
Intracranial Hemorrhage or Cerebral Infarction	6.9	10
Simple Pneumonia w/ Hospitalization	1.5	10
STEMI w/ PCI	7.7	10
<b>TOTAL POINTS</b>	<b>38.4</b>	<b>70</b>

$$38.4/70 = 0.54 \text{ (Category Raw Score)}$$

$$0.54 \times 15 \text{ (Category Weight)} =$$

**8.1 Cost Points**

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