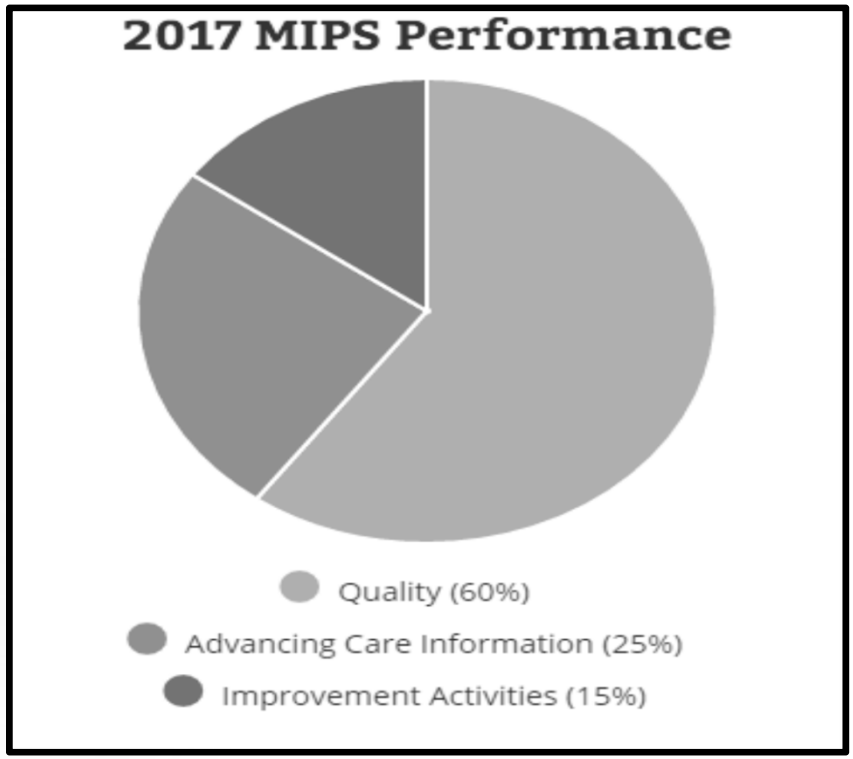
MIPS (Merit-based Incentive Payment System)

Resource Use/Cost Performance Category

Resource Use/Cost Category

The cost measures that are used in MIPS aim to measure how a particular clinician or group impacts a patient's cost, both directly or indirectly. CMS has aimed to design the program that encourages more consideration of the costs of care associated with patients even after other clinicians become involved, so the measures require that clinicians who are most significantly responsible for their care, as measured by Medicare allowed amounts, assume accountability for it.

Calculating the 2017 Composite Performance Score



Resource Use performance score will not be factored in CPS in 2017 only.

Resource Use % Weight in Future Years

Performance Year	Payment Year	Category Weight
2017	2019	0%
2018	2020	10%
2019	2021	30%

Key Points:

- Will compare resources used to treat similar care episodes and clinical condition groups across practices.
- Replacing the Value-based Modifier Program
- 0% of the Eligible Clinicians Composite Score in 2017.

Cost measures will be calculated and performance ratings will be available in the ECs performance Feedback reports but will not be factored in to the ECs composite score for the transitional year of MIPS

- All Cost Measures will be adjusted for: Geographic Payment Rate; Beneficiary Risk Factors; Specialty Adjustments
- All Cost Measures will be derived from Medicare Administrative Claims, so participation will not require use of a data submission mechanism.
- 20 – 35 Minimum Case requirement

2017 Measures

- Total Costs per Capita for All Attributed Beneficiaries (Total Cost per Capita)
- Medicare Spending per Beneficiary (MSPB)
- Episode Based Measures

  10 out of 41 Episode based measures will be used in 2017

Total Costs per Capita for All Attributed Beneficiaries

- Total per capita costs for all attributed beneficiaries (or cases) include payments under both Part A and Part B, but do not include Medicare payments under Part D for drug expenses.
- Expansion of primary care services to align with Medicare Shared Savings Program which include the new care coordination codes for chronic care management (CCM) and transitional care management (TCM)
- Exclusion of nursing visits that occur in a skilled nursing facility.
- Two-step attribution process
- Minimum Case volume of 20 to be scored on the measure

Primary Care Services Identified:

- Healthcare Common Procedure Coding System (HCPCS)/CPT codes:
  - 99201 – 99215
  - *99304 – 99340
  - 99341 – 99350
  - G0402 (Welcome to Medicare Visit)
  - G0438 & G0439 (Annual Wellness Visits)
  - 99495 & 99496 (Transitional Care Management)
  - 99490 (Chronic Care Management)

* Exclude services billed under CPT codes 99304-99318 when claim includes POS 31 modifier.

Two-step attribution process

Two-step process that takes into account the level of primary care services received (as measured by Medicare-allowed charges from final action claims during the performance period) and the provider specialties that performed these services. Only beneficiaries who received a primary care service during the performance period are considered in attribution.

STEP 1: A beneficiary is attributed to a TIN in the first step if the beneficiary received more primary care services from primary care physicians (PCPs), nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) in that TIN than in any other TIN. If two TINs tie for the largest share of a beneficiary's primary care services, then the beneficiary is assigned to the TIN that provided primary care services most recently.

STEP 2: If a beneficiary did not receive a primary care service from any PCP, NP, PA, or CNS during the performance period, then the beneficiary is attributed to a TIN in the second step if the beneficiary received more primary care services from specialist physicians within the TIN than in any other TIN.

Medicare Spending per Beneficiary (MSPB)

- The Medicare Spending Per Beneficiary (MSPB) Measure evaluates solo practitioners and groups on their efficiency and is specialty-adjusted to account for their specialty mix. Specifically, the MSPB Measure assesses the cost to Medicare of services performed during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.
- Minimum 35 cases

MSPB

- **Episode Definition:** An MSPB episode includes all Medicare Part A and Part B claims with a start date falling between 3 days prior to an IPPS hospital admission (index admission) through 30 days post-hospital discharge. An episode includes the 30 days after a hospital discharge in order to emphasize the importance of care transitions and care coordination in improving patient care.
- **Attribution:** Each MSPB episode is attributed to the one TIN responsible for the plurality of Part B carrier (PB) services, as measured by Medicare allowed amounts, performed by EPs during the episode's index hospitalization.

Episode Based Measures

- In lieu of using the total per capita cost measures for populations with specific conditions that are used for the VBM.
- There are episode based measures for a variety of conditions and procedures that are high cost, have high variability in resource use, or are for high impact conditions.
- These measures include Medicare Part A and Part B payments for services determined to be related to the triggering condition or procedure.
- Minimum of 20 cases
- Episode based measures each have different attribution methodologies. Attributing episodes to the clinician with the highest Part B charges is not necessarily appropriate in all cases, particularly for a procedure episode.

Attribution – Acute Condition Episode

Acute condition episode-based measures would be attributed to all MIPS eligible clinicians that bill at least 30 percent of inpatient evaluation and management (IP E&M) visits during the initial treatment, or “trigger event,” that opened the episode. E&M visits during the episode's trigger event represent services directly related to the management of the beneficiary's acute condition episode. MIPS eligible clinicians that bill at least 30 percent of IP E&M visits are therefore likely to have been responsible for the oversight of care for the beneficiary during the episode.

Attribution – Procedure Episode

- For inpatient procedural episodes, the trigger event is defined as the IP stay that triggered the episode plus the day before the admission to the IP hospital.
- For outpatient procedural episodes, the trigger event is defined as the day of the triggering claim plus the day before and 2 days after the trigger date. OR the trigger event is defined as only the day of the triggering claim.

2017 Episode Based Measures

- **Mastectomy** (formerly titled "Mastectomy for Breast Cancer")—Mastectomy is triggered by a patient's claim with any of the interventions assigned as Mastectomy trigger codes. Mastectomy can triggered by either an ICD procedure code, or CPT codes in any setting (e.g. hospital, surgical center)
- **Aortic/Mitral Valve Surgery**—Open heart valve surgery (Valve) episode is triggered by a patient claim with any of Valve trigger codes
- **Coronary Artery Bypass Graft (CABG)**—Coronary Artery Bypass Grafting (CABG) episode is triggered by an inpatient hospital claim with any of CABG trigger codes for coronary bypass. CABG generally is limited to facilities with a Cardiac Care Unit (CCU); hence there are no episodes or comparisons in other settings
- **Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based**—Fracture/dislocation of hip/femur (HipFxTx) episode is triggered by a patient claim with any of the interventions assigned as HipFxTx trigger codes. HipFxTx can be triggered by either an ICD procedure code or CPT codes in any setting
- **Cholecystectomy and Common Duct Exploration**—Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MS-DRGs

2017 Episode Based Measures cont.

- **Colonoscopy and Biopsy**—Episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day. Medical condition episodes are triggered by IP stays with specified MS-DRGs
- **Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia**—For procedural episodes, treatment services are defined as the services attributable to the MIPS eligible clinician or group managing the patient's care for the episode's health condition
- **Lens and Cataract Procedures**—Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day
- **Hip Replacement or Repair**—Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day
- **Knee Arthroplasty (Replacement)**—Procedural episodes are triggered by the presence of a trigger CPT/HCPCS code on a claim when the code is the highest cost service for a patient on a given day.

Final Rule Comment Period

To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **December 19, 2016.**

- Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov.
- By regular mail. You may mail written comments to the following address ONLY:
  Centers for Medicare & Medicaid Services,
  Department of Health and Human Services,
  Attention: CMS-5517-FC,
  P.O. Box 8013,
  Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

- By express or overnight mail. You may send written comments to the following address ONLY:
  Centers for Medicare & Medicaid Services,
  Department of Health and Human Services,
  Attention: CMS-5517-FC,
  Mail Stop C4-26-05,
  7500 Security Boulevard,
  Baltimore, MD 21244-1850

Additional Help!

- Call QPP Service Center:

  1-866-288-8292

  Available: Monday – Friday 8am-8pm
- Send Questions:

  QPP@CMS.hhs.gov

Obtain your EIDM/QRUR

RESOURCES

Quality Payment Programs:

Medicare EHR Incentive Program (Meaningful Use)

Physician Quality Reporting System (PQRS) Website

Quality Payment Program (CMS) Website

Quality Payment Program Timeline

Value-Based Payment Modifier Program Website

PDF **PQRS Cross-Cutting Measures**

PDF **2016 PQRS Qualified Registries**

PDF **Guide for Obtaining a New EIDM Account**

PDF **Clinical Practice Improvement Activities Inventory** (*from the Proposed Rule*)

PDF **CMS Fact Sheet**

Setting up EIDM account
Quality Net Help Desk – 866-288-8912

VBM/QRUR
Physician Value Help Desk – 888-734-6433

Key Dates to Remember!

2016
December 19th – Final Rule Comment Period Ends
December 31st – PQRS, MU and VBM Sunsets

2017
January 1st – MIPS Begins!!
February 28th – Medicare MU Attestation Deadline
UPDATE: Returning participants (Stage 2) can report on a continuous 90 day period!
June 30th – CMS Web Interface Registration Deadline
July – 1st MIPS Performance Feedback Report

2018
March 31st – MIPS Performance Data Submission Deadline
July – 2nd MIPS Performance Feedback Report

2019
January 1st – MIPS Payment Adjustments Begin

Thank you for your attendance

Please submit your questions through the chat feature