Hello, everyone. Thank you for joining today's MACRA Cost Measures Field Testing webinar. The purpose of this webinar is to provide information about the field testing of 11 episode-based cost measures and to re-evaluate cost measures before consideration for the potential use in the cost performance category of the Merit-based Incentive Payment System, MIPS, of the Quality Payment Program. You can listen to the presentation through your computer's speakers. If you cannot hear audio through your computer's speakers, please contact CMS Quality Team at ketchum.com. Again, that is CMS Quality Team at ketchum.com. Questions will be taken via the phone line and the questions box at the end of the presentation. Now I will turn it over to Dr. Paul Rosen, acting director of the Division of Quality Measures at CMS. Please go ahead, sir.

Thank you so much, and I just want to welcome everyone and thank you for being here on this webinar with us, and thanks for your work with measures field testing. I'm from the Division of Quality Measures at CMS, and I'll go through the next few slides for our introduction. So, I guess we'll go to the next slide. So, this is our CMS disclaimer, which basically says -- this is the general summary, and that we're trying to go through the material and answer questions best we can. So, we'll go to the next slide. So, this is our overview for today's webinar. Again, I'll give the introduction. And we'll touch base on the episode-based cost measures, and as you know, we have 11 of these measures. Three of them are the acute inpatient medical condition measures, and eight of them are the procedural measures. And then we'll talk about the two re-evaluated cost measures. That's your Medicare Spending Per Beneficiary, MSPB measure, and your total per capita cost, TPCC. And then we'll go into more detail on field testing, how to understand the field reports, and then we'll end with our question-and-answer session. So, that'll be the overview for this webinar. Next slide, please.

Here are some acronyms that we'll be using. I think most of you are familiar with these -- alternative payment model, the Quality Payment Program, the TIN-NPI number, et cetera, so we can't have a CMS webinar without a bunch of acronyms, so that's what we'll be using. Let's go to the next slide, please.

Yeah, and we'll go to the next one. Great. So, I think as you're familiar about the Quality Payment Program, and there's two tracks to choose from for clinicians. We won't speak much about the Advanced Alternative Payment Models today. Our focus obviously is the Merit-based Incentive Payment System, the MIPS program. And MIPS, as you know, has four components -- quality, cost, interoperability, and the improvement activities. And for today, obviously, we'll be focusing on cost measures as part of the MIPS program in the Quality Payment Program. So, that's your sort of overview. Next slide, please.

Okay, so we know that the cost measures, it'll make up 10% of the final score in MIPS in the 2018 performance period. And in terms of cost performance category, we have the Medicare Spending Per Beneficiary, which is based on the plurality of Part B services billed during the index admission to determine attribution with a case minimum of 35 patients. And then the total per capital cost for primary care -- that's based on the plurality of primary care services rendered by the clinician to determine attribution with a case minimum of 20. Now, the last bullet is the good news here. You know we've been working on decreased burden, so there's no additional reporting requirement for these, and the clinicians are assessed on Medicare claims data. So, no additional reporting requirement. Just want to stress that point. Next slide, please.

Okay, and this is our overview of field testing. And what we'll be doing is we'll be gathering feedback on the draft measure specifications for the cost measures before consideration for use in MIPS. We'll be going over field test report templates and supplemental documentation. And certainly, we'll take feedback into consideration for refining the measures and for future development. And as you know, field testing is taking place now through the month of October, ending on October 31. Next slide, please.

Okay, and I'm sure you've seen this. These are our cost measures that are being field tested. So again, the top 11 ones are the 11 newly developed episode-based cost measures. As I mentioned, we have three nonsurgical procedures, so that would be your COPD, your lower GI bleed, and your psychoses. And then you have the eight procedural-based cost measures. And then you have the two re-evaluated cost measures -- a measure for the Medicare Spending Per Beneficiary and the total per capita cost. And that makes up your 13 cost measures. Next slide, please.

Thanks so much for your attention. I'm going to turn it over to Sri Nagavarapu, who is going to lead the rest part of the presentation. Thank you so much.

Thanks very much, Paul. This is Sri Nagavarapu. I'm co-project director at Acumen for the MACRA Episode Groups and Cost Measures Project, and thanks, all, for joining us. What I'm going to do is walk briefly through the episode-based cost measures and the re-evaluated MSPB and QPCC measures to give you some background, and then jump into aspects having to do specifically with field testing, including the interpretation of reports. My hope is to leave about half an hour for Q&A. And so, I'll move through the slides relatively quickly, but feel free to ask questions over the chat box or in the Q&A. Okay, great. So, what is an episode-based cost measure? So, fundamentally, an episode-based cost measure captures the Medicare payment for care that's furnished to a patient during an episode of care. In general, episode-based cost measures can be defined with five basic components. First is defining and episode group, so that's determining the codes that trigger or open an episode group and the potential subgroups. And the subgroups are used in risk adjustment, and we'll talk about that down the road. Attributing the episode group to clinicians, so determining the assignment of responsibility for an episode of care, to managing clinician or clinicians. Third, assigning costs to the episode group, so determining what services and the cost of those services are included in the episode by considering the role of the attributed clinician and what's under their sphere of influence. And I should note here that whenever we say costs associated with the service, we're referring to Medicare allowed amounts, so that includes the payment for Medicare directly as well as beneficiary payments, such as deductibles. Fourth, risk adjusting episode groups. So, this involves adjusting for factors that are outside the clinician's control that can influence cost to ensure that clinicians are not penalized for factors that are outside of their control. As I noted above, subgroups are ways of dividing up episode groups so that you run separate risk adjustment models within each subgroup in order to allow comparisons of like to like. Fifth, aligning cost with quality. So, this has to do with aligning with indicators of quality to compensate for information that's not adequately captured by just looking at the cost during an episode of care. So, alignment can happen in multiple ways. One way is through the definition of the patient cohort, so through defining an episode group to make sure that the codes that define an episode group are aligned with the codes that

define a cohort for a quality measure. You could also think about alignment in additional ways, such as using common risk adjusters, looking over a common period of time after an initial surgery or treatment, and so on. Next slide, please.

And there is a brief lag on the slides, and so what I'll do is, after saying, "Next slide," sort of start in on the next slide. Okay, great. So, the basic approached to episode-based cost measure development is depicted here in this figure. Essentially, we've created a broad structured process for gathering stakeholder input on cost measures throughout the course of measure development. So, this has included input through a technical expert panel that's met many times to provide strategic guidance on overall measure development, a clinical committee that met in order to try and define an initial list of episode groups that could be useful to develop into measures, clinical subcommittees that are tied to clinical areas based on that initial list of episode groups potentially usable for development. And those clinical subcommittees could be subcommittees such as musculoskeletal, nonspine, that has developed a knee replacement episode group in Wave 1 of measure development, which was a measure that was in this past proposed rule, as well as is now developing a hip-replacement measure that's in Wave 2 and that will be field tested and that we'll talk about in a bit. In Wave 2, there are 10 of these clinical subcommittees overall. Next is measure-specific workgroups.

These are workgroups that are defined around a particular measure. And so, it's a set of experts, partly subset of the clinical subcommittees that are convened to provide input into each aspect of measure development in a very detailed manner. There's a Person and Family Committee that provides input from a beneficiary perspective on the measures, and so at multiple stages of the process, we have provided input from the PFC, over to the Technical Expert Panel, as well as the Clinical Subcommittees and workgroups. And then finally, CMS is hearing from the public through both public comments in rulemaking and through field testing, which is what we're talking about and focused on here today. Next slide, please.

And I should note that, overall, there have been many opportunities to hear from the public and incorporate their thoughts over time on the development of cost measures. So, this slide lists some of those opportunities. There's postings related to CMS episode groups that were originally designed for the Supplemental Quality Resource Use Reports, the Supplemental QRURs. There are postings related to cost measure development, so that's a draft list of episode groups, the preliminary list of episode groups that I mentioned earlier. That also included an operational list of episode groups for the first set of episode groups that were developed into measures. That was posted in January of 2018. Finally, there are a series of rulemaking efforts that have allowed CMS to garner public comment on cost measures in general as well as particular cost measures in the specifics of measure specifications. Through these comments, we've created this process, the culmination of what you're seeing today in the field testing and measures. Next slide, please.

So, I talked a little bit about these bodies earlier in the slide with the diagram. The Technical Expert Panel, as I mentioned, is sort of the high-level advisory role. That includes 19 members, including from the types of bodies that you see there on the slide. The TEP has met in August 2016, December 2016, March 2017, August 2017, and most recently May 2018. And at each point in the process, they've provided input on new aspects of measure

development that can inform the overall development of measures. So, for instance, there was one TEP that was focused on aspects of risk adjustment in questions related to risk adjustment. The clinical committee is, as I mentioned, the groups that help develop in December, posting a list of preliminary episode groups for potential development. And the clinical subcommittees are bodies that work on measure development activities for both the first wave of measure development, the Wave 1 measures that were in the proposed rule, as well as the Wave 2 measures that are being scale tested right now. And as you can see, the participation from the stakeholder has been extensive, and we've been excited to work with such a broad range of clinicians with so much expertise across a large range of specialty societies. This is a process that really could not work in terms of the measure development framework without this sort of input. Next slide, please.

So, some key points that we've gotten from stakeholder feedback both in public comment periods as well as through the TEPs, clinical committee, and clinical subcommittees, are listed on this slide here. And these are high-level points. We've also gotten a lot of extremely detailed feedback that we've tried to incorporate as much as possible in order to continually refine the measure development process. So, we took comments from Wave 1, tried to restructure the process in certain ways, tried to preserve all the aspects of the process that people really liked, and came out with a slightly refined process for Wave 2 that I think and hope has been helpful in the development of measures. And as we go, we'll continue to make refinements based on cost. But the high-level points that we've heard about and that we've tried to preserve and reflect throughout the measure development framework are listed here. So first, the definition of episode groups and cost measures have to yield actionable information so that you can actually use that information to guide improvements to patient care. The attribution of claims and episodes to clinicians has to be clear and credible at the time of service and should consider the patient relationships. And this is something where in the future, as patient relationship codes potentially come into use in Medicare on a nonvoluntary basis, this is an aspect that can potentially be incorporated into attribution. Next, the assignment of cost to episode groups should only hold clinicians accountable for patient outcomes that are within the scope implied by their clinical role, so that the costs that are assigned to any episode-based measure reflect costs that are under the influence of the attributed clinician. Next, cost measures should account for patient complexity through appropriate risk adjustment. They must be aligned with quality measures to promote delivery of high-quality and efficient care. And finally, broad stakeholder feedback is crucial to the development and implementation of this process, and we'll continue to be soliciting input, trying to provide as much advanced preparation time for our clinical subcommittees and workgroups as possible, and ensure that lessons learned across one clinical subcommittee are sort of translated across all the clinical subcommittees in order to ensure a robust measure development framework. Next slide, please.

So, this is a list of the Wave 2 clinical subcommittees as well as the episode-based cost measures that have been developed. CMS selected the 10 clinical areas for Wave 2 through consideration of input that we received from the TEPs, based on criteria they used to prioritize measures for development. The Wave 2 subcommittees selected one to two episode groups to develop into cost measures, and they also provided input on the scope of the episode group, how broad the patient cohort should be, as well as what

composition should go into the smaller workgroup that would develop the detailed aspects of the measure. These smaller workgroups were a function of -- were an idea that stemmed from comments we got in Wave 1 because people felt that small workgroups would be in better position to work on the really detailed aspects of these measures. This led to 11 measure-specific workgroups in Wave 2, and these workgroups provided detailed input on each of the five components of measures that we saw earlier. And the left column here lists the clinical subcommittees in Wave 2, and the right column lists the 11 episode-based cost measures. Next slide, please.

This slide shows you a quick timeline of how we've come to this point in field testing. So, the first spot there is the clinical subcommittee in-person meeting that happened in mid-April. The clinical subcommittee chose episode groups for development and also gave those criteria for picking the workgroups. Once that happened and once the workgroups were constituted, using composition of the clinical subcommittees as well as additional members when necessary, then the workgroup met in an in-person meeting in mid-June. After that, the initial input of the workgroup on the way to define the episode groups, attribution, service assignment of costs was taken into account. The next touch base was in the workgroup SARA webinar. SARA stands here for service assignment and risk adjustment. This was an opportunity for the workgroup to look carefully at what costs were assigned to episode-based cost measures and what risk adjusters are being used and make suggestions on both dimensions for changes. We then started the preparation for field testing, incorporating all the input from the clinical subcommittee and workgroups for each measure and building the measures using Medicare pledge data, predominantly data from 2017. For the episode-based cost measures, this was all data from 2017, and we'll talk a bit about the data used for MSPB in 2016. That brings us to field testing and this point that we're at now. The goal of field testing is to collect feedback on the draft measure specifications for these 11 measures that have been built with the input of the workgroups as well as collect feedback on the supplemental documentation that goes along with it and whether the field test reports are of a format that's useful to you all because ultimately, the goal is to provide actionable information. Finally, after field testing is over, we'll take all of your public comments on field testing, we'll gather them up, talk to the workgroups again about them, and have a post-field test refinement webinar with the workgroups. There, we'll be able to incorporate changes that have come up as ideas during field testing that the public has brought up. Next slide, please.

This is an iterative process that's worked great during Wave 1 of measure development, and by having kind of multiple touch points at which the measure specifications are evaluated, it allows us to go into the details of each measure and make sure that people feel comfortable with the detailed aspects of measure specifications. Okay, great. So, next, alternative MSPB and TPCC measures. Next slide, please.

So, as Paul noted, these are two measures that are currently in use in MIPS. Right now, we're reevaluating these measures as part of the usual measure re-evaluation process. So, the MSPB and TPCC measures that are being presented to you all in field testing do not affect your MIPS performance score in any way. These are just field-tested measures in order to get your input on different aspects of the re-evaluation that's ongoing. So, this slide kind of walks through the re-evaluation for MSPB and TPCC. We predicated the re-evaluation on initial stakeholder input from public comments that have been received by CMS over the past few years on these

measures and related measures. And then we sought specific input from our TEP to get strategic guidance during two meetings. The TEP suggested that we constitute a workgroup for the MSPB, the Medicare Spending Per Beneficiary measure, in order to help us decide which costs and which services should be excluded from the calculation of the measure because they're unlikely to be related to the services provided by the attributed clinician. This MSPB Service Refinement Workgroup that the TEP had suggested was constituted and included 25 members from 20 specialty societies. Then two webinar meetings were convened with this workgroup during this past summer. Next slide, please.

Just to give you some quick background, the MSPB measure has been part of the MIPS cost performance category since the 2017 MIPS performance period. Previously, it was used in the Value Modifier Program. So now it's being re-evaluated before consideration for potential future use in MIPS. Throughout the slides here, as you see in the footnote, we'll use "MSPB clinician" to refer to the re-evaluated measure just for convenience. The stakeholder feedback that we've gotten has suggested refining the measure to ensure that attributed clinicians are responsible for a patient's care during the episode and also to remove services that are not clinically related to the underlying reason for the index admission and the treatment provided by the attributed clinician. Note -- and again, I want to emphasize that the re-evaluated measure being field tested here is separate from the measure used in the 2017 and 2018 MIPS performance periods. So, the field testing information and the measure score that are presented to you here for the re-evaluated measures are just intended for your feedback on future refinements and do not affect your MIPS score or payment adjustments. Next slide, please.

So, this table summarizes changes that are in the re-evaluated MSPB clinician measure relative to the current MSPB measure. The middle column there, right, the attributes of MSPB measure in use for MIPS in 2017, along two dimensions, attribution and service assignment. The right column shows changes for attribution and service assignment under re-evaluated measures. So, just to go through this quickly, the MSPB measure for MIPS in 2017 is attributed first at the clinician or TIN-NPI level. And the way attribution works is that each episode is attributed to the clinician billing the plurality of costs for Medicare Part B services that are rendered during the index admission. So, the largest share of cost. In terms of service assignment, the current MSPB measure is an all-cost measure that includes all Medicare Part A and B claims paid during the period from three days prior to the index admission through 30 days after discharge. The re-evaluated MSPB clinician measure attributes first at the clinician group level, specifically and to kind of make that concrete, for medical episodes, so episodes tied to medical DRGs for hospital inpatient stays. Episodes are attributed to any clinician group that is responsible for managing the medical condition. So, defined in a way that we'll talk about momentarily. For surgical episodes, they're attributed to the surgeon or surgeons performing the main procedure of an episode. For service assignments, unrelated services are excluded based on each specific group, so DRGs that are aggregated to the MDC level. So, the list of services that are excluded from the measure are allowed to differ by the MDC level. So, some examples are listed here that no orthopedic procedures for episodes that are triggered by DRGs that are under Disorders of Gastrointestinal System or no valvular procedures for episodes that are triggered for episodes that are triggered by DRGs under the Disorders of the Pulmonary System, MDC. Next slide, please.

So, this slide gives you a visual depiction of MSPB clinician episodes. So, episode costs sum the standardized Medicare allowed amounts. By standardized, we mean official CMS standardized payments that remove differences due to geographic adjustments and policy-motivated adjustments. So, they sum standardized Medicare allowed payments for Parts A and B services received by a patient in an episode window that surrounds the admission for the acute inpatient hospital stay. The MSPB clinician measure is the ratio of standardized observed cost to risk-adjusted expected cost that's averaged across all episodes attributed to a clinician or clinician group and then multiplied by the national average observed episode cost in order to turn this ratio into a dollar amount that's easily interpretable. The measure can be attributed again at the TIN or the TIN-NPI level. Next slide, please.

So, for Total Per Capita Cost, this gives you a quick overview of the re-evaluation of the measure there. The TPCC has, again, been part of the MIPS cost performance category since the 2017 performance period for MIPS, and as MSPB was, it's been used in the Value Modifier Program previously. So, through the comments that CMS has gotten during its use in the Value Modifier Program as well as more recently, we've consolidated stakeholder feedback in order to inform the current re-evaluation. Our re-evaluation is focused on two critical points of stakeholder feedback. One is that a primary care relationship should be better identified. And two, people have noted that it would be preferable to allow for multiple clinicians and clinician groups to be attributed responsibility for a patient's primary care management, recognizing the care coordination that goes on in primary care. Again, as a note, this re-evaluated measure that's being field tested does not affect your MIPS score or payment adjustments in any way. Next slide, please.

So, this slide walks through the basic refinements to the measure. So, in the current TPCC measure, a beneficiary is attributed to the TIN-NPI from whom the beneficiary received the most primary care E&M services. If two TIN-NPIs tie, then the beneficiary is attributed to the TIN-NPI that provided the most recently. If the beneficiary didn't receive an E&M primary care service from a primary care provider, the beneficiary is attributed to the non-primary care clinicians who provided the most primary care services for E&Ms. The re-evaluated TPCC measure alters this attribution in order to change the way that the existence of a primary care relationship is identified. This requires an E&M service to have an associated primary care service, which could be something like a diagnostic service in a lab or a list of other services that's available in the methodology documentation that's posted online or require a follow-up E&M service from the same clinician group. This allows for the attribution of episodes to multiple clinician groups over the course of a performance period. And the way the measure works is that each attributable event where you see a sequence of two E&M services from the same clinician group or an E&M service that has an associated primary care service -- each of those attributable events initiates a one-year risk window, and we look at the months of that one-year risk window that are included in the performance period, and assess cost for beneficiaries during those months. And those are attributed to the clinician after being risk adjusted. Finally, the measure excludes clinicians who frequently perform certain non-primary care services. So, an example here that we've listed has to do with major surgeries, and so if we see evidence in claims data that the clinician is performing major surgeries for their patients, that we take that as evidence that the E&M claims that have been

billed could be tied to preparation for the surgeries, and we exclude those clinicians from attribution. Next slide, please.

So, this picture here depicts the way that the TPCC measure works. The large green triangle there is an attributable event as defined in the previous slide. The blue triangle shows the primary care service, such as a diagnostic test, that occurs within a short period of time next to that candidate event. The risk window is that one year that I mentioned in the previous slide. And then you look for the overlap, so that risk window with the measurement period or the performance period. And so, that measurement period is listed there in the figure. You'll notice there's 13 blocks there. What we do is we divide up the calendar year into 13 four-week blocks, so by month here, we mean one of these four-week blocks. So, we look at the months in the measurement period that are in the risk window, and those months are the attributable months over which cost is counted and assigned to the attributed clinician and clinician group. TPCC is then the sum of the risk-adjusted Part A and Part B costs across all months -- and by month here, we're using the term episode to describe a month -- that are attributed to a clinician or clinician group during the measurement period. And again, this measure can be attributed and reported at the TIN or the TIN-NPI level. Next slide, please. That brings us to the field testing. I wanted to give an overview of the measure, so next slide, please.

And what we'll do next is walk through some of the particulars of field testing, including the overarching purpose for field testing, the accessing of reports and the interpretation of reports. So, field testing was a process that was initiated for cost measures last year in the October to November 2017 time period. We really appreciated the feedback that we got from stakeholders last year, and what we did is posted a report that summarizes all the feedback we received on the Wave 1 measures. Those are the measures, the eight episode-based cost measures, that were in this past proposed rule. The clinical subcommittees in Wave 1 took that feedback from field testing and considered it in refining the eight episode-based cost measures. And the other change that came out of this is based on comments we got there as well as further discussions with the TEP. We changed the field test report template in order to try and make things more actionable while preserving the aspects of it that people really liked. For this year's field testing, what we've done is to try and make the measure specifications a bit shorter and easier to navigate. The test reports now contain more information that will help you understand and improve cost measure performance. And that includes a glossary and an Understanding Your Report tab. It also includes some tables for some additional data elements that stakeholders requested during the comment periods or through the TEPs and clinical subcommittees. Next slide, please.

And these additional tables are intended to provide some additional data that can be used to pinpoint what's driving cost and these measures for clinicians or clinician groups. So, the way that field test reports work is that clinicians and clinician groups that are attributed the following number of places for at least one of the measures during the measurement period will get a field test report. So, these are TINs and some NPIs that have at least 10 episodes for one of the episode-based cost measures, at least 35 episodes for the MSPB clinician measure, and at least 20 beneficiaries for the TPCC measure. Stakeholders who received a field test report can access it through the CMS Enterprise Portal. Those who did not receive a field test report understandably will be interested in seeing the reports look like, and we really valued that feedback last year from those

who didn't get a report themselves. And so again, as in last year, we're providing a mock report that are posted on the MACRA Feedback Page that people can take a look at and provide feedback. And so, the documents here are again the field test report and the mock field test report. Next slide, please.

As with the episode-based cost measures, the MSPB performance period is calendar year 2017. The TPCC performance period that's reflected in the field test report is based on the fiscal year. So, for episode-based cost measures, the draft measure specifications are publicly posted on the MACRA Feedback Page. This includes the development process document to kind of walk you through the process that we went through quickly today, a draft measure methodology for each measure, as a PDF file, and then a draft measure codes list for each measure. That's an Excel file. It's important that the draft measure methodology be reviewed with the corresponding measure codes list file to get a full understanding of the specifications of the cost measure, and all these specifications reflect extensive input from the measure-specific workgroups, and based on the feedback that you all provide on these draft measure specifications, we'll go back to the workgroups and further refine the measures. And you see a list of the documents that I've just discussed here. Next slide, please.

So, the draft measure specifications for MSPB clinician and TPCC are also going to be posted -- or, sorry, are also posted on the MACRA Feedback Page. That includes the methodology for each re-evaluated measure in a PDF file and, again, a codes list for each re-evaluated measure in an Excel file. To get the most out of this, again, it's important to review the methodology document with the measure codes list. For those who are intending to just get a high-level overview, the methodology document by itself could be sufficient. For those looking to provide detailed input on the measure specification, looking at the measure codes list and providing your feedback on that would be great. As with, as I said, those cost measures, the measure specifications here incorporate a lot of stakeholder input, including from the TEPs and for MSPB, the Service Refinement Workgroup that I mentioned earlier. What we'll do is go back and make refinements to measure specifications based on feedback we receive from field testing. Next slide, please.

And the documents for MSPB and TPCC are at the bottom. For supplemental documentation, there is a short fact sheet to give an overview of field testing. There is an FAQ document to cover a comprehensive set of questions and answers that you all may have. And any thoughts you have on the clarity of information in these documents is appreciated. Next slide, please.

So, the way we're collecting feedback is through an online feedback survey. So, the feedback here will cover all 13 of these measures. To make it as easy as possible for stakeholders to provide feedback, the survey will have multiple choice and clear categories of answers that can be selected, free text responses, and then an option to skip all of those questions and attach a comment in PDF or Word format. To the extent that it's possible, using the multiple-choice questions is great in that it allows us to look at commonalities of answers across stakeholders' comments very quickly and easily and in a very consistent way. But we wanted to provide the option to skip those questions just in case that people found it easier to either in addition or instead, provide a comment in PDF or Word format. But the multiple-choice answers are extremely useful as well. This survey will open

on October 3 and close on October 31 at 11:59 p.m. Eastern, and the link is provided there. Next slide, please.

So, now we'll talk about very quickly just accessing the field test reports and give you some resources to help with that. So, if you think you have a field report for yourself or your clinician group because you meet the minimum number of cases for either the episode-based cost measures or the re-evaluated cost measures, then you can access your reports through the CMS Enterprise Portal. To do so, you'll need an active EIDM account and the Physician Quality and Values Program's role. To get step-by-step instructions on signing up for an EIDM account, there's a guide that we link to here, and I that think is also listed in the appendix of the slide deck. If you have an existing EIDM account but you just need to ensure that you have the right role, then you can use the guide that's linked to there. You can also refer to the User Access Guide that's available on the MACRA Feedback page. And we provide a phone number as well as an e-mail address here for any questions that people have about setting up an account and being able to access your report. The more people we get accessing the report, the better because the wider the feedback that we'll be able to get on the measures and the more refinement that we'll be able to do and make sure that the measures are reflecting clinical practice and providing actionable information. Next slide, please.

So, what I'll do next is walk through the field test reports for the episode-based cost measures and the re-evaluated measures in order to... Next slide, please.

...in order to explain a little bit about the way the reports are structured and orient you to them. So first I'll walk through the episode-based cost measures. Again, these reports are presented in Excel files. There are two versions of this field test report for TINs and TIN-NPIs. And the following slide will kind of go through some key metrics found in the reports. The cover page in some sense of the Excel file looks like this, the screenshot that you have on the screen here, where it provides some links to specific measures, so here it's elective primary hip arthoplasty and inpatient COPD, as well as links to reference materials and high-level summary of results. And so, this is to make it as easy as possible for you to navigate the reports that you get, to focus on information that you want to focus on, potentially ignore the information that is overly detailed. Or if you want to focus on high-level summary results and something captures your attention and you want to dig deeper into it, you can use these other tabs and the tables that we kind of walk through in the following slides in order to drill them into those results and get a better sense of what's driving your scores. Next slide, please.

So, what we've done is trying to structure these reports in a way that is as intuitive as possible using input from the tests as well as public comment from last year's field testing. So, this slide kind of starts us off with talking about the high-level summary results test. That give you results for each of the episode-based cost measures that are attributed and reported for your TIN and your TIN-NPI. What you see here in the screenshot is the rows indicate each of the episode-based cost measures as well as give some episode counts for the TIN and then a series of summary statistics, and so we'll walk through a couple of those. This slide specifically is walking through the average episode risk score percentile. The intent here is to indicate on average how expensive your episodes are expected to be relative to other TINs episodes as predicted through the risk-adjustment model. So,

based on the comorbidities or the history of comorbidities for a patient, this is intended to capture how expensive that patient is likely to be. A lower percentile here indicates that your episodes are on average expected to be among the least costly episodes across all TINs or TIN-NPIs, while a higher percentile indicates the opposite. The complexity of your patient's history is taken into account in the final risk-adjusted measure score, but this is to give you some information about how complex your patients are relative to the national average. Next slide, please.

So, if you look further down in the report, you see a table that focuses on clinical themes. So, what we mean here by clinical themes is types of services that contribute cost to your episode-based cost measure. These are clinical categorizations of services that are assigned during the window of time for the episode of care. They're created for the purpose of illustrating clinically important sources of episode costs in your feedback reports and hopefully providing actionable information to help improve care delivery. I should note that these categories or themes are not mutually exclusive or exhaustive classifications. They're meant to be just informative classifications of the types of services that appear in your cost measures. So, the two examples here are preoperative work-ups and post-acute care and rehabilitations. To walk through these columns a bit, the second column shows the average cost of these services per episode. The third column shows the percent difference in your average cost per episode versus TINs in your risk bracket. By "risk bracket," what we mean is we look at your average risk score among your patients, as we talked about in the last slide, look at every TIN that has average risk scores in the same decile of the risk-score distribution as you, and then do comparisons to those TINs only. The idea here is to try and get something as informative as possible for you because your patients may be more complex than other TINs' patients, and so comparisons to all TINs nationally could be misleading because of that, and so what we've done is try and focus on TINs that are in your risk bracket in comparisons here. Next there is the share of episodes with any cost from the given clinical theme. So, this shows whether, like what fraction of your episodes have a cost in the given category and then shows comparisons to the national average and TINs in your risk bracket. Next slide, please.

Here -- we talked a little bit about this in the previous slide in terms of the definition of a risk bracket. The thing I want to focus on here is the actual numbers that you see there. So, the numbers illustrate, again, the percent difference in the average cost for that category of services or that theme for your TIN versus TINs in your risk bracket, and so the positive number here indicates cost that's higher than TINs in your risk bracket, and a negative number indicates costs that are lower. Next slide, please.

And we've had a chance to walk through this information already, so next slide, please.

So, if you want to drill down to get more detailed information, and as you saw in the previous slides, like the high-level summary slide, there's information on your episode counts, so this is going back to slide 38 -- there's information on your episode counts, your average episode risk score percentile, your cost measure score for your TIN and the national average and the percent difference between your TIN's average risk-adjusted episode cost and the national average. Then we walked through the clinical theme slides. Those are intended to give you some information on what's driving your cost measure scores. If people are interested in more detailed

information beyond that high-level summary and the clinical themes table that we walked through, that information is in Appendix A and Appendix B. Appendix A is meant to supplement the information in each of the Results tabs. it breaks down utilization and cost by Medicare setting and service category, for specific types of services for Part B physician/supplier claims, and then looking at specific services from inpatient claims. And these data, again, are presented in comparison to TINs and TIN-NPIs in your risk bracket and the national average. If you want even more detail than that, you can look in Appendix B. That'll provide information at the episode level for all episodes attributed to your TIN or TIN-NPI that were used in calculating your score. So here you can look at individual observations for each of your episodes that go into your measure score. Finally, for detailed information on how all of the statistics we've walked through and the ones in the appendices are calculated, you can look at the glossary, which provides additional guidance to users. Next slide, please.

So now we'll talk briefly about the MSPB clinicians field test report, and I'll move quickly through this as well as the TPCC one in order to get to the questions and answers. So, as a quick overview, the MSPB clinician measure field test report has two versions -- one for TIN and one for TIN-NPI. As we mentioned, the attribution for these measures in the re-evaluated MSPB measure is different from the current MSPB measure. For surgical DRGs, again, these are attributed based on the surgeon or surgeons that are performing the core surgical service within each surgical DRG. For medical DRGs or medical episodes, these are attributed first to the TIN that passes a 30% threshold for E&M services provided during the inpatient hospitalization, and for TIN-NPIs, this is attributed to TIN-NPIs who bill an E&M within a TIN that passes that 30% threshold. So, if a TIN or TIN-NPI crosses the 35-episode case minimum, they have a report that's shared with you here. The field test reports contain the following sections. So, results, a brief overview of the report, an Appendix A and Appendix B, where Appendix B here is a glossary. Each section has a hyperlink to the field testing feedback survey. And the following slides kind of illustrate some key tables that you'll find within the reports. Next slide, please.

These reports are modeled as much as possible off of old versions that people may be familiar with in other CMS programs for measures that are like these in order to try and be as familiar as possible for people. Table 1, starting off, details your performance on the clinician measure, the national median, and your TIN and TIN-NPI's performance in terms of its percentile rank nationally. So here, just in terms of interpretation, a lower score indicates, again, that your episode costs are lower than expected for the care provided for the particular patients and episodes that are included in the calculations. A higher measure score indicates the opposite. The percentile rank gives the percentage of TINs or TIN-NPIs that received the same or higher MSPB clinician measure scores than your TIN or TIN-NPI. So as an example, in that first box, for the MSPB clinician measure, your TIN's score is $16,000. The national median is $18,696. And the percentile rank of 95 means that 95% of TINs have a higher MSPB clinician measure score than you. And again, higher here means worse performance. Next slide, please.

In addition to your TIN or TIN-NPI's clinician measure scores, there's additional tables that provide some more detail for you. Table 2 is the clinician cost breakdown by claim type, so this shows your episode cost by different Medicare claim types compared to the state and national averages. Table 3 shows your clinician cost breakdown by major diagnostic category, so

groupings of DRGs for hospital fit. That compares your episode cost to the average expected cost calculated by the risk adjustment model. Table 4 looks into breakdown by very detailed categories of service, Medicare service categories. And then Table 5 looks at other statistics about your TIN and TIN-NPI's clinician performance in order to give you some more idea of how your measure score is calculated. Next slide, please.

So, finally we'll go quickly through the TPCC field test report, which looks very analogous to the MSPB report, and so I'll be able to go through this quickly here and move to the questions and answers. Again, there are two versions of the TPCC field test report -- either a TIN or a group report and a TIN-NPI individual report. They contain the same sections that parallel the MSPB reports, and we'll walk through a couple of the tables. Next slide, please.

Again, each section will have a hyperlink to the survey so that you can have easy access to them. Table 1 is structured exactly analogously to the MSPB's reports. So again, it'll show your TIN's score per episode cost. And again, an episode here is a four-week block of time. It'll show the national median and your percentile rank. Next slide, please.

The tables for the most part are structured analogously to MSPB with one exception. So, Table 4 shows the cost breakdown again by claim type with comparison to state and national average. Table 3 is a new table that compares episode cost by specialty types and also compares to your state and nationally. This is only available in the TIN-level report and is intended to inform TINs about the specific clinicians within their TIN that are being attributed to these episodes. Table 4 is a breakdown by categories of service. And then Table 5, again, provides some basic statistics for your TIN and TIN-NPI's TPCC performance. We have a footnote here in the actual table to make clear that this table does not allow you to directly derive your measure score, but it's just intended to give you information that can help in understanding some of the key drivers. Next slide, please.

Okay, great. And so, that brings us to the Q&A session, and so I'll stop there. Thanks, everyone, for being patient and listening through this, and we look forward to your additional questions.

Okay. We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via phone, dial 1-866-452-7887. If prompted, please provide conference ID number 3753629. And once again, that is 1-866-452-7887. The conference ID is 3753629.

Once you join the audio portion or if you are already on the audio portion, please press star 1 to ask your question. Again, that's star 1 to ask a question.

Okay. Our first question comes from Ed Bolding. This question is, "Are these 11 cost measures in addition to the eight discussed in the MIPS/MACRA rule?" Thanks for the question. So, these 11 cost measures are distinct from the eight that are discussed in the proposed rule. Those eight have gone through a similar process in Wave 1 in terms of development and were then proposed by CMS in the rule. These 11 cost measures are a distinct set of measures based on the same measure development framework and based on the process that we walked through today. And they were designed in order to provide measures that could be considered for potential use in the MIPS program in the future.

We have an audio question from Kim Sweet.

Yes. Hello. For these field test reports, what I'm wondering is, are these reports going to be including the results from the episode measures as well as the TPCC capitated cost results as well as the MSPB results? And if so, does that mean that these are going to be replacing the QRUR reports as well as the QRUR table reports?

Thanks for the question. So, the field test reports for the 11 episode-based cost measures will be presented to you all in a separate file from the field test reports for MSPB and the field test reports for TPCC. So, there'll be an Excel file that has the results for the episode-based cost measures. Then there'll be a PDF file along with a CSV file that has the results for MSPB. And there'll be a separate PDF file and CSV file for TPCC. The CSV files for MSPB and TPCC are intended to provide episode-level information or beneficiary-level information that can help dig deeper into the PDF files into those measures. In terms of the QRURs, CMS is phasing out the Value Modifier Program, and so in the future, those measures won't be reported for the Value Modifier Program.

We have an audio question from David Richardson.

Yes. Good morning. So, we're preparing for reporting for the 2018 year. So how should we use these cost measure field test reports? Is it preparation for changes to the program? Just looking to see how I should be using some of my analysis with the MIPS program.

Thanks for the question. So, these field test reports are intended to provide us feedback on the measure specifications for these 11 measures, and so they could certainly be used to kind of give you an indication of ways that episode-based cost measures are constructed and elements to keep in mind for the future, but I would say that the biggest use of these is actually information that will come back to us, where if you take a look at the field test reports, look at aspects of the measure specification that make sense, that don't make sense, look at aspects of the documentation that make sense and don't make sense and provide comments on those, we can make adjustments to the measures at this stage, and we can also make adjustments to the types of supplemental documentation so that the types of both the measure construction and the type of documentation that you all see in the future in MIPS can be as useful as possible.

Thank you.

We have a follow-up question from Kim Sweet.

Thank you very much. My question, I guess, is, when we submit to the Survey Monkey and tell what we think about these reports or have questions, these explanations are not really clear on the PDF or for the Excel of the information that we're looking at. So, can we ask questions? And will we be provided answers as to what some of these things are? For example, on the PDF report for the TPCC, Table 2, it has a line there that says "carrier," and there's no definition as to what is meant by "carrier." Does that mean carrier for Medicare Part A and B? Or does that mean all carriers? So again, my question is, will we be able to ask such questions, and will we get a response back as to -- or an answer to our questions? Does that make sense?

It does. Thanks. So, I would encourage you to ask a question such as this early on in the process by submitting questions to the help desk. The address is qpp@cms.hhs.gov. That's an address that's monitored by several different groups in order to be able to questions such as yours because as much as possible, it'd be great to be able to answer questions like that while you have a chance to review the report so that by the time you submit the survey, you'll have an understanding of any sorts of issues like that, where that's been clarified and you're able to kind of focus on the specifics of the measure specifications in your survey responses. The other thing --

So, you're anticipating that the QPP help desk is going to understand these reports as well? That's your anticipation?

That's right, and so they'll forward questions sent to this e-mail address to the appropriate parties to get you answers to them as soon as we can. The other point that will be extremely useful in interpreting the field test reports and the underlying measure specifications will be the measure methodology documents and the codes list that are posted online.

Okay. Thank you very much.

All right. Sure.

There are no additional audio questions at this time.

Oh, I should note that just in order to save you an e-mail to the QPP help desk, the term "carrier" refers to Part B physician/supplier claims. So, there are folks that'll refer to that as Part B carrier claims, and others will call that Part B physician/supplier claims.

Okay. Our next question comes from Maria Mazzoccoli. "What would cause me to receive a TPCC report but not an MSPB or EBCM for our TIN?"

Thanks for the question. So, it's possible for a TIN or TIN/NPI to receive just a report for one of these measures or a subset of these measures and not the others, and so in this case of receiving a TPCC report but not an MSPB or EBCM for the TIN, what this suggests is that the TIN has sufficient number of beneficiaries to pass the 20 beneficiaries threshold in order to receive a TPCC report. So, these are 20 beneficiaries who meet all of the measure criteria for TPCC. So, that includes criteria that eliminate beneficiaries from consideration due to the specific items that are listed in the TPCC methodology document. Analogously, if the TIN did not have enough attributed cases for acute inpatient hospital admissions for MSPB -- and by enough, we mean 35 of those cases -- then the TIN will not receive an MSPB report. And it's possible that the TIN has seen, let's say, 50 cases of acute inpatient hospital admissions but that, let's say, 20 of those cases are not cases where the beneficiary has sufficient history in Medicare Fee for Service in order to be able to risk adjust properly for the beneficiary. In that case, the beneficiary inclusion and exclusion criteria will remove those 20 cases, bringing the TIN down to just 30 cases and under the episode case minimum of 35, and in that case, the TIN would not get an MSPB report. And analogous considerations are true for the EBCMs. For each of those, the case minimum is 10. If it's the case that the TIN doesn't have enough of a particular procedure for a particular acute inpatient medical condition after applying these criteria for beneficiary exclusion and inclusion, like

the one I mentioned as an example, then the TIN would not receive an EBCM report.

We have a follow-up question from Kim Sweet.

Thank you. This is great. I get to ask a lot of questions. [Laughs] My next question -- this will be my final one -- is, on the TPCC report, PDF report, some of the tables, our specialist says by the result -- excuse me -- was state information. And what I'm wondering is, with the state information, if a patient has costs in multiple states, is that going to be included in the state information? Or for this provider, will the information just be strictly the state that they practice in? Does that make sense?

It does. That's a great question. So, the state is defined by where the clinician or clinician group does the plurality of their Part B costs. And so, it could be the case that a beneficiary gets care in multiple states, but the state information there in the tables is defined by where the clinician is doing the predominant amount of their practice.

Great. Thank you very much.

There are no additional audio questions at this time.

Okay. Our next question comes from Barbara Mulik. Is there a list of providers that will be excluded from TPCC? Example -- interventional radiologists?

Thanks for the question. So, the Measure Methodology document for TPCC provides an overview of the types of providers that'll be excluded from attribution for the measure based on the criteria that we talked about in the presentation. To give one example from the presentation, this would be whether you have a suspicious amount of major surgeries. So, the idea here is that if we look at your billing, you bill for major surgeries, by definition provided in the methodology document, and for a given beneficiary who you have a candidate attributable events list, for at least a fraction of those beneficiaries, a certain percentage of those beneficiaries you've provided a major surgery for them, then you would be excluded from attribution in TPCC. So, that's the case for major surgeries, and that's to address stakeholder comments related to attribution in TPCC, to surgeons who may have been billing primary care E&Ms primarily for initial consultation or follow-up that falls outside of the global claim. There are other types of exclusions like this that are listed in the Methodology document with details that are provided in the overall files. The other types of exclusions have to do with those providing, for instance, chemotherapy for patients. At the same time, we do not have a list of HCFA specialties specifically that are excluded from TPCC. The reason for this is that in past experience with data on HCFA specialties that's reported by the clinicians themselves, there's possibilities for specialty designations to actually change over time in manners that aren't recorded in the self-reported specialty designations, and so as much as possible, our focus has been on excluding providers based on the types of claims that they're billing rather than the self-reported specialty that they have. For that, we then would be -- don't have a list of HCFA specialties that are included, but instead have a list of providers that are excluded if they bill certain patterns of services that indicate that they're not performing primary care for a beneficiary.

Our next question comes from Amy Bullen. She asks, "Is there a benefit to participating in this if we probably will not be considered part of the primary care area of the 11 measures since we are radiologists?"

Thanks for the question. It depends on the type of practice that your TIN conducts and if it's possible that the type of practice would be attributed measures according to the attribution roles that are listed in the Methodology document, so very briefly, for the episode-based cost measures, for procedural measures, it's whether or not the particular surgery or procedure was performed. For acute inpatient medical condition measures, it's whether or not E&M claims were billed during these medical DRGs in a sufficient manner. For MSPB it's again whether you've done the core procedure during the hospital stay for surgical DRGs, or for medical DRGs, whether a sufficient number of E&Ms were billed. And then for TPCC, it's whether primary care E&Ms have been billed in combination with primary care services or successively in the nature we talked about. So, it's possible that some TINs that are exclusively radiology may not have any of these measures attributed to them, but it may be possible if any of the conditions I kind of outlined there apply to you, if the TIN contains clinicians who may satisfy any of those conditions.

And very quickly to circle back to the previous question about interventional radiology, I should have provided another example of an inclusion that's specifically targeted at therapeutic radiation. And so, it's possible that that will address a set of the clinicians that the question asker had in mind regarding interventional radiology. One other note I should add as we wait for other questions here is that the goal of our episode-based cost measure development is to develop episode-based cost measures that capture the types of costs that are under the influence of attributed clinicians based on a clear recognition of their role in patient care. And so even for clinicians who are not receiving measures in this wave, we would look forward to hearing feedback that they may have on the overall framework for measure development as well as the way the field testing reports are structured in terms of the templates and so on or how actionable the information there is because even if they're not actually receiving measures, being able to look at the mock field test reports, being able to look at the methodological documentation, and providing us information and feedback based on people's thoughts on those will help us in the development of future measures that could affect those clinicians down the road, and so that sort of feedback is also greatly appreciated, even if you're not specifically getting a confidential field test report on the Enterprise Portal.

Our next question comes from Rod Baird. For TPCC, if the initial primary care E&M occurs during the current year, what costs are included for that current year? Is it from the encounters date to the end of the year or only for the months in the subsequent year?

Thanks for the question. When there's an initial E&M claim for primary care, we look to see whether there's a primary care service such as a diagnostic test that's occurring nearby to that E&M within plus or minus three days. Or we see whether there's another primary care E&M or a primary care service from the same TIN within 90 days. If either of those conditions are true, then we start a one-year risk window from the point in time of that initial E&M. And we look at any of the months or four-week blocks that occur in that risk window that happen in the performance period. And so, if the performance period is a fiscal year for 2017, we count the costs, the risk-

adjusted costs, only for those months that are in fiscal year 2017 and in the risk window. So, months that happen after the performance period are not counted in that year's measure, and months that happen before the performance period are not counted in that year's measure.

Are there any audio questions at this time?

We have an audio question from Rod Baird.

Good afternoon. Thank you for that very informative program. Are these reports available for every group that is currently active in MIPS as a primary care group?

Thanks for that. The reports will only be available for groups that have at least 20 beneficiaries' costs attributed to them after the application of the measure inclusion and exclusion criteria. So, for instance, if there is a group that focuses on primary care, but most of their beneficiaries are not enrolled in Medicare Fee for Service, so that they don't pass the 20-beneficiary threshold for counting in the TPCC measure, in that case, that group may not receive a field test report. At the same time, we would appreciate any feedback that groups like that would have on the TPCC measure because we understand that in the future, their patient composition may change -- maybe it's open more towards Medicare Fee for Service beneficiaries, in which case, in the future, they may receive a TPCC measure, and so hearing their feedback now would be great, and the way to do that would be to look at the mock field test reports for TPCC to provide feedback that way. But the measure is focused on Medicare Fee for Service beneficiaries, and so it's possible that there are primary care practicing groups that don't have sufficient beneficiaries that...more than 20 beneficiaries that meet the Fee for Service requirements or other requirements in the measure, and so won't get a field test report.

Would it be possible to repost the instructions for getting those field test reports if you are certain you are in the group who would have them? Because we manage several groups, and they couldn't find them.

We can definitely send you in the chat box information on where to go. In the slides, here, there's information on places where you can get user guides to access the reports, and if the user guides aren't helpful or for some reason that you're not able to find the reports by following the instructions there, please do e-mail the address you see here on the screen.

Thank you.

There are no additional audio questions at this time.

Okay. It looks as though we are just about out of time here. So, that will conclude the Q&A portion of the webinar. Sri, you may now close the call.

Thanks, everyone, for attending the webinar, and I hope that you're able to get the word out to your contacts in various specialty societies or your organizations. We're excited about the field testing process. It's something that we really benefited a lot from in Wave 1 of the measures for the eight

episode-based cost measures that were proposed, and we're looking forward to that sort of feedback again to make refinements to these Wave 2 measures,

which include the re-evaluated MSPB and TPCC measures. So, thanks for attending, and we look forward to hearing from you all.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.