MIPS Cost Performance Category in 2019 (Year 3) Webinar
Tuesday, March 12, 2019

Hello, everyone. Thank you for joining today's MIPS Cost Performance Category in 2019 (Year 3) Webinar. The purpose of this webinar is to provide information about the Merit-based Incentive Payment System, MIPS, Cost performance category for Year 3(2019) of the Quality Payment Program. The presentation will be followed by a Q&A session, where attendees will have the opportunity to ask questions. Now I will turn it over Adam Richards, Health Insurance Specialist in the Center for Clinical Standards and Quality at CMS. Please go ahead.

All right, great. Thank you. And hello, everyone. Thank you for joining us for today's call to learn about and really discuss the Cost performance category under the Merit-based Incentive Payment System. And this is for the 2019 performance year. And we've heard from many of you that you're really seeking additional information on the Cost performance category webinar and that that information will go a long way in helping each of you prepare for the 2019 performance year. I think we have a very rich discussion planned for you today, where we'll focus on a variety of topics that you have all flagged or us as priority areas. And we'll talk about those topics in just a moment as part of our introduction. But I will say, you know, one of our primary goals for today is to make sure that each of you walk away feeling a little bit better about this performance category. You know, we have all of our cost subject matter experts with us -- many in the room, many online. And they'll all be attempting to answer your questions within the chat, as well as on the phone lines toward the end of our discussion today. So, if you do get an answer on this platform, using the chat box, it's likely from one of our subject matter experts. Two housekeeping items before we get started. We are not going to deep-dive into the general MIPS program requirements today. We'll gloss over a few key elements in the next few moments, but our focus really is on the Cost performance category. We highly recommend that you review our slide deck recording from our MIPS 101 webinar that we hosted about two weeks ago, if you are interested in the MIPS pathway in general. There's a lot of valuable content within that slide deck that will really help you get started for 2019. I know many folks also associate Quality and Cost together, so if you're interested in learning more about the Quality performance category, that webinar is also posted on qpp.cms.gov, in our webinar library. I highly encourage you to check out those two resources, if you're interested in deep-diving a bit. The other item I just want to flag for you. I always start our webinars off by saying, you know, and encouraging you to sign up for our Quality Payment Program listserv. It's a simple process. You just visit qpp.cms.gov, scroll to the bottom of the page, and enter your email. Really, that minute or two that it takes you will provide you with valuable updates. It will let you know when all of our future webinars are planned. It's really a great resource to stay connected with us on all things Quality Payment Program. In fact, yesterday, we had released several resources related to our facility-based measurement, facility-based preview, some information on Promoting Interoperability, and more. And all of that was announced through the Quality Payment Program listserv. If those topics are of interest to you and you haven't signed up for the listserv, highly recommend you do so, so you don't miss anything else in the future. So please sign up. All right, charging forward. Just to talk a little bit about our topics for today. I think we've got a really rich discussion here. We'll start with our normal quick overview of MIPS for Year 3, just going through some of the basics. Then we'll jump into the overview of the Cost performance category, really talking about the 2019

cost measures, diving into a bit on the Medicare spending for beneficiary, the Total Per Capita cost measures, and the eight episode-based measures. Again, just kind of walking through some of that information. We'll talk about scoring the Cost performance category at a high level, as well as just give you some pointers on how you can really prepare for costs in 2019, which I think are very helpful. We'll also end, then, as we normally do, with an overview of our resources and where you can find additional help and support, whether it's specific to the Cost performance category or if you're interested in just more general supports in participating in the Quality Payment Program in 2019. Charging on to the next slide to really kick things off and walk through our overview of the Quality Payment Program. Our discussion always centers around this similar starting point, which is the makeup, if you will, of the Quality Payment Program. And I think it's helpful for those who are newer to the program to understand the program's general structure. We are required, based on the Medicare Access and CHIP Reauthorization Act of 2015, to implement the Quality Payment Program, which consists of, really, two pathways by which clinicians may participate. We have the Merit-based Incentive Payment System, which we'll talk a little bit about today. We also have the Advanced Alternative Payment Models for clinicians who are interested in earning additional incentives for taking on additional risk related to patient outcomes. There will not be a major focus on the Advanced APM side of the program today. I think it was last week or two weeks ago -- we did have an APMs 101 webinar that I thought was very helpful in walking through just the general understanding of alternative payment models, as well as the Advanced Alternative Payment Model pathway of the Quality Payment Program. If you are interested in APMs, highly recommend checking out that recording, as well. Again, that is on our webinar library page on qpp.cms.gov. Okay, moving into the MIPS portion of our discussion to really get this webinar started. Just to talk a little bit about the background behind MIPS. It's very possible that many of you on the line are quite familiar with what we called our legacy programs, which are listed on the screen. We had the Physician Quality Reporting System, or PQRS, Value-Based Payment Modifier, as well as the Medicare EHR Incentive Program, which really focused on the use of CEHRT. Under the Quality Payment Program, we've combined elements of all three of those previous programs into what we know as MIPS and what we're talking about today. Yet, even though those programs have sunset, I believe that there are a number of similarities that you'll notice within the current MIPS performance categories. For example, you know, the Quality performance category is very similar to PQRS. Cost, which we're going to talk about today, has similarities to the Value-Based Modifier program. And, as I mentioned earlier, with Medicare EHR Incentive Program, that was focused on the use of CEHRT, which is very closely aligned to our Promoting Interoperability performance category. I think having some of that experience will certainly be advantageous to our newer clinician types, but also for those who are familiar with the program. Regardless, we do have plenty of help and support out there that is available to you as you kind of navigate the program in 2019. Moving on to the next slide, just to talk a little bit about the performance categories. Again, won't go into too much detail here. But, as you can see, MIPS is comprised of four performance categories, all of which add up to 100 final points. I always like to call this out, because we will assign a final score to each eligible clinician, and that final score can range from 0 to 100 points. Of course, that final score is compared to what we call a performance threshold, which is essentially the minimum amount of points that a clinician must receive in order to avoid a negative payment adjustment. Comparing the final score to that performance threshold will determine if a clinician receives a positive, negative, or neutral payment adjustment. And since we're talking

about the 2019 performance year, that relates to the 2021 payment year. You may be asking yourself, "Well, why is that 2021?" If we -- Well, in just a moment, when we get to the next slide, we'll talk a little bit about this cycle from MIPS, which I think will help to convey that point. Before we get there, I'm going to jump to the next slide, just to talk a little bit about eligibility. I know we get a number of questions here. When we determine eligibility for clinicians who are included in MIPS, we have a general starting point -- two general starting points, really. First, we look to see if you are considered a MIPS eligible clinician type for a given performance year. For 2019, we have physicians, physician assistance, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. Those clinician types have not changed from the first two performance years, the 2017 and 2018 performance years. What we've added for 2019 includes clinical psychologists, physical therapists, occupational therapists, audiologists, speech language pathologists, registered dieticians or nutritional professionals, or groups that contain such clinicians. If you are one of those clinician types, that's the starting point. We then move on to the next slide, which is kind of our second point, and we determine whether if you, as a MIPS eligible clinician, have enough volume to participate for the performance year. We do that by comparing you to what we call the low-volume threshold. What we do is we conduct determination periods, MIPS determination periods, where we'll look to see if you, as a MIPS eligible clinicians, exceed the criteria that we have listed on-screen. You would have to bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule. You would also have to furnish covered professional services to more than 200 Medicare beneficiaries. And -- and this is new for 2019 -- you would have to provide more than 200 covered professional services under the physician fee schedule. You need all three of those elements, while being a MIPS eligible clinician type, to be included for the performance year. Again, as you can see kind of "So What?" behind this to really explain this a little more, if you exceed all three of those criterion, you are included in MIPS and are required to participate by submitting performance data. If you do not exceed those three criterion, you are generally excluded from MIPS. We do have some new options for 2019. It's called the opt-in policy that allows you to opt in to the program if you are excluded. There's a really great fact sheet that we just put out on to the resource library yesterday that focuses on opt in. So highly recommend checking that out if this is something that interests you. Let's move on to the next slide, and then I promise I will stop talking. This is getting back to what I mentioned earlier, just talking a little bit about the timeline for the Merit-based Incentive Payment System and, really, the Quality Payment Program in general. Right now, for 2019, we are in the performance period aspect of the performance year, so clinicians are, you know, educating themselves on the requirements, collecting data, seeing patients, so on and so forth. We then move into the submission period, which will begin and open up next January, and that will run through March of 2020. So that's our submission time frame for the 2019 performance year. After clinicians submit data to us, we will provide feedback, we'll score that data, and, ultimately, we will come up with a payment adjustment for clinicians based on their performance. And that payment adjustment will be applied beginning in 2021, based on the 2019 performance year. I'm going to end there. That's our overview of MIPS. And I think it's now a good segue to jump into the Cost performance category, so it's my pleasure to introduce Joel Andress to talk us through Cost at a high level.

Thank you, Richard. I appreciate that. Good afternoon, ladies and gentlemen. Thank you for joining us this afternoon. My name is Joel Andress. I am the cost measure lead for MIPS here at CMS. As Richard has indicated, we'll be talking about the 2019 Cost performance category next, covering not only how the category works, but also the measures that now populate the category for 2019 and how the scoring will be assessed in this year. The Cost category will comprise 15% of your score in 2019. As before, there are no reporting requirements for this category. We'll note that a couple of times in this presentation, because it's important to take note. You are not required to report any data other than what you already report through claims. The measures are calculated here at CMS using the data that we receive through the claims process, and so there's no additional reporting burden associated with the Cost performance category. As with past years -- or as with last year, I should say, we will be assessing you on the Medicare Spending Per Beneficiary measure and the Total Per Capita Cost measure. All right, for 2019, we will also be adding eight episode-based measures that we'll be discussing in greater detail further down the presentation. Next slide, please. Thank you. For 2019 performance year, MIPS uses cost measures that assess the beneficiary's cost of care during the year and/or an episode of care. These measures are evaluated at either the NPI or TIN levels, depending on whether you are reporting data as an individual or as part of a group. Next slide, please. The eight new episode-based measures are each associated with a series of acute episodes of care, either medical condition treatment or procedural episodes. They're designed with extensive clinician and patient input and more narrowly defined as a series of costs that are broader than SPV and TPCC measures. In short, they are intended to capture a much narrower scale of costs that are more specific to particular clinicians within the program. Next slide, please. There are certain features that apply to the MSPB, TPCC, and the episode-based cost measures in common. We'll discuss a few of those first and then we'll go into what differentiates these measures in greater detail following that. First, payment standardization. All costs that are assessed within these measures are standardized to preserve differences that result from care delivery choices, while excluding differences resulting from geographic location and excluding payment adjustments that are the result of special Medicare programs. The purpose of this is to ensure that we have an even playing field in assessing the costs for each provider. Secondly, benchmarks. For each measure, we establish a single national benchmark that's based upon the period of performance, rather than a historical baseline. And these benchmarks are the point of comparison that allows us to score the cost measures for this category. And then the attribution of beneficiaries and their costs to clinicians. Under MIPS, CMS will attribute cost measures at both the TIN/NPI and TIN level. That means we recognize how you're reporting, elsewhere, your data for the program and, likewise, the attribution of patients, as well as the attribution of cost will comport with that. Next slide, please. Thank you. We'll start our discussion with the MSPB measure. This measure should be somewhat familiar to the audience, because we used it in last year's program. However, to briefly cover this, the MSPB assesses both Part A and B spending associated with each acute-care episode, while comparing observed costs to expected costs. The purpose of this is to allow us to look at costs associated with hospitalizations and then compare the performance of costs in one episode against what we expect to see from episodes being treated by the average clinician. An MSPB episode includes all Part A and B claims with start dates within the episode window. That window begins three days before the index admission, or the triggering admission, that starts an episode and extends to 30 days past the discharge of the patient from that hospitalization. And so, you incorporate some costs

that go beyond the actual hospital stay itself. Next slide, please. Thank you. Here, you can see the formula for calculating the performance for both individual clinicians and groups. As you can see, the numerator is comprised of the sum of the ratios of payments standardized across for all MSPB episodes attributed to an individual clinician's TIN/NPI. And what that means is that we take the ratio for each individual episode, sum them together, and multiply that by the national average. And we divide that, then, by the total number of MSPB episodes to provide us with a score for that particular clinician. This works similarly for the measure at the group level, except that the episodes for which we are summing the ratios include all episodes attributable to every TIN/NPI within the group's TIN. And, again, the denominator is, likewise, a combination of all episodes attributed to the individual clinicians that operate under that group's TIN. Next slide, please. So, up in counts for costs in the MSPB measure. All Medicare Part A and B claims for items and services provided during the episode window are included in an MSPB episode. That includes claims from the inpatient hospital, the outpatient, skilled nursing facility, home health agency, hospice care, durable medical equipment, prosthetics, orthotics, and supplies, and non-institutional physician and supplier claims. Next slide, please. Next, we're going to look at the attribution for the MSPB measure. We attribute each hospitalization episode to the clinicians who provided the most Part B physician/supplier services between the period of the admission and discharge of the hospitalization. In the event that there is a tie, the episode instead will be attributed to the clinician with the most Part B services bill lines. In those cases where there is also a tie in the count of service bill lines, then the episode is randomly attributed to one of those clinicians. CMS attributes the MSPB episodes at the individual clinician level via the clinician's unique TIN-NPI. And for groups of clinicians who are participating in MIPS, a single measure score will be calculated for and assigned to the group, based on combined data for the entire group. Next slide, please. To determine the clinician who provided the most Part B physician/supplier services, CMS considers the following Part B service billed by MIPS eligible clinicians. Part B services provided on the admission date and in a hospital setting with a place of service restricted to hospital inpatient, outpatient, or emergency room. Part B services provided during the index hospital stay, regardless of place of service. And Part B services provided on the discharge date with a place of service restricted to the inpatient hospital. Next slide, please. As in prior years, we provide a case minimum for the MSPB. For this measure, you must have at least 35 episodes attributed to the clinician or the group in order to be scored on the MSPB measure. If you don't meet that minimum, then you will not be scored on the MSPB measure. We'll talk about that implications that has for scoring later on in the presentation. You will also not be scored on the MSPB measure if you did not bill Part B services in hospital stays during the performance period, so the calendar year 2019 for Year 3. Next slide, please. Thank you. Now we'll turn to the other measure that is carrying over from Year 2, the Total Per Capita Cost, or TPCC measure. CMS uses the Total Per Capita Cost for all attributed beneficiaries in order to assess total Medicare Part A and Part B costs for a beneficiary during the performance period by calculating the adjusted risk, per capita costs for beneficiaries attributed to the individual clinician or group of clinicians. This is in contrast to the MSPB, which focuses on costs associated with hospitalizations, rather than TPCC focused on primary care offered to patients. The measure is calculated and expressed by CMS at either the TIN or TIN-NPI level. The numerator is a sum of the Part A and B costs incurred by all beneficiaries attributed to an individual MIPS clinician or group that has been annualized, risk-adjusted, and

specialty-adjusted. This is, again, as with the MSPB measure, to ensure that we have a level playing field in terms of the attribution of costs to the clinicians for whom these patients are attributed. The denominator is the number of Medicare beneficiaries who are attributed to an individual MIPS clinician's TIN/NPI or in the case of group TIN during the performance period. Next slide, please. Thank you. Right. So, we have a specific series of steps for calculating the TPCC measure, beginning with the attribution of beneficiaries to TIN/NPIs. We then calculate the payment standardized per capita costs, annualize those costs for partial year enrolled Medicare beneficiaries included in the measure. In short, that allows us to account for patients who are not enrolled in Medicare for the entirety of the year. We then risk-adjust the costs based on patient risk factors. We provide specialty adjustments to the costs to reflect the fact that costs are different for different clinical specialties. And then we calculate the TPCC measure for either the TIN/NPI or TIN, as is appropriate. And then we will report that measure through the program. Next slide, please. Thank you. Beneficiaries are attributed to a single TIN/NPI based on the amount of primary care services the beneficiary received and the clinician specialties that performed those services during the performance period. Only beneficiaries who received a primary care service during the performance period can be attributed to a TIN/NPI. And the beneficiary is attributed to a single TIN/NPI or to a single entity's CMS Certification Number assigned to either a Federally Qualified Health Center or Rural Health Clinic in one of two steps. It's important to note that in the event that they're assigned to either a Federally Qualified Health Center or a Rural Health Clinic, in that case, the patient will be excluded from the measure, as well as from the risk adjustment. And so, they would not be a part of the assessment used for the MIPS program. Next slide, please. Thank you. The Total Per Capita cost measure continues to use a two-step attribution process with which you may be familiar. It first identifies whether or not the beneficiary received any primary care services from a PCP, nurse practitioner, physician assistant, or a CNS. If the answer is yes, then the beneficiary is attributed to the TIN/NPI that provided more allowed charges for primary care services than any other TIN/NPI. If the answer is no, a second question is asked, regarding whether the beneficiary received any primary care services from a specialist physician. In the event that the answer is yes, the beneficiary is then attributed to the TIN/NPI of the specialist physician that provided more allowed charges for primary care services than any other TIN/NPI. If the answer is no, then the beneficiary is not attributed to any TIN/NPI and falls out of the measure. Next slide, please. As with the MSPB measure, a minimum number of beneficiaries must be attributed to the TIN/NPI or TIN in order to receive scoring within the MIPS program. This minimum is the same for both the TIN/NPI and TIN requiring, 20 beneficiaries to be attributed before we will score them. MIPS eligible clinicians and groups with 19 or fewer beneficiaries attributed won't be scored on the TPCC measure. And, as with the MSPB measure, we'll talk about the implications for that later on in the presentation. Next slide, please. Now that we've discussed the two measures that are carried over from the previous year, we'll be talking about the eight measures, the episode-based cost measures, that are being introduced to the program for the first time in 2019. The episode-based cost measures represent the cost to Medicare for items and services furnished to patients during an episode of care or, as we've termed here, an episode. These measures are intended to inform clinicians on the cost of care for an episode during which the manage the care for an acute inpatient medical condition or perform a procedure, with the goal being to ensure that we incentivize high-value care that is patient-centered. It's important to note that these are distinguished from

the TPCC and the MSPB measure, in that they only include items and services related to the episode for a clinical condition or procedure that are within the reasonable influence of the attributed clinician, as opposed to all services that are provided to a patient over a given time frame. Next slide, please. Here, you can see a graphic demonstration of the calculation of these measures. The numerator is the sum of the ratio of the observed to expected payment standardized cost for all episodes attributed to a clinician, and again, dependent upon which episode measure you're considering. This is then divided by the total number of episodes attributed to the clinician and then multiplied by a national average. And this provides you with the performance rate on the measure. Next slide, please. In order to calculate episode-based cost measures, we make use of Medicare Parts A and B fee-for-service claims, based on the definition for episode groups. Episode groups were designed to represent a clinically cohesive set of medical services rendered to treat a given medical condition. They are intended to combine all items and services provided for a patient to assess the cost of care within the clinician's influence and are defined around treatment for a condition or performance of a procedure. Next slide, please. Okay, I just want to clarify. We're seeing Slide 28 on the presentation. I want to clarify that we're now moving to Slide 30. All right. The episode-based cost measures in the 2019 performance period are based on two types of episode groups that we've already mentioned briefly here. The first are procedural episode groups, which focus on procedures for defined purpose or type, such as surgeries. The second group are acute inpatient medical condition episode groups, representing treatment for self-limited acute illness or treatment for flares. To be assessed on episode-based measures, you are again required to meet a specific case minimum, but it varies by the type of episode group. 10 episodes are required for procedural measures, while 20 episodes are required to receive a score for acute inpatient medical condition measures. And move to the next slide, Slide 31, please. On this slide, you can see the list of measures, episode-based cost measures, that were implemented for Year 3 of the MIPS program. More detailed specifications and information are available through links provided later on in this slide deck. You'll have the opportunity to review those at your leisure. And, of course, we welcome any questions regarding those measures once you've had a chance to do so. Next slide, please. We'll turn to attribution, which, again, works a little bit differently for these measures than it does for the MSPB and TPCC measures. In the case of procedural episode groups, these are fairly straight -- or I should say relatively straightforward, in that they are attributed to each MIPS eligible clinician who renders the trigger service. So, in the case of a surgery, it would be the clinician or the surgeon who performed the procedure. For acute inpatient medical condition episode groups, however, episodes are attributed to each eligible clinician who bills inpatient evaluation and management claim lines during a trigger inpatient hospitalization or under a TIN that renders at least 30% of the inpatient E&M claim lines in that hospitalization. Also note this does allow for overlapping episodes. We don't exclude overlapping episodes. And, so, if a patient already qualified for one episode, we allow that to continue as a separate episode that's independently assessed for Cost, since allowing for overlapping episodes incentivizes communication and care coordination as a patient progresses through the care continuum. As an example of this, if a patient is re-hospitalized for pneumonia after an initial episode, this would trigger two separate episodes of care for pneumonia, and costs would be assessed independently for each. Next slide, please. This will be a brief part. We'll turn next, on the next slide, to the Cost reporting requirements for the Cost category. As mentioned before, there are no additional reporting

requirements. You need merely to continue submitting your claims data as you do normally. CMS will be making use, in the 2019 year, of Medicare Part A and B claims, with dates of service from January 1, 2019, to the December 31, 2019, in order to calculate the Cost performance category score. Next slide, please. And now we'll turn to the Cost performance category scoring. Next slide. In order for a cost measure to be scored, as we've noted going through each one of the individual measures, an individual clinician or a group must have enough attributed cases to meet or exceed the case minimum associated with that measure. Now, what this means is that you will only be scored on measures where you meet this case minimum. And so, if there are measures for which you do not meet the minimum requirement, those measures will be dropped out of the scoring process, so will not contribute either to your numerator or denominator while scoring. In the event that you are not scored on any of the measures, the weight of the Cost performance category will be redistributed to the Quality performance category and your score will be assessed as normal from there. Next slide, please. In order to calculate the Cost performance category score, we will assign 1 to 10 achievement points to each scored measure based upon the group's performance on the measure compared to the performance period benchmark. I should say the clinician or group's performance. As a result, the achievement points assigned for each measure depends on which decile range you or your group's performance on the measure is in between. Note the Cost performance category percent score will not include improvement scoring for this year or, indeed, until the 2022 MIPS performance period. Next slide, please. Here, you can see an example of scoring for the individual measures. As you will see, for those measures for which you are not scored, you will see no contribution either to the points that are earned or to the total possible points that could be achieved. Meanwhile, you will receive scores based on your performance compared to the benchmark for each individual measure. And these will be summed together for your total score. You will then divide the number of points that you've achieved by the number of points that were possible to arrive at a percentage score, which is then multiplied by the weight of the performance category. Because Cost is worth 15 points, you'll then multiply it by .15, and that will get you the total score for -- your percentage by the .15, and that will get you your total score for the Cost performance category. Next slide, please. Thank you. Let's see. If you don't meet the case minimums to be scored on any of the cost measures, as we mentioned, your score will be redistributed to Quality, which will bring the Quality score up to 60%. We will automatically reweight the Cost performance category for MIPS eligible clinicians who are located in the CMS designated regional locale that has been affected by extreme or uncontrollable circumstances. If a MIPS eligible clinician is located in an affected area, we will assume the clinician does not have sufficient cost measures applicable and assign a weight of zero to the Cost performance category, which will then be redistributed to the Quality category, as normal. As an additional note, if other performance categories are re-weighted, we will not, at any point in time, redistribute that weight to the Cost performance category. Your Cost performance category will always be either 15% of your score or 0% of your score in 2019. Next slide, please. So, the question then becomes, how can you get ready for the Cost category in 2019? Next slide, please. The first step is to continue submitting claims as usual. Although, we will note that certain types of claims are some of our largest drivers of cost. Those include hospitalizations, ED use, readmissions, and the use of post-acute care services. So, you should be aware of this as you're submitting your claims bills. And also, be cognizant of this as you're making treatment decisions for your patients. You don't have to submit any additional data for the Cost category. Again, it's just a continuation of

claims submission as per usual business. Next slide, please. However, simply because you are going to continue submitting claims does not mean that you shouldn't be cognizant of how those claims will have an impact on our assessment of your Cost performance. Keep in mind that as we risk adjust for patient complexity, it's important to carefully document, through the claims, patient risk factors and comorbidities that may influence our assessment of their risk, because by documenting that, you give us a better understanding of the complexity of these patients, and then we're able to more accurately assess your responsibility for the costs that are incurred as you treat them. Additionally, you want to be sure that your ICD-10 coding and other documentation thoroughly detail the clinical complexity of the diagnoses you're treating. One key issue is that if it's feasible, avoiding designations of unspecified or codes that make use of unspecified or uncomplicated designations -- it will enable us to get a more accurate read on the condition of your patients, and that means that our assessment of your responsibility for costs will likewise be enhanced. Next slide, please. We also recommend, in preparing for this year, that you go back and review last year's performance feedback. This has been provided in a number of venues. The episode-based cost measures, while they haven't been in the program previously, were made available through our field-testing reports back in October. And if you have those available to you, we certainly recommend going back and reviewing your performance on them. QRUR files, APM reports, and bundled payment reports will also provide you important information regarding your performance on the existing cost measures. Additionally, you may have been getting feedback for several years on cost measures that were included in prior programs, and reviewing these reports may also be beneficial to you. Next slide, please. As mentioned earlier, we do have a suite of resources available to you, which you can link to through this presentation, regarding, specifically, the Cost category but also regarding the detailed measure specifications and codes that are used for those measures for your perusal. We encourage you to review these and get in touch with us with any questions you may have regarding the measures or the category itself. You can do so through the QPP mailbox or through the hotline provided at the bottom of this slide. Next slide, please. With that, I'll turn it over to my colleague, Richard.

Okay.

Continue with the presentation.

All right. Thank you, Joel. Appreciate you walking us through that. I know that was a lot of information for everyone to kind of consume, so, again, we'll have an opportunity for some questions in just a few minutes. I also see there's some good questions coming in through the Q&A that our subject matter experts are trying to tackle right now. Just a couple of things. We just want to talk a little bit about help and support. As Joel mentioned, we have a lot of really great resources specific to the 2019 Cost performance category available on qpp.cms.gov. Just head on over to the resource library, and you'll be able to find all those resources. We will also post this slide deck, the recording, and transcript on our webinar page within the next week or two, so be on the lookout for that. Best way to stay up to date is by signing up for that listserv. If you haven't done so already, please do. Just some other opportunities here, if you do need support, again, whether it's related to the Cost performance category specifically, whether you need just general MIPS supports, or whether you're really starting to think about that transition to an Alternative Payment Model or an Advanced Alternative Payment Model. We really have support networks set

up for all of those different questions and all of those different scenarios. As you can see on screen, this is our technical assistance initiative. This is absolutely free to anyone who is included in the Quality Payment Program and is participating. As you can see, each one of our networks is tailored, you know, based on whether you're in a large practice, versus a small practice. We also have support that's available, as I mentioned, if you are thinking about potentially transitioning into an Alternative Payment Model or even an Advanced Alternative Payment Model. We have a great model. The Transforming Clinical Practice Initiative can help your practice prepare for that transition. If you're just looking for, you know, general support on Quality Payment Program, I highly recommend, you know, reaching out to either our Small, Underserved, or Rural Support initiative for those of you who are in small practices and need that customized support or, if you are in a large practice, reaching out to our Quality Innovation Networks. Again, all of this is free, and they all stand by right now and they're able to help you with customize solutions. Joel also mentioned leveraging the Quality Payment Program website, as well as our Quality Payment Program service center. Again, you can contact us either phone or via email, and that information is on screen, as well. Okay, so, with that, I think we're going -- I'm going take us into the Q&A portion of our discussion today. I'm going to turn it over to the operator to walk you through how you can get into the queue to ask us a question.

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 the phone, please dial 1-866-452-7887. Again, that's 1-866-452-7887. If prompted, please provide the I.D. number 9976729. Again, I.D. number 9976729. Once you join, you may press *1 to ask a question.

Okay, great. Just before we get started, I just want to let everyone know, again, we're going do our best. We have a number of our subject matter experts here to answer your questions. There may be scenarios or situations that you're experiencing where we may have to take it offline and follow up with you outside of this webinar. If, at any point, it gets silent, don't worry. We haven't lost you. We're just putting our heads together in the room and with our subject matter experts to just think through the question. With that, I'm going to check in on the phone line. Do we have any callers?

There are no questions at this time. If you would like to ask a question, please press *, then the number 1 on your telephone keypad. Again, that is *1 to ask a question.

Okay. We'll keep the phone line open. We are going to scour through the Q&A chat. Again, we're getting a lot of really good questions here. A number of these are being answered as I speak, so I'm going to try to navigate around. Let's see if we have any trending questions. We do have the names of the eight episode costs listed on our slides, on an earlier slide, and, again, we'll have that information out as a part of the slide deck and recording when we do post this. Just checking back into the phone line. Do we have any callers?

We do have a question from Sandy Swallow.

Okay, great. Hi, Sandy.

Hi. Thank you for the presentation. I would like to just ask if you know yet what the 2018 performance period feedback reports will look like, as far

as the Cost category. Will we get to see more information than what we saw in the 2017 feedback reports so that we can actually start to look a little closer at our performance? And then, a second thing on that would be -- these presentations are very helpful, but what I think would be really helpful would be if we can have some resources that showed examples, either on your presentation or as a resource guide out on the website. Thanks.

Okay, thanks, Sandy. Great on having some examples in our feature resources. That's something we can certainly take back. And we'll try to answer your first question now. I'm going to turn it to Mindy.

Hi. This is Mindy Riley. We heard, very loud and clear last year -- Even though cost was not scored last year, we provide some preliminary scoring insights, if you will, for MSPB and TPCC. And we did hear very loud from a number of clinicians and groups that they would like additional details, similar to what they've received in the QRUR. We are actively moving towards being able to provide beneficiary level detail for those cost measures, as well as the ACR measure, with the release of this summer's final feedback report.

Thank you. That will be very helpful and much appreciated, I'm sure.

Just it won't look exactly like the QRUR, but it will have a fair amount of detail, and we would like to hear your feedback as it's released.

Okay. Thank you.

And this is Steven.

That's okay. The QRUR was too confusing.

Yeah, that was one of our -- was to hopefully limit down the amount of data to give you a cleaner picture. But related to U.I. functionality, it will be relatively similar to what you experienced in Year 1. The reports will be downloadable that Mindy was mentioning, but related to the actual scoring of the measures, it will look somewhat similar. However, we have created some additional functionality pieces to hopefully give additional information on the page to assist with the scoring methodology.

Performance. Thank you, Steven and Mindy. I do just want to flag a couple of questions that we're seeing in the chat, particularly one that says -- from Susan Whitaker -- "Can you please explain how specialty adjustment works for the Total Per Capita Cost measure? And how do you define the specialty by taxonomy code?"

So, I'm going to turn to our Acumen team to take that one on.

Hi. This is Sri Nagavarapu from Acumen. Specialty is defined using self-reported specialty from the claims. People will sometimes refer to this as HCFA specialty -- H-C-F-A. The first part of the question about specialty adjustment and how that works, essentially, you can think about this as for an individual clinician. The observed cost for that clinician would be compared to the expected costs relevant to that clinician's specialty. For group practices, we recognize that there may be multiple specialties involved in a group, and so that expected cost is constructed by weighting across the different expected costs for those specialties, nationally, within that group. And the intent here is to recognize the fact that

different specialties or teams or groups with different specialties will tend to see different types of patients.

Okay. Fantastic. And I'm going keep you on the line just a for one more that I'm seeing come in here that I think you may be able to help us answer. It says, "If I understand well --" And this is from Yvonne. "If I understand well, a beneficiary's costs for hospitalization are not included in Total Per Capita Cost measure, but only primary care services are included. Why is there a claim type of inpatient reports for Total Per Capita Cost?" Can you help us answer that one?

Sure. The Total Per Capita Cost measure actually includes all Part A and B costs during the measurement period. That includes outpatient, as well as inpatient services and primary care services that are provided by physicians or other clinicians. The role with primary care services in the TPCC measure is really for attribution. Attribution occurs based on examining which clinician provides the predominant share of primary care evaluation and management claims, so primary care services during the measurement period. But all Part A and B costs are actually included in the Total Per Capita Cost measure.

Fantastic. Thank you so much. I want to check back in -- And I know we're getting closer to the top of the hour, but want to check back in on the phone line to see if we have any questions.

No additional questions at this time. If you do have a question, *1 to ask your question.

Okay. Fantastic. And, as I mentioned, we do have some questions coming in through the chat. We do have our subject matter experts working fast and furiously to answer those questions. Those were a couple that we just went over, were some of the trending questions that we saw. Again, I do want -- or I do encourage you to -- If you are interested in more information about the Cost performance category, just seeing a lot of questions on where you can find some of the specific information. That is available in a number of our resources that we have available in the Quality Payment Program resource library. A number of the Cost resources that Joel went over earlier do cover some of the more specific questions that you're having, you know, just around certain methodologies, attribution, the case minimums that Joel mentioned earlier. So, always a good resource to go over to our resource library and check out the materials on the Cost performance category. Last check in on the phone line, last call for questions.

There are no questions at this time.

Okay. Fantastic. Well, we are at the top of the hour. As I mentioned earlier, we will do our best to post the transcript, the recording, and the slide deck from today's webinar within our webinar resource library within about a week or two, so be on the lookout for that. Please sign up for the Quality Payment Program listserv, if you have not done so already. We'll be continuing to communicate different program milestones out through that listserv. It's a great resource to stay connected with us. We appreciate your time today. Thank you, everyone, so much, and we'll talk to you all again soon.

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