Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM:

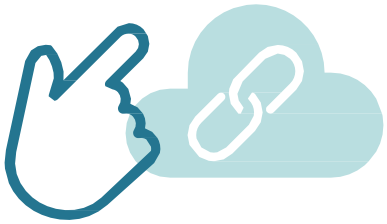
Participating in the Cost Performance Category in the 2019 Performance Year

Updated 4/27/2020

CONTENTS

*CMS is implementing multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. Refer to the **Quality Payment Program COVID-19 Response Fact Sheet** for more information.*

HOW TO USE THIS GUIDE



Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

The table of contents is interactive. Click on a chapter in the table of contents to read that section.

You can also click on the icon on the bottom left to go back to the table of contents.

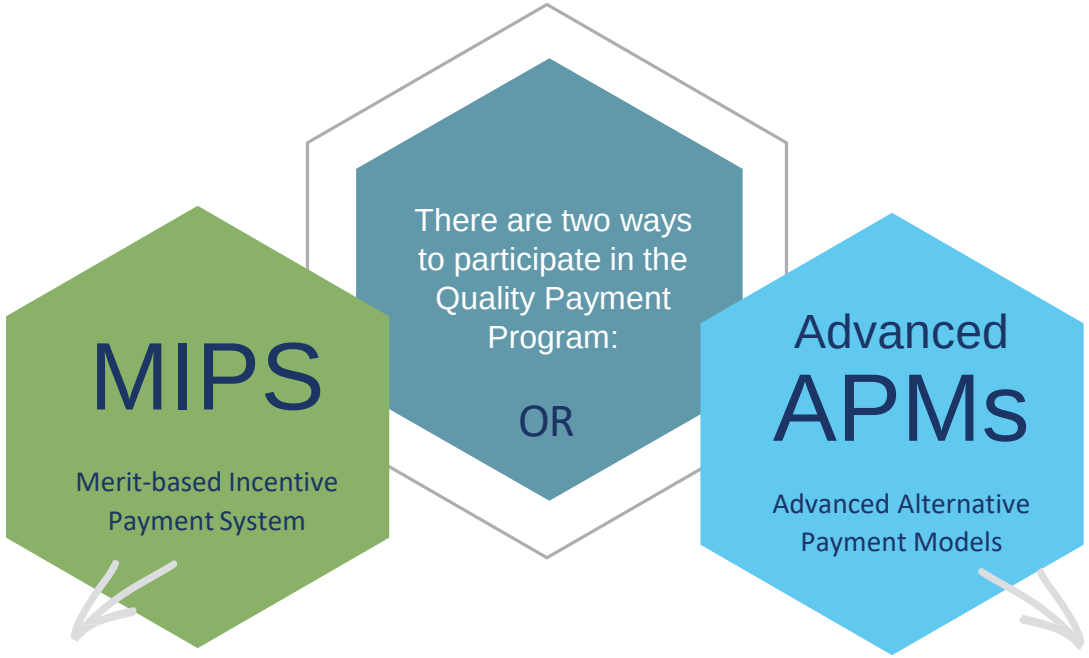
Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct the reader to more information and resources.

INTRODUCTION TO THE QUALITY PAYMENT PROGRAM

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. By law, MACRA requires CMS to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



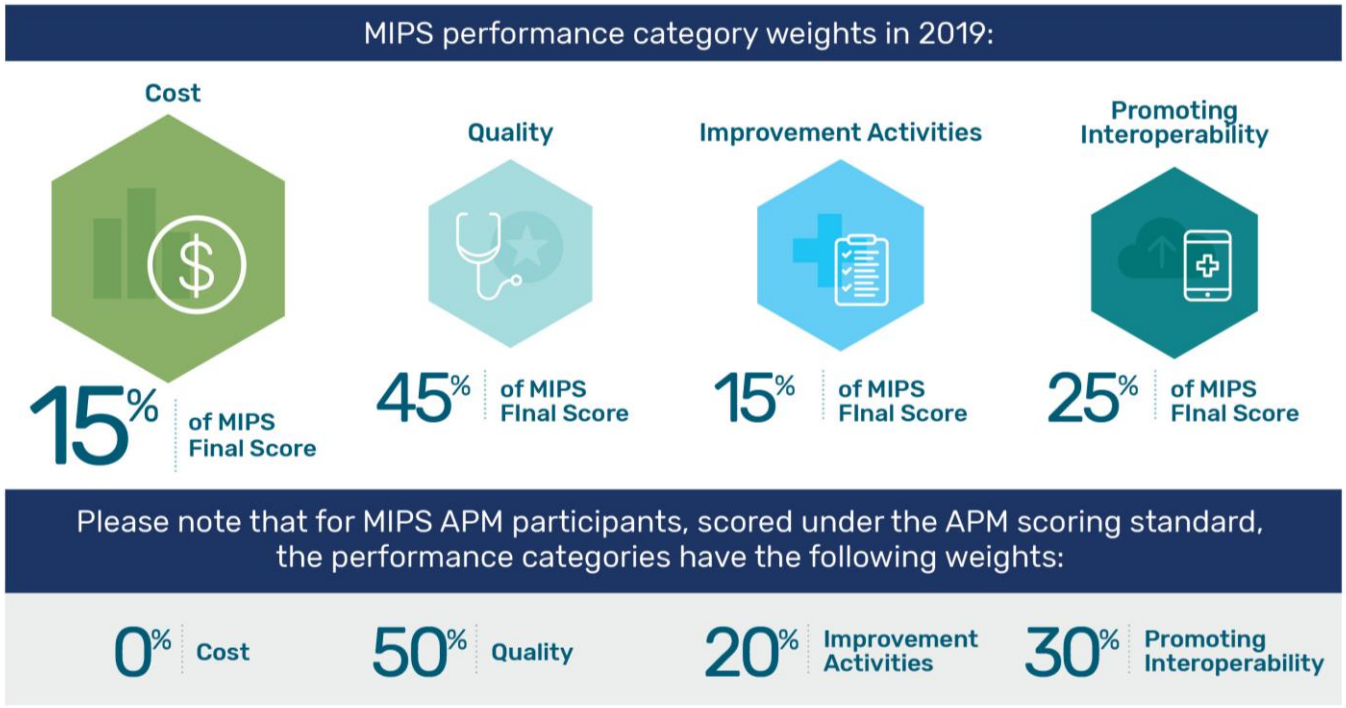
If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

MIPS OVERVIEW

What is the Merit-based Incentive Payment System (MIPS)?

There are **four** performance categories under MIPS that affect future Medicare payments. Each performance category has a specific weight, and your performance in these categories contributes to your MIPS final score.



To learn more about how to participate in MIPS:

- *Visit the MIPS Eligibility and Individual or Group Participation web pages on the Quality Payment Program website*
- *View the 2019 MIPS Participation and Eligibility Fact Sheet*
- *Check your current participation status using the QPP Participation Status Tool*

This guide focuses on the **Cost** performance category in 2019 (or "Year 3") of the Quality Payment Program.

COST BASICS

Cost Performance Category

The Cost performance category is an important part of MIPS. Although clinicians don't personally determine the price of individual services provided to Medicare beneficiaries, they can affect the amount and types of services that are provided to their patients. By better coordinating care and seeking to improve health outcomes by ensuring their patients receive the right services, clinicians play a meaningful role in delivering high quality care at a reasonable cost.

- For the **2017 performance year,** CMS didn't score the Cost performance category, so Cost performance accounted for 0% of your 2017 MIPS Final Score
- For the **2018 performance year**, the MIPS Cost performance category had a maximum score of 100 and accounted for 10% of your 2018 MIPS Final score
- For the **2019 performance year**, the MIPS Cost performance category:

Has a maximum score of 100

Accounts for 15% of your 2019 MIPS Final Score

- For the **2020** and **2021 performance years**:
  - The MIPS Cost performance category weight will be between **10%** and **30%** as established by the Bipartisan Budget Act of 2018; the Cost performance category weight is required to be 30% beginning with the 2022 performance year/2024 payment year
  - CMS will establish the MIPS Cost performance category weights for these performance years in future rulemaking

Cost Basics

CMS uses Medicare claims data to calculate cost measure performance, which means clinicians do not have to submit any data for this performance category.

A total of **10 cost measures** are used to evaluate performance in the Cost performance category in the 2019 MIPS performance year. Two of the ten measures were used to evaluate performance in the 2017 and 2018 MIPS performance years. These two measures are:

The Total Per Capita Costs for All Attributed Beneficiaries measure, or "TPCC"

AND

The Medicare Spending Per Beneficiary measure, or "MSPB."

For the MSPB measure, CMS will use Medicare Parts A and B claims for episodes with index admission discharge dates between January 1 and December 1, 2019 for the MSPB measure.

The TPCC measure assesses total Medicare Parts A and B costs for a beneficiary during the 2019 performance year by calculating the risk-adjusted, per capita costs for beneficiaries attributed to an individual clinician or group of clinicians.

Cost Basics

Beginning with the 2019 MIPS performance year, 8 episode-based measures will also be used to evaluate cost.

The 8 episode-based measures that are now included in the Cost performance category for the 2019 MIPS performance year are included in the table below.

Measure Topic	Measure Type
• Elective Outpatient Percutaneous Coronary Intervention (PCI)	• Procedural
• Knee Arthroplasty	• Procedural
• Revascularization for Lower Extremity Chronic Critical Limb Ischemia	• Procedural
• Routine Cataract Removal with Intraocular Lens (IOL) Implantation	• Procedural
• Screening/Surveillance Colonoscopy	• Procedural
• Intracranial Hemorrhage or Cerebral Infarction	• Acute inpatient medical condition
• Simple Pneumonia with Hospitalization	• Acute inpatient medical condition
• ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	• Acute inpatient medical condition

COST MEASURES

Overview of the TPCC, MSPB, and Episode-based Cost Measures

Certain features apply to the TPCC, MSPB, and episode-based measures. These include:

- **Payment Standardization—**The payments included in the TPCC, MSPB, and episode-based measures are payment-standardized (sometimes referred to as "price standardized") to preserve differences that result from health care delivery choices, exclude geographic differences, and exclude payment adjustments from special Medicare programs. Payment standardization assigns a comparable amount for the same service provided in different settings to reveal differences in spending that results only from care decisions and resources use. (More details are included in this CMS Price (Payment) Standardization—Detailed Methods document.)

The allowed amounts for Medicare services[1] can vary across geographic areas due to several factors, such as:

- Regional differences in labor costs and practice expenses
- Differences in relative price of inputs in local markets where a service is provided
- Extra payments from Medicare in medically underserved regions
- Policy-driven payment adjustments such as those for teaching hospitals

[1]Medicare fee-for-service allowed amounts include the amount of the Medicare Trust Fund payment plus any applicable beneficiary deductible and coinsurance amounts. In some cases, beneficiary deductibles and coinsurance amounts may be covered by third party payers other than Medicare.

Overview of the TPCC, MSPB, and Episode-based Cost Measures

Certain features apply to the TPCC, MSPB, and episode-based measures. These include:

- **Benchmarks**—CMS will establish a single, national benchmark for each cost measure. These benchmarks are based on the performance year, not a historical baseline period. Therefore, CMS can't publish the actual numerical benchmarks for the cost measures before the start of each performance year. All MIPS eligible clinicians that meet or exceed the case minimum for a measure are included in the same benchmark.

  The MSPB benchmark used to determine MIPS eligible clinicians' 2019 Cost performance category score will be based on 2019 claims data.

- **Attribution** of beneficiaries and their costs to clinicians. In the VM Program, cost measures were attributed to a TIN (associated with either a group practice or a solo practitioner). Under MIPS, CMS will attribute cost measures at the TIN-NPI level. Although cost measures will be attributed to individual clinicians, cost measure *performance* can be assessed by CMS at either the individual clinician level or group level.

  If you're participating in MIPS as a group and submitted data as a group for other MIPS performance categories, your Cost performance category score will be determined by aggregating the scores of the individual clinicians within the TIN. However, the method used to attribute beneficiary costs to MIPS eligible clinicians at the TIN-NPI level differs for each measure.

- **Risk Adjustment** accounts for patient characteristics that can influence spending and are outside of clinicians' control, such as clinical risk factors. All measures included in the Cost performance category are adjusted for clinical risk. However, the specific methodology used to risk adjust each measure varies. Methodological detail can be found in each measure's specification documents. Risk adjustment should not be confused with the complex patient bonus, which is applied at the final score level and adjusts again for patient clinical complexity as well as some elements of social complexity.

Medicare Spending Per Beneficiary (MSPB) Overview

The MSPB measure assesses total Medicare Part A and Part B costs incurred by a single beneficiary immediately prior to, during, and 30 days following a qualifying inpatient hospital stay and compares these observed costs to expected costs.

Expected costs are based on the clinical condition or procedure that triggers the episode along with other factors that may influence cost, but are not directly related to patient care.

An MSPB episode includes all Medicare Part A and B claims with start dates within the episode window—the period of time beginning **3 days before an index admission through 30 days** after hospital discharge.

An index admission is the admission with a principal diagnosis of a specified condition that meets the inclusion and exclusion criteria for the measure.

All Medicare Parts A and B claims for items and services provided during the episode window are included in an MSPB episode, including the following claim types:

- *Inpatient hospital*
- *Outpatient*
- *Skilled nursing facility*
- *Home health*
- *Hospice*
- *Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)*
- *Non-institutional physician/supplier claims (Medicare Part B Carrier claims)*

MSPB Attribution

CMS “attributes” each MSPB episode to a single MIPS eligible clinician (identified by a single TIN-NPI) who billed the largest amount of Medicare Part B claims—measured by the dollar amount of Medicare-allowed charges—during the period between the index admission date and the discharge date.

In the case of a tie, an episode will be attributed to the clinician with the most Part B services bill lines. If multiple clinicians have the same count of service bill lines, the episode is then randomly attributed.

As noted above, CMS attributes MSPB episodes at the individual clinician level via clinicians’ unique TIN-NPI. However, for groups of clinicians who are participating in MIPS as a group, a single measure score will be calculated for and assigned to the group, based on combined data.

To determine the clinician who provided the most Part B physician/supplier services, CMS considers the following Part B services billed by MIPS eligible clinicians:

- *Part B services provided on the admission date and in a hospital setting with place of service (POS) restricted to hospital inpatient (POS code 21), outpatient (POS code 19 or 22), or emergency room (POS code 23)*
- *Part B services provided during the index hospital stay, regardless of POS*
- *Part B services provided on the discharge date with a POS restricted to inpatient hospital*

MSPB Attribution

Beneficiaries are excluded from the MSPB measure (and their hospital stay costs are not attributed to a clinician) for any one of the following reasons:

- The beneficiary was not continuously enrolled in both Medicare Parts A and B during the **93-day period prior to the index admission through 30 days after discharge**
- The beneficiary died during the episode
- The beneficiary was enrolled in Medicare Advantage (MA) or Medicare was the beneficiary's secondary payer at any time during the episode window or the 90-day look-back period. If Medicaid was the beneficiary's primary payer during an episode because of exhaustion of Part A benefits, these episodes are not excluded and are attributed to a TIN-NPI
- The beneficiary was discharged for the index admission in the last 30 days of the performance year

Beneficiaries are also excluded if **their index admission**:

- Did not occur in a "subsection (d) hospital[2]" paid under the Inpatient Prospective Payment System (IPPS) or an acute hospital in Maryland
- For the episode was involved in an acute-to-acute hospital transfer[3]
- Occurred within the 30-day post discharge period of another MSPB episode for the same beneficiary[4]

This time frame includes an additional 90-day period (referred to as the "90-day look-back period") because this period is used to identify a beneficiary's comorbidities for use in risk-adjustment

[2]Subsection (d) hospitals do not include: psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals, and hospitals involved extensively in the treatment for or research on cancer.

[3]If an acute-to-acute hospital transfer and/or hospitalization in an IPPS-exempt hospital occurs during the 30 days following discharge from an index admission, then these post-discharge costs are included in the MSPB episode.

[4]In this case, the second hospital admission is considered a readmission and its costs are still included in the initial MSPB episode; the readmission does not trigger a new MSPB episode.

MSPB Case Minimum

The minimum case volume for the MSPB measure is 35, meaning 35 MSPB episodes must be attributed to a MIPS eligible clinician or group for the measure to be scored. For groups, a total of 35 MSPB episodes must be attributed across all clinicians (including MIPS eligible clinicians AND eligible clinicians) who have re-assigned their billing rights to the group's TIN.

A clinician who is participating in MIPS as an individual will not receive a MSPB measure score if the clinician does not bill Medicare for Part B physician/supplier services furnished to beneficiaries during hospital stays and therefore doesn't meet the case minimum.

MSPB Risk Adjustment

The MSPB measure is risk adjusted to account for beneficiary age and illness severity. A beneficiary's illness severity is determined by using the following indicators:

- 79 Hierarchical Condition Category (HCC) indicators[5] from a beneficiary's claims during the 90-day period before the start of the episode
- Recent long-term care status
- End stage renal disease (ESRD) status
- The Medicare Severity Diagnosis-Related Group (MS-DRG) code of the index hospital admission[6]
- The 79 HCC indicators are in Version 22 of the CMS-HCC model
- In the MSPB risk adjustment methodology, a separate risk adjustment model is used to calculate the risk-adjusted, expected MSPB episode cost for each major diagnostic category (MDC). MDCs are determined by the MS-DRG of the index hospital admission.

The goal of risk adjustment is to enable more accurate comparisons across clinicians and groups who treat beneficiaries of varying clinical complexity. Risk adjustment removes differences in illness severity and controls for other risk factors that may affect measured outcomes but are outside of a clinician or group's control.

[5]The 79 HCC indicators are in Version 22 of the CMS-HCC model

[6]In the MSPB risk adjustment methodology, a separate risk adjustment model is used to calculate the risk-adjusted, expected MSPB episode cost for each major diagnostic category (MDC). MDCs are determined by the MS-DRG of the index hospital admission.

MSPB Risk Adjustment

The MSPB risk adjustment method accounts for:

- A beneficiary's comorbidities (the presence of more than one simultaneous clinical condition) by including interactions between HCC variables and enrollment status variables
- The reason a beneficiary qualified for Medicare—referred to as a beneficiary's entitlement category
- Disease interactions that are included in the Medicare Advantage risk adjustment model
- NOTE: The MSPB measure is not adjusted to account for beneficiary sex, race, nor provider specialty. It's adjusted based on the index admission diagnosis-related group.

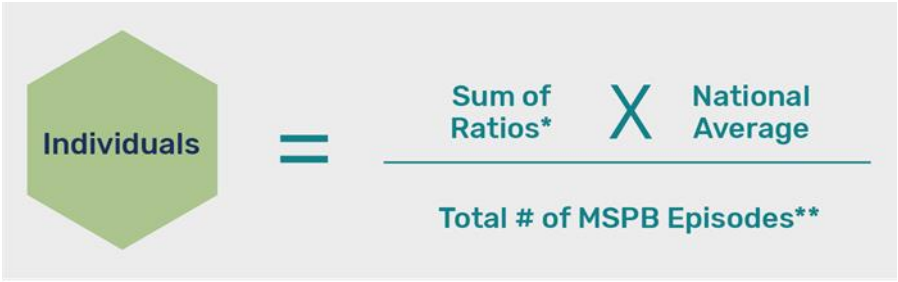
MSPB Calculation

CMS uses the following six steps to calculate the MSPB measure:

1. Step 1: Define the population of index admissions.
2. Step 2: Calculate payment-standardized MSPB episode spending.
3. Step 3: Calculate the expected, risk-adjusted MSPB episode spending.
4. Step 4: Exclude outliers.
5. Step 5: Attribute episodes to individual clinicians.
6. Step 6: Calculate and report the MSPB measure for each TIN-NPI or TIN.

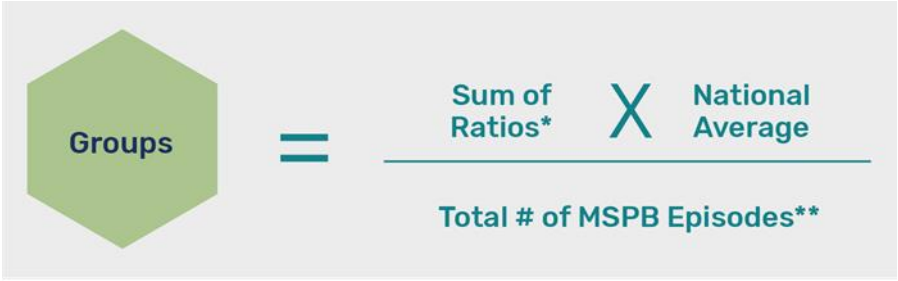
Expected episode spending represents the relationship between independent variables (e.g., age, enrollment status, comorbidities, HCCs) and the standardized episode cost. It's calculated using a model based on beneficiary age and severity of illness, as described in the risk adjustment methodology section of the measure information form. The risk-adjusted measure reflects a TIN-NPI's average ratio of observed to expected episode spending across all episodes attributed to the TIN-NPI.

MSPB Calculation



*The sum of the ratios of payment-standardized observed to expected MSPB episode costs for all MSPB episodes attributed to an individual clinician's TIN-NPI

**Total number of MSPB episodes attributed to an individual MIPS eligible clinician's TIN-NPI



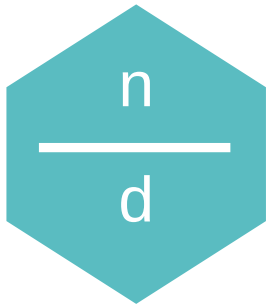
*Sum of the ratios of payment-standardized observed to expected MSPB episode costs for all MSPB episodes attributed to all individual eligible clinicians' TIN-NPIs under the group's TIN

**Total number of MSPB episodes attributed to all individual eligible clinicians' TIN-NPIs under the group's TIN

TIP: *For more detailed information, see the 2019 MIPS MSPB Measure Information Form.*

Total Per Capita Cost for all Attributed Beneficiaries (TPCC)

The TPCC measure assesses total Medicare Parts A & B costs for a beneficiary during the performance year by calculating the risk-adjusted, per capita costs for beneficiaries attributed to an individual clinician or group of clinicians. The measure is calculated and expressed by CMS at the TIN or TIN-NPI level.

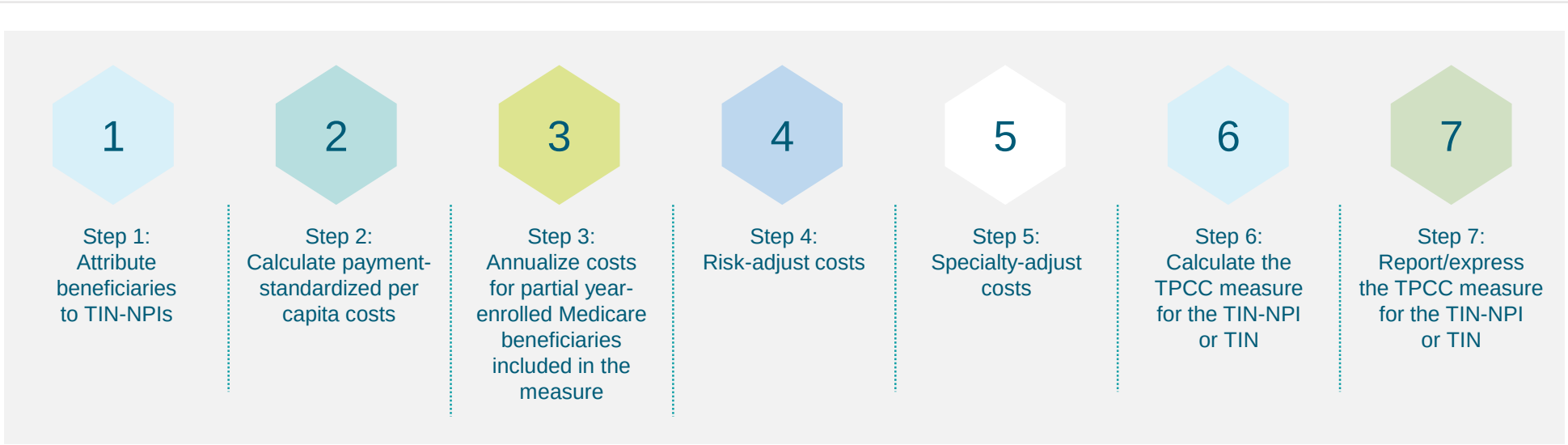


Numerator = Sum of the annualized, risk adjusted, specialty-adjusted Medicare Parts A & B costs incurred by all beneficiaries attributed to an individual MIPS eligible clinician (TIN-NPI) or all individual eligible clinicians in a group (identified by TIN) that is participating in MIPS as a group

Denominator = Number of Medicare beneficiaries who are attributed to an individual MIPS eligible clinician's TIN-NPI (if participating in MIPS as an individual) or the number of all Medicare beneficiaries who are attributed to a group of individual eligible clinicians participating in MIPS as a group (TIN) during the performance year

TPCC Calculation

The TPCC measure is calculated through the following steps:



TPCC Attribution

Beneficiaries are attributed to a single TIN-NPI based on the amount of primary care services a beneficiary received, and the clinician specialties that performed those services, during the performance year.

Only beneficiaries who received a primary care service during the performance year can be attributed to a TIN-NPI. A beneficiary is attributed to a single TIN-NPI or to a single entity's CMS Certification Number (CCN) assigned to either a Federally-Qualified Health Center (FQHC) or Rural Health Clinic (RHC) in one of two steps, which are outlined on the next page.

NOTE: If a beneficiary is attributed to an FQHC or RHC's CCN, then that beneficiary and the beneficiary's costs are not included in the TPCC measure calculated for an individual MIPS eligible clinician or group and the beneficiary is excluded from risk adjustment.

Primary care services include:

- *Evaluation and management services furnished in office and other non-inpatient, non-emergency room settings*
- *Initial Medicare visits*
- *Annual wellness visits*

For a full list of Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes and descriptions, review the table in Appendix B of the 2019 Cost Performance Category Fact Sheet.

TPCC Attribution

Two-step attribution process:

Step 1:

If a beneficiary received more primary care services from an individual TIN-NPI that is classified as either a primary care physician (PCP), nurse practitioner (NP), physician assistant (PA) or clinical nurse specialist (CNS) than from any other TIN-NPI during the performance year, then the beneficiary is attributed to that TIN-NPI. If, during the performance year, a beneficiary received more primary care services from an entity's CCN than from any other TIN-NPI, then the beneficiary is attributed to the CCN.

Step 2:

If a beneficiary did not receive a primary care service from a TIN-NPI classified as either a PCP, NP, PA, or CNS during the performance year, then the beneficiary may be assigned to a TIN-NPI in "Step 2." If a beneficiary received more primary care services from a specialist physician's TIN-NPI than from any other provider's TIN-NPI during the performance year, then the beneficiary is assigned to the specialist physician's TIN-NPI.

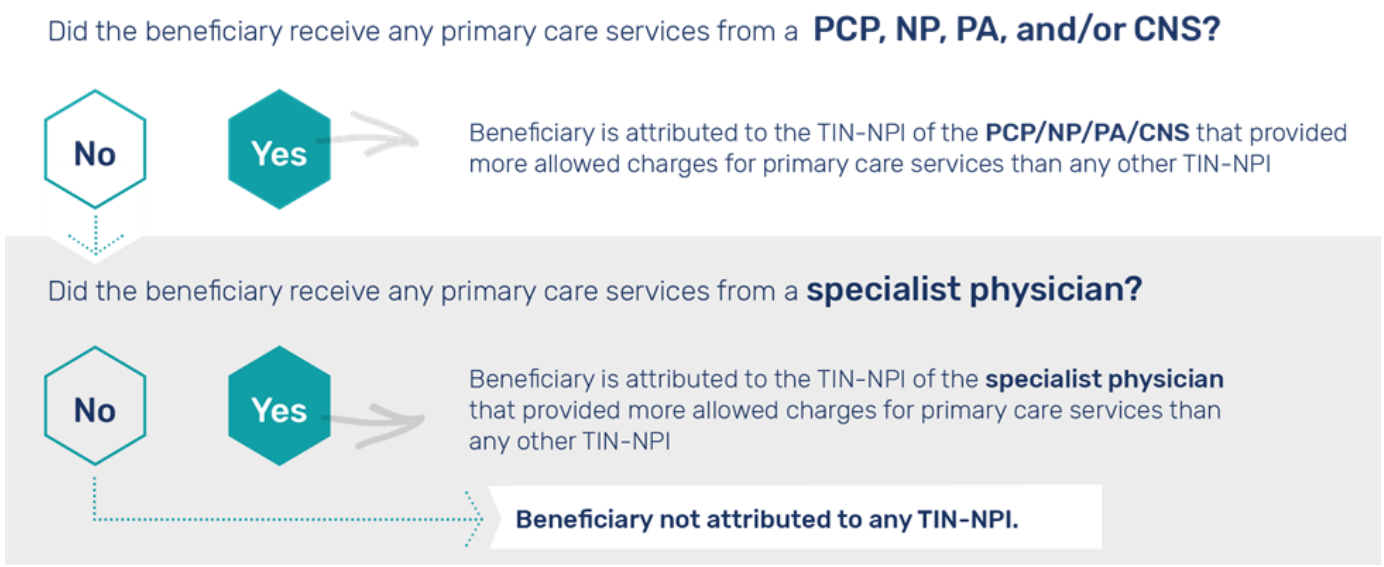
TIP: For a list of medical specialties included in Step 2, please refer to Table 3 of the 2019 MIPS TPCC Measure Information Form. For a list of Healthcare Common Procedure Coding System (HCPCS) codes that identify primary care services, please refer to Table 2 of the same document.

TPCC Attribution

A beneficiary is excluded from the population measured if the beneficiary:

- Was not enrolled in both Medicare Parts A & B for every month of the performance year
- Was enrolled in a private Medicare health plan during any month of the performance year
- Resides outside the United States (including territories) during any month of the performance year

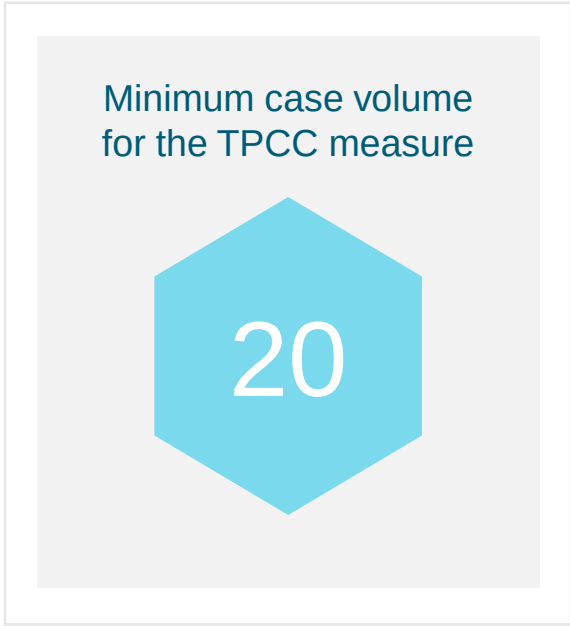
If a beneficiary was enrolled in Medicare Parts A and B for a partial year because he/she newly-enrolled in Medicare or he/she died during the performance year, then the beneficiary is included in the measure.



TPCC Case Minimum

- The case minimum for the TPCC measure is 20. To be scored on the TPCC measure:
  - MIPS eligible clinicians participating in MIPS as individuals must have at least 20 different beneficiaries attributed to their TIN-NPI
  - Groups participating in MIPS must have a total of 20 beneficiaries attributed to TIN-NPIs across the TIN-NPIs under the group's TIN

- MIPS eligible clinicians and groups with 19 or fewer beneficiaries attributed to them won't be scored on the TPCC measure.



TPCC Risk Adjustment Methodology

Two measures of risk are used in the TPCC risk adjustment methodology:

Beneficiaries' CMS-HCC risk scores derived from either the New Enrollee Model or the Community model

AND

ESRD status

- Separate CMS-HCC models exist for new enrollees and continuing enrollees. The new enrollee model accounts for each beneficiary's age, sex, disability status, original reason for Medicare entitlement (age or disability), and Medicaid eligibility, and is used when a beneficiary has less than 12 months of medical history. The community model is used when a beneficiary has at least 12 months of medical history. The community model includes the same demographic information as the new enrollee model but it also accounts for clinical conditions as measured by Hierarchical Condition Categories (HCCs).

Specialty adjustment

- Specialty adjustment is also applied to the TPCC measure. Specialty adjustment differs from risk adjustment because it is performed at the provider level rather than the beneficiary level.
- CMS adjusts the TPCC measure based on the specialty of the individual MIPS eligible clinician (for those participating in MIPS as an individual) or the specialty composition of a group of clinicians participating in MIPS as a group under a specific TIN. An individual clinician's specialty is identified based on the CMS specialty code listed most frequently on Medicare Part B claims for services provided by the clinician during the performance year.

TIP: For information on how specialty adjustment was implemented in the 2018 VM Program, please refer this 2018 VM Program fact sheet.

Episode-based Cost Measures Overview

Episode-based measures assess the cost of the care that is clinically related to their initial treatment of a patient and provided during an episode's time frame. Episode-based measures differ from the TPCC and MSPB measures because they only include items and services related to the episode of care for a clinical condition or procedure, as opposed to including all services that are provided to a patient over a given timeframe.

- The episode-based measures are categorized into "episode groups." Episode groups:
- Represent a clinically cohesive set of medical services rendered to treat a given medical condition.
- Combine all items and services provided for a patient group to assess the cost of care
- Are defined around treatment for a condition or performance of a procedure.

CMS has posted detailed methodology documents for each of the eight episode-based measures finalized for 2019.

Each episode-based measure has a corresponding measure code list file that contains medical codes used in the measure-specific methodology and used in the specifications, including episode triggers, exclusions, episode sub-groups, assigned items and services, and risk adjustors.

Episode-based Cost Measures Overview

The eight episode-based cost measures are categorized into one of the following episode groups:

Procedural episode group (triggered by performance of a major procedure)

AND

Acute inpatient medical condition group (triggered by evaluation and management claims during hospitalizations with specific Diagnostic Related Groups or DRGs).

To be assessed on episode-based measures, you must meet the minimum case volume.

The minimum case volume for **procedural episode-based measures** is 10, meaning 10 episodes must be attributed to a MIPS eligible clinician or group for the measure to be scored. For groups, a total of 10 procedural episode-based episodes must be attributed across all clinicians (including MIPS eligible clinicians AND eligible clinicians) who have re-assigned their billing rights to the group's TIN.

The minimum case volume for **acute inpatient medical condition episode-based measures** is 20, meaning 20 episodes must be attributed to a MIPS eligible clinician or group in order for the measure to be scored. For groups, a total of 20 acute inpatient medical condition episode-based measures must be attributed across all clinicians (including MIPS eligible clinicians AND eligible clinicians) who have re-assigned their billing rights to the group's TIN.

Attribution: Episode-based Cost Measures

Procedural episodes are attributed to MIPS eligible clinicians who render a “triggering service,” which is identified by HCPCS/CPT procedure codes.

For acute inpatient medical condition episodes, we will attribute episodes to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a TIN that renders at least 30 percent of the inpatient E&M claim lines in that hospitalization.

A trigger hospitalization is defined as a hospitalization with a particular Medicare Severity Diagnosis Related Group (MS-DRG) identifying the episode group. Relevant MS-DRGs and trigger rules are identified in the measure methodology documents.

Overlapping Episodes

CMS does not exclude episodes if a patient already qualified for another episode, since allowing for overlapping episodes incentivizes communication and care coordination as a patient progresses through the care continuum. For example, if a patient is re-hospitalized for pneumonia after an initial episode, this would trigger two separate episodes of care for pneumonia.

Risk Adjustment Methodology for Episode-based Measures

Risk adjustment methods for the eight episode-based measures in both episode groups:

Adjust for differences in clinical complexity at the time each episode begins

AND

Include risk adjustors from the CMS- Hierarchical Condition Category (HCC) model and additional measure-specific risk adjustors

Risk adjustors are identified using beneficiaries' Medicare claims history during the period prior to the start of the episode. Claims from the triggering hospitalization or on the triggering Part B Physician/Supplier claim are typically not included. The risk adjustment method used for each episode-based measure is enhanced/customized by the use of risk factors specifically adapted for each episode group.

REPORTING REQUIREMENTS

Reporting Requirements

CMS will use data from Medicare Part A and B claims—with dates of service from January 1, 2019 to December 31, 2019—to calculate your Cost performance category score.

AND

You **do not** need to submit any data or take any separate actions for this performance category.

AND

MIPS eligible clinicians should continue to see patients and submit claims data as usual.

SCORING

Scoring

For a cost measure to be scored, an individual MIPS eligible clinician or group must have enough attributed cases to meet or exceed the case minimum for that cost measure.

1

If only one Cost measure can be scored, that measure's score will serve as the Cost performance category score.

multiple

If multiple Cost measure are scored, the Cost performance category score is the equally weighted average of all the scored measures.

For example, if 7 out of 10 Cost measures are scored, the Cost performance category is the equally weighted average of the seven scored measures.

none

If none of the ten measures can be scored, the Cost performance category will count toward 0% of your MIPS final score, and we'll reweight your Quality performance category score to 60%, Improvement Activities to 15%, and Promoting Interoperability to 25%.

Cost

0%

Quality

60%

Improvement Activities

15%

Promoting Interoperability

25%

To calculate Cost performance category score in 2019, CMS will assign 1 to 10 achievement points to each scored measure based on the MIPS eligible clinician or group's performance on the measure compared to the performance year benchmark.

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 until the 2022 MIPS performance year/2024 MIPS payment year.

2019 Cost Performance Category Scoring Example

Measure	Total Possible Measure Achievement Points Available	Total Possible Measure Achievement Points Available
TPCC Measure	8.2	10
MSPB Measure	6.4	10
Elective Outpatient PCI Measure	Not scored	N/A-not scored
Knee Arthroplasty Measure	7	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia Measure	5.5	10
Routine Cataract Removal with IOL Implantation Measure	9	10
Screening/Surveillance Colonoscopy Measure	Not scored	N/A-not scored
Intracranial Hemorrhage or Cerebral Infarction Measure	4.8	10
Simple Pneumonia with Hospitalization Measure	6.7	10
STEMI with PCI Measure	Not scored	N/A-not scored
TOTAL	47.6	70

In the example above:

The group's Cost performance category score is (47.6/70=0.68), which is equal to a Cost performance category percent score of 68%. Because the Cost performance category is worth 15 points in the MIPS final score, this group would earn 10.2 points towards their final score (68 x .15=10.2)

REWEIGHTING

Reweighting the Cost Performance Category

CMS will automatically reweight the Cost performance category for MIPS eligible clinicians who are located in a CMS-designated region or locale that has been affected by extreme and 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 in the final score even if we receive administrative claims data that would enable us to calculate cost measures for that clinician

If other performance categories are reweighted, the Cost performance category will always be weighted at either 15% or 0%—we will not redistribute weight to the Cost performance category for the 2019 performance year.

Note, the Quality, Cost, Improvement Activities and Promoting Interoperability performance categories will be reweighted to zero percent for MIPS eligible clinicians who join an existing practice (existing TIN) during the final 3 months of the performance year that is not participating in MIPS as a group, or a practice that is newly formed (new TIN) during the final 3 months of the performance year regardless of whether the clinicians in the practice report for purposes of MIPS as individuals or as a group.

FACILITY-BASED SCORING

Facility-based Scoring

Beginning the 2019 performance year, CMS will automatically apply facility-based measurement to MIPS eligible clinicians and groups who both are eligible for facility-based measurement and have a higher combined Quality and Cost performance category score. To determine eligibility for facility-based measurement, CMS will use claims data from the 12-month segment beginning on October 1, 2017 and ending on September 30, 2018, including a 30-day claims run out.

If a group or clinician's combined facility-based Cost and Quality scores are higher than their regular MIPS Cost and Quality scores, CMS will automatically apply facility-based scores for these performance categories when calculating MIPS Final Scores.

An individual MIPS eligible clinician is eligible for facility based measurement if:

Individuals

75% MINIMUM

The clinician furnishes 75 percent or more of his/her covered professional services in sites of services identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), emergency room (POS 23) and/or on-campus outpatient hospital (POS code 22);

AND

1 POS Code

The clinician billed at least a single service with POS codes for inpatient hospital or the emergency room during the first segment of the MIPS determination period;

AND

70 POINTS

Can be attributed, using a methodology detailed in the final rule, to a facility with a value-based purchasing score for the applicable period (i.e., a FY 2020 Total Performance Score on the Hospital VPB program).

Groups

75%

A facility-based group is a group in which 75 percent or more of its eligible clinician NPIs billing under the group's TIN meet the facility-based individual determination. MIPS eligible clinician is eligible for facility-based measurement under MIPS if they are determined to be facility-based as part of a group.

Facility-based Scoring

To be eligible for facility-based measurement and scoring, CMS must be able to attribute a clinician or group to a hospital with a value-based purchasing score.

To Be Eligible for Facility based Scoring

Individual Clinicians

Individual clinicians are attributed to the hospital where they provide services to the most Medicare patients.

- If there's a tie—that is, you treat an equal number of Medicare patients at two different hospitals—we'll use the higher of the two hospitals' VBP scores.

Groups

Groups are attributed to the hospital where they have the most facility-based clinicians attributed.

- CMS scores MIPS Cost and Quality performance based on a facility's percentile performance in the Hospital VBP program:
  - First, CMS identifies the MIPS percentile performance for clinicians who aren't included in facility-based scoring, then assigns corresponding MIPS scores for Cost and Quality.

To learn more, see the 2019 Facility-based Measurement Fact Sheet.

FEEDBACK

Cost Performance Category Feedback

For the 2019 MIPS performance year, Cost performance category feedback will be provided in the Summer of 2020.

In July 2018, CMS provided feedback on TPCC and MSPB cost measure performance to MIPS eligible clinicians and groups even though the Cost performance category did not count towards 2017 MIPS Final Scores nor will it affect 2019 payments.

Feedback on 2018 MIPS performance year cost measure performance will be available in summer 2019 and CMS is looking to incorporate beneficiary-level data, if technically feasible.

Feedback on 2018 MIPS performance year cost measure performance will be available in summer 2019 and CMS is looking to incorporate beneficiary-level data, if technically feasible.

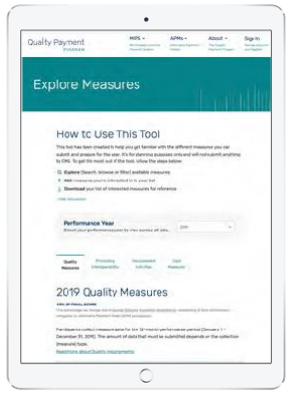
RESOURCES, GLOSSARY, AND VERSION HISTORY

Resources, Glossary, and Version History

Additional Resources

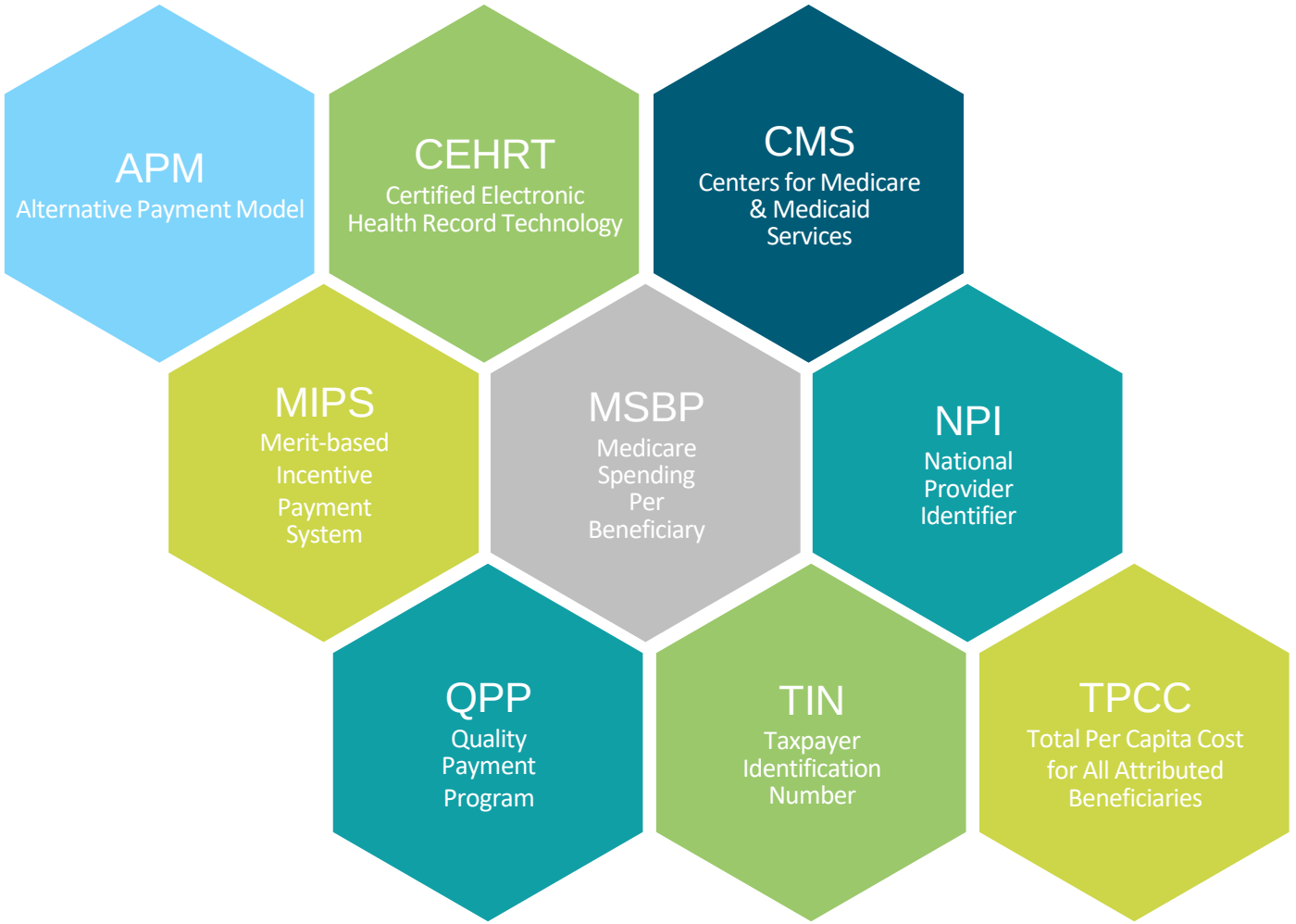
The following resources are available in the QPP Resource Library.

- 2019 Cost Measure Information Forms
- 2019 Cost Measure Code Lists
- 2019 Cost Requirements
- 2019 Cost Measures
- 2019 Cost Performance Category Fact Sheet
- 2019 MIPS Participation and Eligibility Fact Sheet



Resources, Glossary, and Version History

Glossary



Quality Payment PROGRAM

Version History

Date	Description
4/27/2020	Added disclaimer language regarding changes to 2019 MIPS in response to COVID-19.
6/4/2019	Original posting