Hidden Cost: The Overlooked MIPS Category

Sam Ross, QPP Manager
Quality Payment Program of Illinois
August 25th, 2020

Quality Payment Program of Illinois

Visit our website at http://qpp-il.org! We will help you navigate the complexities of the new CMS payment models so you can focus on what you do best – taking extraordinary care of your patients.

When you sign up for the QPP Resource Center®, you get access to resources that help you establish your baseline, identify goals, learn about requirements, and monitor progress. Plus, QPP Advisors are available to answer questions as they come up.

Northern Illinois University

Northwestern University

ALTARUM INSTITUTE
SYSTEMS RESEARCH FOR BETTER HEALTH

AllianceChicago
Innovating for better health

CHITREC

Quality Payment Program
of Illinois

This material was prepared by the QPP Resource Center®, the Quality Payment Program for the Midwest, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not constitute legal advice and do not necessarily reflect CMS policy.

CMS

Agenda

- MIPS Basics
- Cost Category Overview
- Cost Considerations
- Q&A

MIPS Basics

Why am I included?

- Many believe MIPS does not apply because:
  - “I don’t use electronic health records”
  - “I’m a solo/small practice”
  - “I only treat patients in the hospital/nursing homes”
  - “This doesn’t apply to my subspecialty”

- Clinicians are included if they:

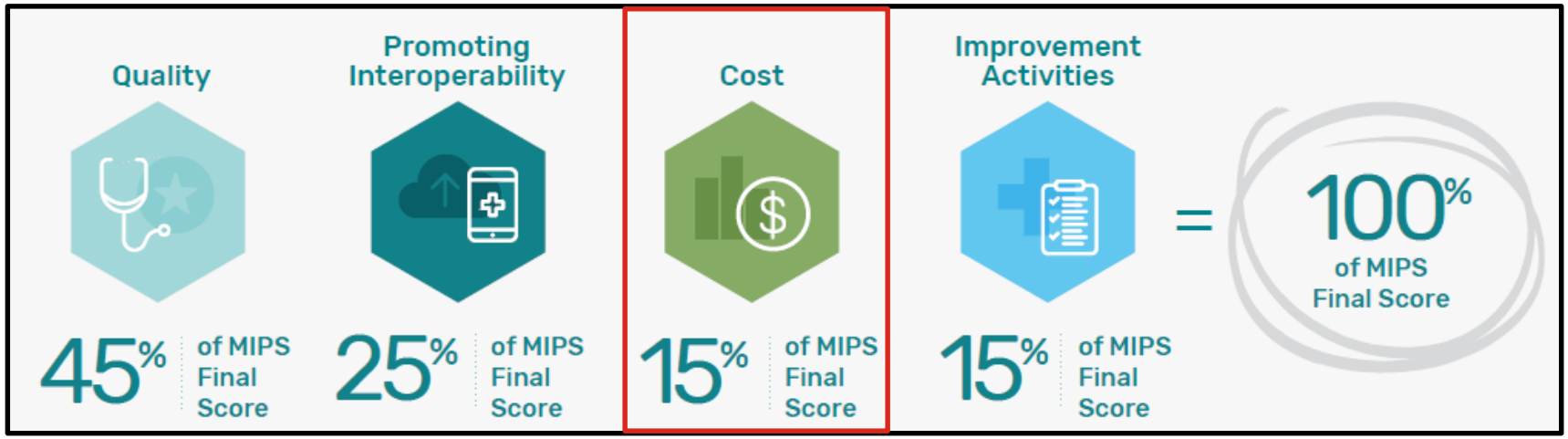
Bill more than $90k	See more than 200 patients	Provide more than 200 services

Visit https://qpp.cms.gov/participation-lookup to review MIPS participation status by searching individual NPI

- Clinicians meeting 1 or 2 can “opt-in”

How do I participate?

- Collect and report data on quality, EHR, cost and improvements



NOTE: these percentages apply for 2020; category weights change over time (**Cost must be 30% by 2023**)

- Special status can change requirements:
  - Small practice hardship for Promoting Interoperability (EHR)
  - Limited Cost measures based on specialty

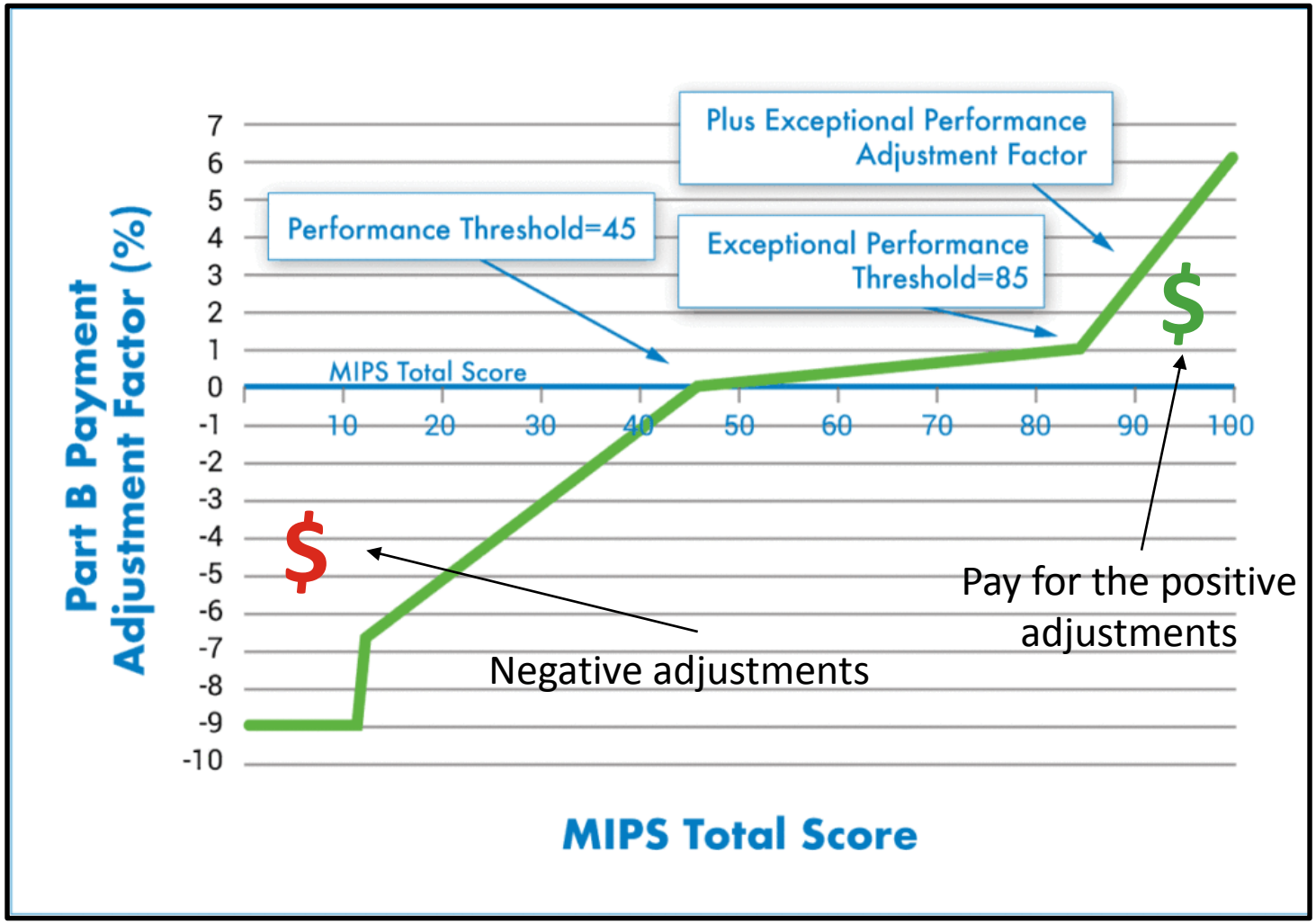
What if I don't participate?

- "Negative adjustment" on Medicare payments
- Applied two years later:

2018 Non-Participant	2020 Non-Participant
• Adjusted -7% in 2020 • -2% for sequestration • -5% for MIPS	• Adjusted -11% in 2022 • -2% for sequestration • -9% for MIPS (maximum)

- Adjustment resets each year

Can I get a positive adjustment?



NOTE: this chart applies for 2020 and will change over time

Cost Category Overview

Cost Measure Types

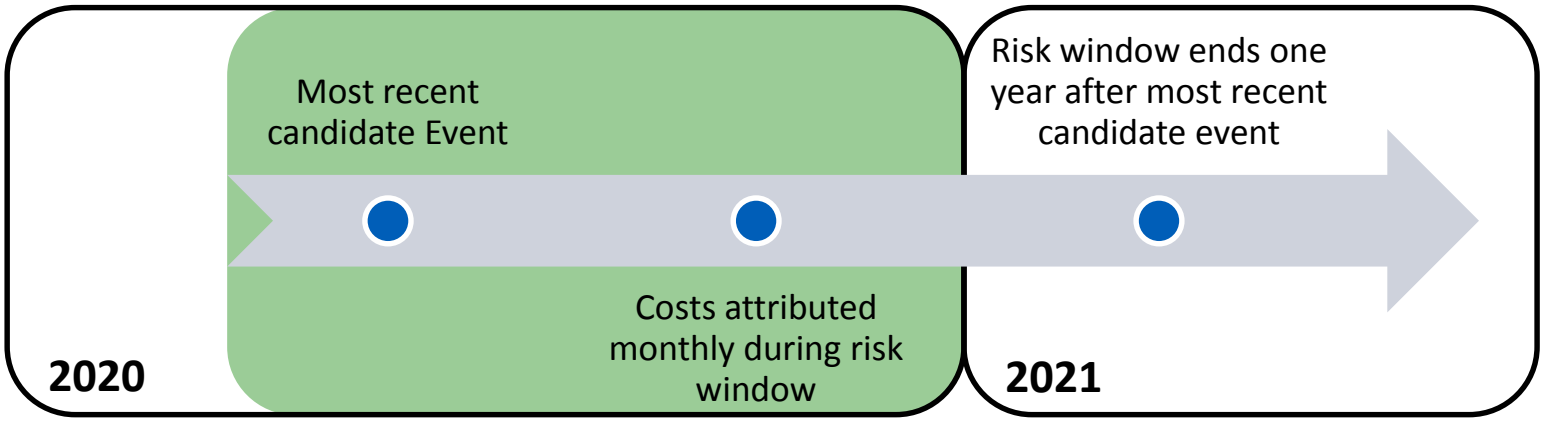
- 20 measures across 3 types
- Adjusted for geography, specialty (TPCC only) and patient risk

TPCC	MSPB Clinician	Episode-Based (18)
• Total Per Capita Cost • Measures overall care	• Medicare Spending Per Beneficiary Clinician • Measures care for services related to inpatient stay	• Measures care during an episode time frame • Acute inpatient or procedural

TPCC

- PCP relationship(s) established based on E&M
  - Starts with “candidate event”
  - Patient attributed for following year-long “risk window”
  - Excludes non-PCP and PCPs with <20 attributed patients

- Evaluated on a monthly basis:
  - PCP attribution(s)
  - Patient risk score
  - Measure performance



MSPB

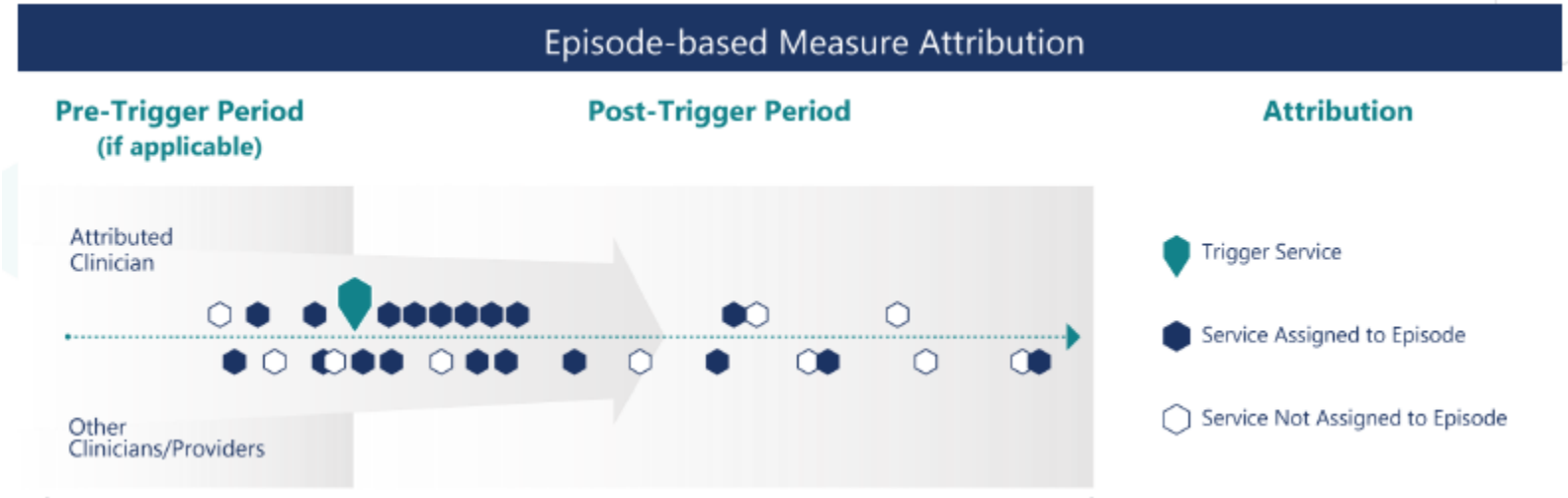
- Episode established by inpatient services
  - Spans 3 days prior to admission through 30 days past discharge
  - Costs attributed to clinicians based on:
    - Volume of E&M services during episode (medical MS-DRG)
    - Related procedures (surgical MS-DRG)

- Excludes unrelated services and clinicians with <35 attributed episodes

Episode-Based (18)

- Episode established by E&M services
  - Time period varies by measure
  - Costs attributed to clinicians based on:
    - Volume of E&M services during episode (acute inpatient)
    - Related procedures (procedural)

- Excludes unrelated services and clinicians with <20 (inpatient) or <10 (procedural) episodes



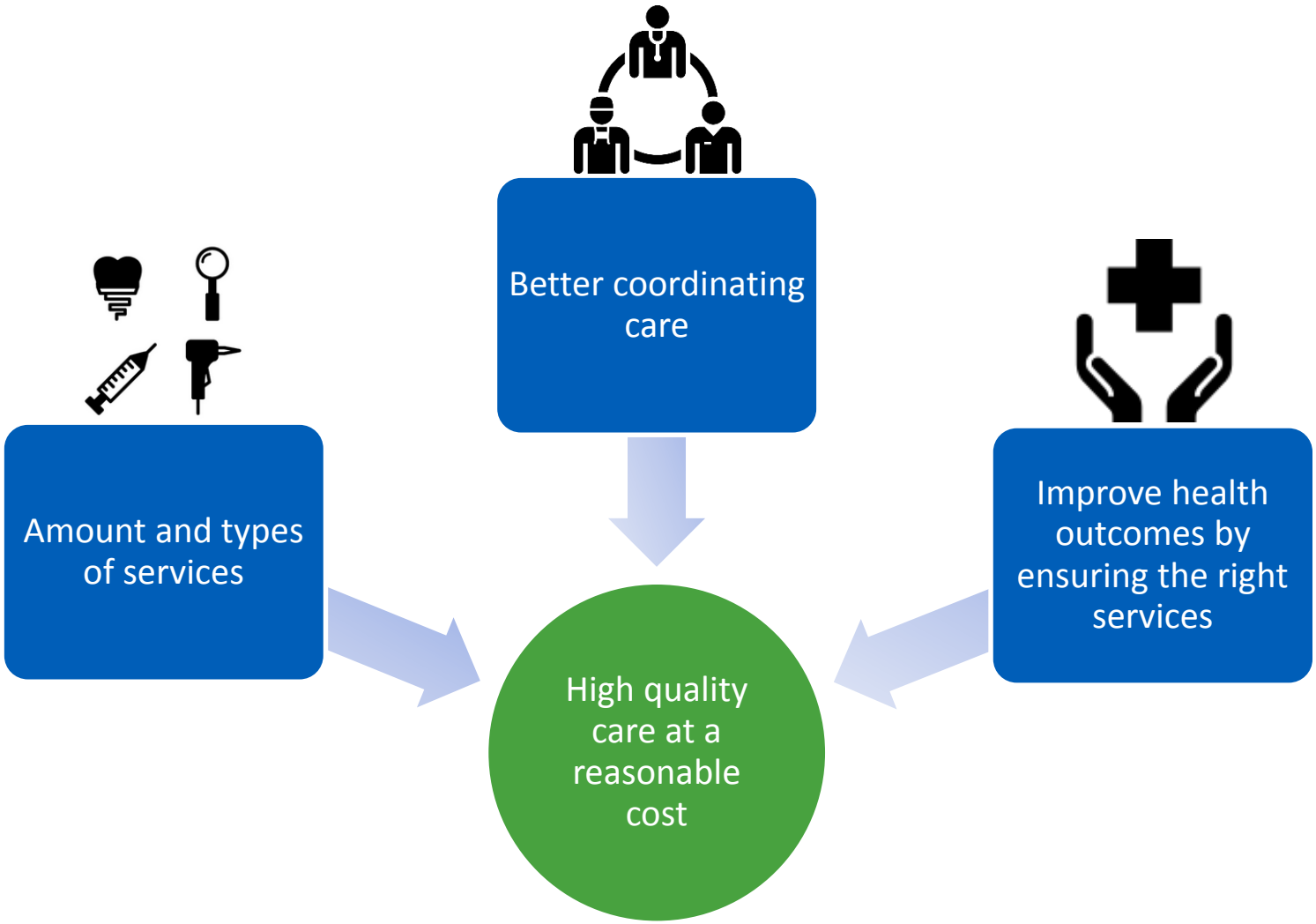
Cost Category Scoring

- Measures scored from 1-10 based on benchmark
- If only 1 measure can be scored, category is based on that measure
- If 2+ measures can be scored, based on equally-weighted average
- Category scored from 0-100% then multiplied by 15-point weight

Measure	Score
TPCC	6.2/10
MSPB	4.5/10
Episode-Based 1	8/10
Episode-Based 2	3.1/10
TOTAL	**21.8/40 (0.545) * 15 = 8.2 points**

Cost Considerations

CMS on How Clinicians Affect Cost



General Tips

- Confirm/update your specialty in PECOS
- Review 2019 performance feedback
- Reducing avoidable hospitalizations/readmissions has highest impact
- Focus on preventive medicine
- Complete diagnostic description for risk-adjustment
  - Include secondary ICD codes for all visits
  - Review HCC codes
- Examine referral patterns for preference on high quality, low cost partners

Identify Applicable Measures

- Billing primary care services? TPCC likely applies
- Treating patients during inpatient stay? MSPB Clinician may apply
- Performing inpatient or surgical procedures? Episode-Based may apply

Episode-Based Measures for 2020 Performance Year		
Elective Outpatient PCI	AKI w/ New Dialysis	Lumpectomy/Mastectomy
Knee Arthroplasty	Elective Hip Arthroplasty	Non-Emergent CABG
Revascularization of Lower Extremity	Femoral/Inguinal Hernia Repair	Intracranial Hemorrhage or Cerebral Infarction
Routine Cataract Removal	Hemodialysis Access Creation	Renal or Ureteral Stone
Colonoscopy	Lumbar Spine Fusion	Simple Pneumonia
STEMI with PCI	COPD Exacerbation	Lower GI Hemorrhage

Code Lists and Measure Information Files

- Measure Information Forms describe measures in detail

Episode Window: *During what time period are costs measured?*

Pre-Trigger Window: 0 days Post-Trigger Window: 30 days

Triggers: *Patients receiving what medical care are included in the measure?*

- A procedure code for hemodialysis or dialysis procedure (CPT/HCPCS 90935, 90937, 90945, 90947) that occurs during an IP stay, or
- A relevant inpatient E&M service code (CPT/HCPCS 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99291) billed by a nephrologist during an IP stay, when also accompanied by either (i) a diagnosis code for acute kidney failure and a revenue center code for inpatient renal dialysis, or (ii) a diagnosis code for acute kidney failure and a particular ICD-10 procedure code for urinary filtration or irrigation of peritoneal cavity using dialysate, percutaneous approach

- Code Lists identify services applicable to measures

Service Category	Clinical Theme	Window	Procedure Code Type	Procedure Code	ICD-10 CM 3-Digit Diagnosis Code
ED	(1) Dialysis	Post-Trigger	CPT/HCPCS	99291	Z49
ED	(1) Dialysis	Post-Trigger	CPT/HCPCS	99291	Z99
ED	(1) Dialysis	Post-Trigger	CPT/HCPCS	99292	Z49
ED	(1) Dialysis	Post-Trigger	CPT/HCPCS	99292	Z99
ED	(2) Follow-Up for Kidney Disease	Post-Trigger	CPT/HCPCS	99281	I12
ED	(2) Follow-Up for Kidney Disease	Post-Trigger	CPT/HCPCS	99281	I13

Alternative Reporting Options

- Alternative Payment Model (APM)
  - Category weighted at 0% for MIPS APM
  - Advanced APM qualifying participants exempt from MIPS

- COVID-19 Extreme and Uncontrollable Circumstances (EUC)
  - Application to re-weight Cost to 0%
  - Subject to case-by-case review

- Facility-based scoring
  - Special status for certain inpatient clinicians
  - Cost scored from hospital performance in VBP program

Resources

- 2020 MIPS Summary of Cost Measures
- 2020 Cost Quick Start Guide
- 2020 MIPS Cost User Guide
- 2020 Cost Measure Information Forms
- 2020 Cost Measure Code Lists

Q&A

THANK YOU!!

Quality Payment Program of Illinois

https://www.qppresourcecenter.org/

nu@qpp-il.org

844-QPP-DESK (844-777-3375)