

# Quality Payment PROGRAM

## MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

### 2020 Cost Performance Category Quick Start Guide

Updated 8/28/2020



## Contents

Already know what MIPS is?  
Skip ahead by clicking the links in the Table of Contents

<a href="#">How to Use This Guide</a>	3
<a href="#">Overview</a>	5
<a href="#">What is the Merit-based Incentive Payment System?</a>	6
<a href="#">What is the Cost Performance Category?</a>	7
<a href="#">What's New with Cost in 2020?</a>	8
<a href="#">Get Started with Cost Measures in Four Steps</a>	9
<a href="#">Step 1. Understand the Cost Performance Category Measures</a>	11
<a href="#">Step 2. Understand How Cost Measures are Calculated</a>	12
<a href="#">Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians</a>	16
<a href="#">Step 4. Understand What Cost Performance Feedback Will Be Available</a>	22
<a href="#">Help, Resources, and Version History</a>	23
<a href="#">Appendix</a>	27

**Purpose:** This resource focuses on the Cost performance category, providing high level information about the cost measures, including calculation and attribution for the 2020 performance period. For comprehensive information about these measures, please refer to the Measure Information Forms (linked in the [Help, Resources, and Version History](#) section).

**COVID-19 and 2020 Participation:** For the 2020 performance year, we will be using our Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, and virtual groups to **submit an application** requesting reweighting of one or more MIPS performance categories to 0%. We have introduced a new high-weighted COVID-19 clinical trials improvement activity, which provides an opportunity for clinicians to receive credit in MIPS. For more information about the impact of COVID-19 on Quality Payment Program participation and additional flexibilities proposed in the 2021 QPP Proposed Rule on Quality Payment Program participation, see the [Quality Payment Program COVID-19 Response webpage](#).



## 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.



## Overview



# Overview

## What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across four categories that lead to improved quality and value in our healthcare system.

If you're [eligible for MIPS in 2020](#):

- You generally have to submit data for the [Quality](#), [Improvement Activities](#), and [Promoting Interoperability](#) performance categories. (We collect and calculate data for the Cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based off your performance during the 2020 performance period and applied to payments for covered professional services beginning on January 1, 2022.

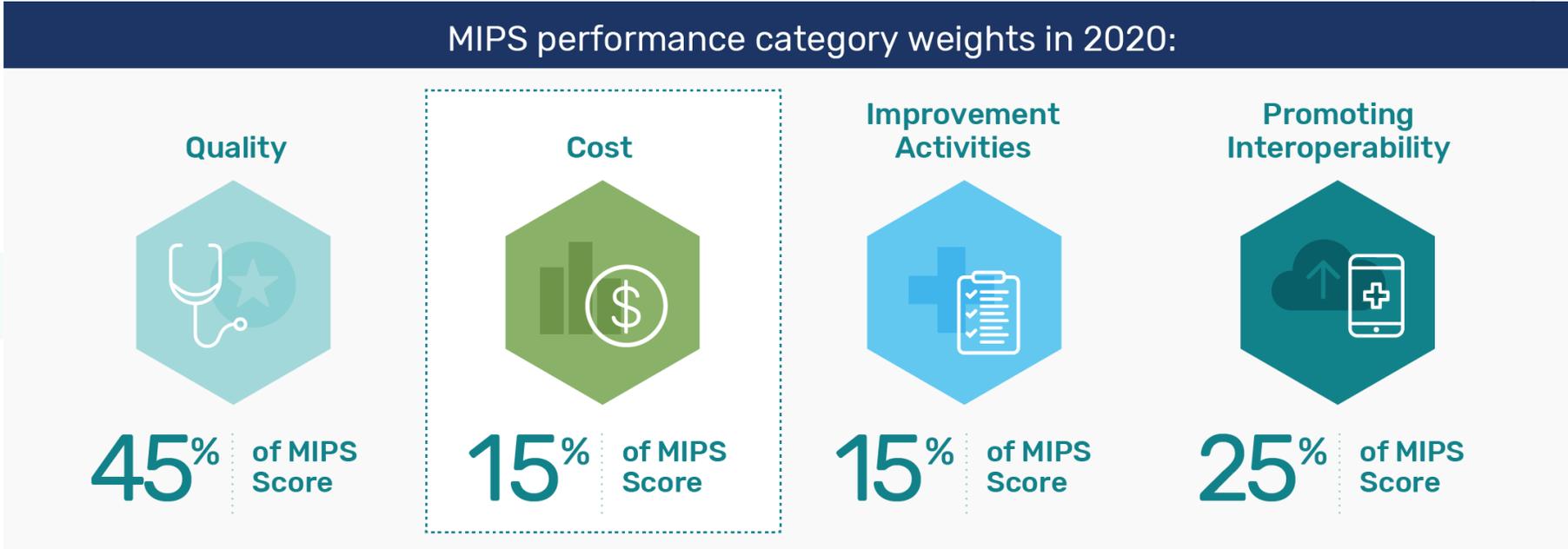
### **To learn more about how to participate in MIPS:**

- Visit the [How MIPS Eligibility is Determined](#) and [Individual or Group Participation](#) web pages on the [Quality Payment Program website](#).
- View the [2020 MIPS Eligibility and Participation Quick Start Guide](#).
- Check your current participation status using the [QPP Participation Status Tool](#).

# Overview

## What is the MIPS 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.



# Overview

## What's New with Cost in 2020?

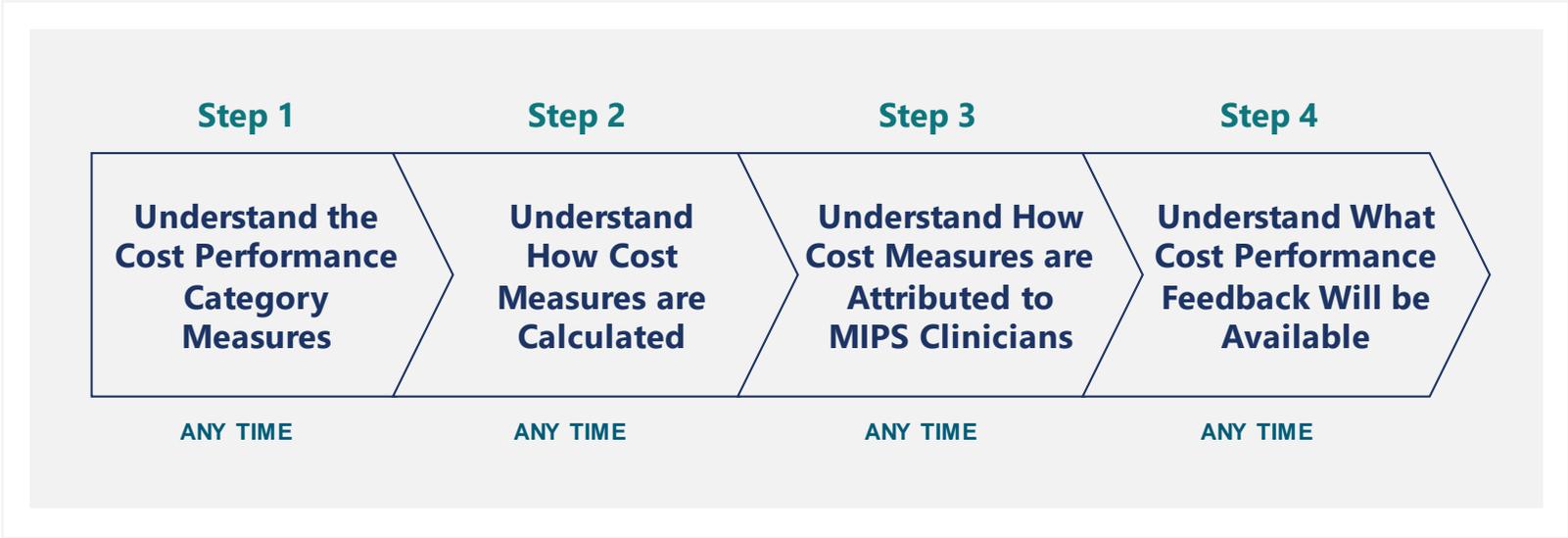
- **Revised Medicare Spending Per Beneficiary measure:**
  - Updated name – Medicare Spending Per Beneficiary Clinician (MSPB Clinician) measure
  - Refined attribution methodology for medical and surgical episodes
  - Service exclusions for costs that are unlikely to be influenced by clinicians
- **Revised Total Per Capita Cost (TPCC) measure:**
  - Refined attribution methodology for identifying primary care relationships
  - Specialty exclusions for clinicians who don't provide primary care services
  - Refined risk adjustment to account for changes in patient health status during the year
- **Added 10 new Episode-based cost measures**





## Get Started with Cost Measures in Four Steps

# Get Started with Cost Measures in Four Steps



# Get Started with Cost Measures in Four Steps

## Step 1. Understand the Cost Performance Category Measures

There are 20 cost measures in total for the 2020 performance period.

Measure Name	Description	Adjustments*	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	Assesses the primary care clinician’s overall care for a Medicare patient during the performance period	<ul style="list-style-type: none"> <li>✓ Payment standardized</li> <li>✓ Risk adjusted</li> <li>✓ Specialty-adjusted</li> </ul>	20 Medicare patients	Medicare Part A & B claims
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	Assesses the cost of care for services related to qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient	<ul style="list-style-type: none"> <li>✓ Payment standardized</li> <li>✓ Risk adjusted</li> </ul>	35 episodes	Medicare Part A & B claims
Episode-based measures (18 measures)	Assess the cost of care that is clinically related to initial treatment of a patient and provided during an episode’s time frame	<ul style="list-style-type: none"> <li>✓ Payment standardized</li> <li>✓ Risk adjusted</li> </ul>	20 episodes for acute inpatient measures 10 episodes for procedural measures	Medicare Part A & B claims

\*For more information on payment standardization, risk adjustment, and specialty adjustment, please see the [Help, Resources, and Version History](#) section.

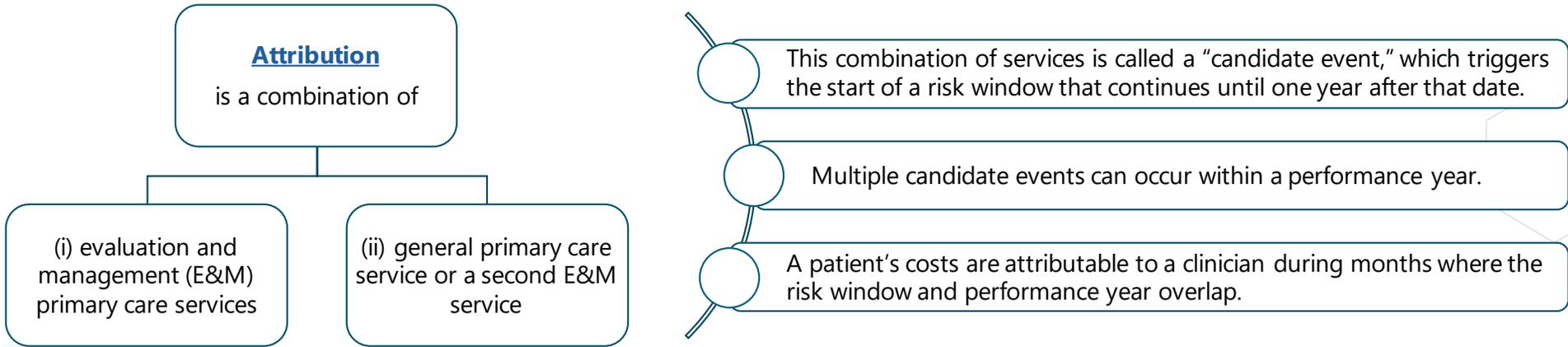
# Get Started with Cost Measures in Four Steps

## Step 2. Understand How Cost Measures are Calculated

This section provides a brief overview of the steps used to calculate the cost measures.

### Total Per Capita Cost (TPCC) Measure Calculation

We are making changes to the methodology for the TPCC measure calculation beginning with performance year 2020.



**We will exclude eligible clinicians who:**

primarily deliver non-primary care services (e.g. general surgery)

..... OR .....

practice in specialties unlikely to be responsible for primary care services (e.g. dermatology)

- We will also determine a patient’s risk score on a monthly, rather than annual, basis, using risk factors from the year prior to each month. This will help us reflect changes in the Medicare patient’s health status during the performance period for risk adjustment.
- We will assess costs on a monthly basis rather than an annual basis.

# Get Started with Cost Measures in Four Steps

## Step 2. Understand How Cost Measures are Calculated *(continued)*

### TPCC Measure Calculation *(continued)*

Step	Description/Additional Information
1. Identify candidate events	This is the start of a primary care relationship between a clinician and Medicare patient.
2. Apply service category and specialty exclusions	This excludes candidate events for certain clinicians. For example, clinicians whose candidate events meet thresholds for certain service categories (e.g., global surgery) or practice under certain specialties (e.g., dermatology).
3. Construct risk windows	For remaining candidate events, this opens a year-long risk window beginning with the initial E&M primary care service of the candidate event.
4. Attribute months to TINs and TIN-NPIs	Months in the risk window that occur during the performance period are attributed to the remaining eligible TIN-NPIs within the TIN responsible for the majority share, or plurality, of candidate events for a patient.
5. Calculate monthly standardized observed cost	This sums the cost of all services billed for the beneficiary during a given month. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
6. Risk-adjust monthly costs	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
7. Apply specialty adjustment	This accounts for the fact that costs vary across specialties and across TINs with varying specialty compositions.
8. Calculate the measure score	This is done by dividing each TIN and TIN-NPI's risk-adjusted monthly cost by the specialty-adjustment factor and multiplying by the observed cost across the total population of patient months where the risk window overlaps with the performance year.

# Get Started with Cost Measures in Four Steps

## Step 2. Understand How Cost Measures are Calculated *(continued)*

### Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Measure Calculation

We are also making changes to the MSPB Clinician methodology beginning with performance year 2020.

- The [attribution methodology](#) will distinguish between medical episodes and surgical episodes.
- We will exclude unrelated services specific to groups of Medicare Severity – Diagnosis Related Group (MS-DRGs) aggregated by Major Diagnostic Categories (MDCs), such as orthopedic procedures.

Step	Description/Additional Information
1. Define the population of index admissions	An episode is opened by an inpatient hospital admission (“index admission”). Medicare Part A and Part B claims billed 3 days prior to and during the index admission and 30 days after hospital discharge are considered for inclusion.
2. Attribute MSPB Clinician episodes	Episodes with medical MS-DRGs are attributed to: 1) the TIN that billed at least 30% of inpatient E&M services during the index admission, and 2) any TIN-NPI who billed at least one E&M service that was used to meet the 30% threshold for the TIN. Episodes with surgical MS-DRGs are attributed to the TIN and TIN-NPI that provided the main procedure for the index admission.
3. Exclude unrelated services and calculate episode standardized observed cost	This removes services clinically unrelated to the index admission and sums the cost of the remaining services. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Risk-adjust MSPB Clinician episode costs to calculate expected cost	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
5. Exclude outliers and winsorize costs	This mitigates the effect of outlier high- and low-cost episodes on each TIN-NPI or TIN’s MSPB Clinician measure score.
6. Calculate MSPB Clinician Measure score	This is done by calculating the ratio of standardized observed episode costs to winsorized expected episode costs and multiplying the average of this cost ratio across episodes for each TIN-NPI or TIN by the national average observed episode cost.

# Get Started with Cost Measures in Four Steps

## Step 2. Understand How Cost Measures are Calculated *(continued)*

### Episode-based Measure Calculation

Step	Description/Additional Information
1. Trigger and define an episode	This relies on billing codes that open, or “trigger,” an episode. The pre- and post-trigger period length of the episode varies by measure.
2. Attribute the episode to a clinician	For acute inpatient condition episodes, this is a clinician billing E&M services under a TIN that bills 30% of inpatient E&M services during the inpatient stay.  For procedural episodes, this can be any clinician who bills the trigger procedure code.
3. Assign costs to the episode and calculate the standardized episode observed cost	The cost of the assigned services is summed to determine each episode’s standardized observed cost. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Exclude episodes	This removes unique groups of patients in cases where it may be impractical and unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.
5. Risk-adjust cost to calculate expected episode costs	This step accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
6. Calculate the measure score	This is done by calculating the ratio of standardized observed episode costs to expected episode costs and multiplying the average cost ratio across episodes for each TIN-NPI or TIN by the national average episode cost.

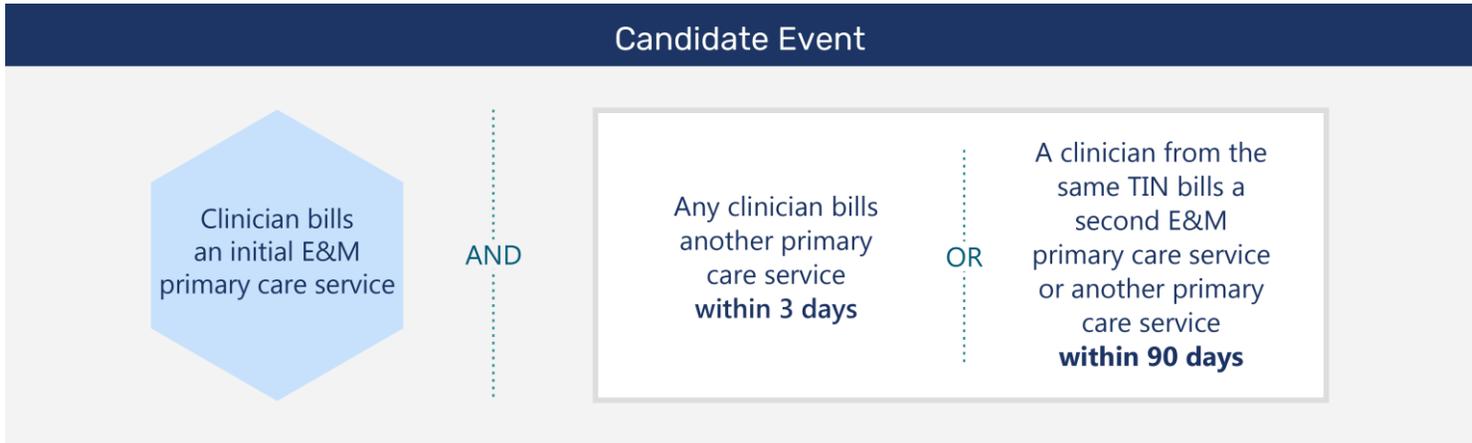
# Get Started with Cost Measures in Four Steps

## Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians

Although we generally attribute cost measures to individual clinicians, we can assess cost measure performance at the individual clinician (TIN-NPI) level or group (TIN) level, depending on how you participate.

### TPCC Measure Attribution<sup>1</sup>

TPCC attribution begins with a “candidate event,” or services triggering the start of the primary care relationship.

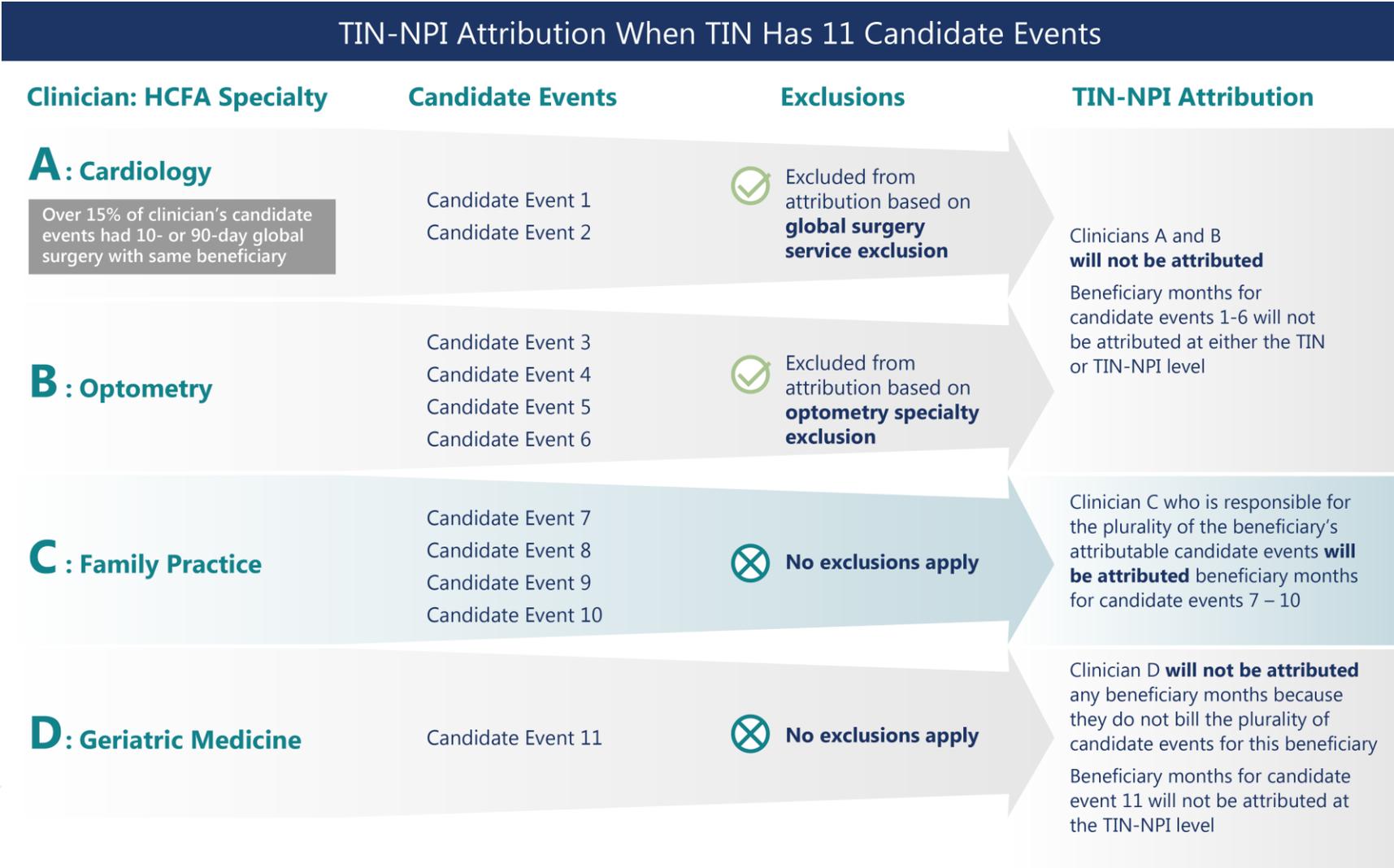


<sup>1</sup> Please review the revised [Total Per Capita Cost Measure Information Form](#) for information about TIN (group) attribution.

# Get Started with Cost Measures in Four Steps

## Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

### TPCC Measure Attribution *(continued)*



# Get Started with Cost Measures in Four Steps

## Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

### MSPB Clinician: Episode Attribution

MSPB Clinician attribution begins by identifying the “episode,” triggered by an inpatient hospital admission.



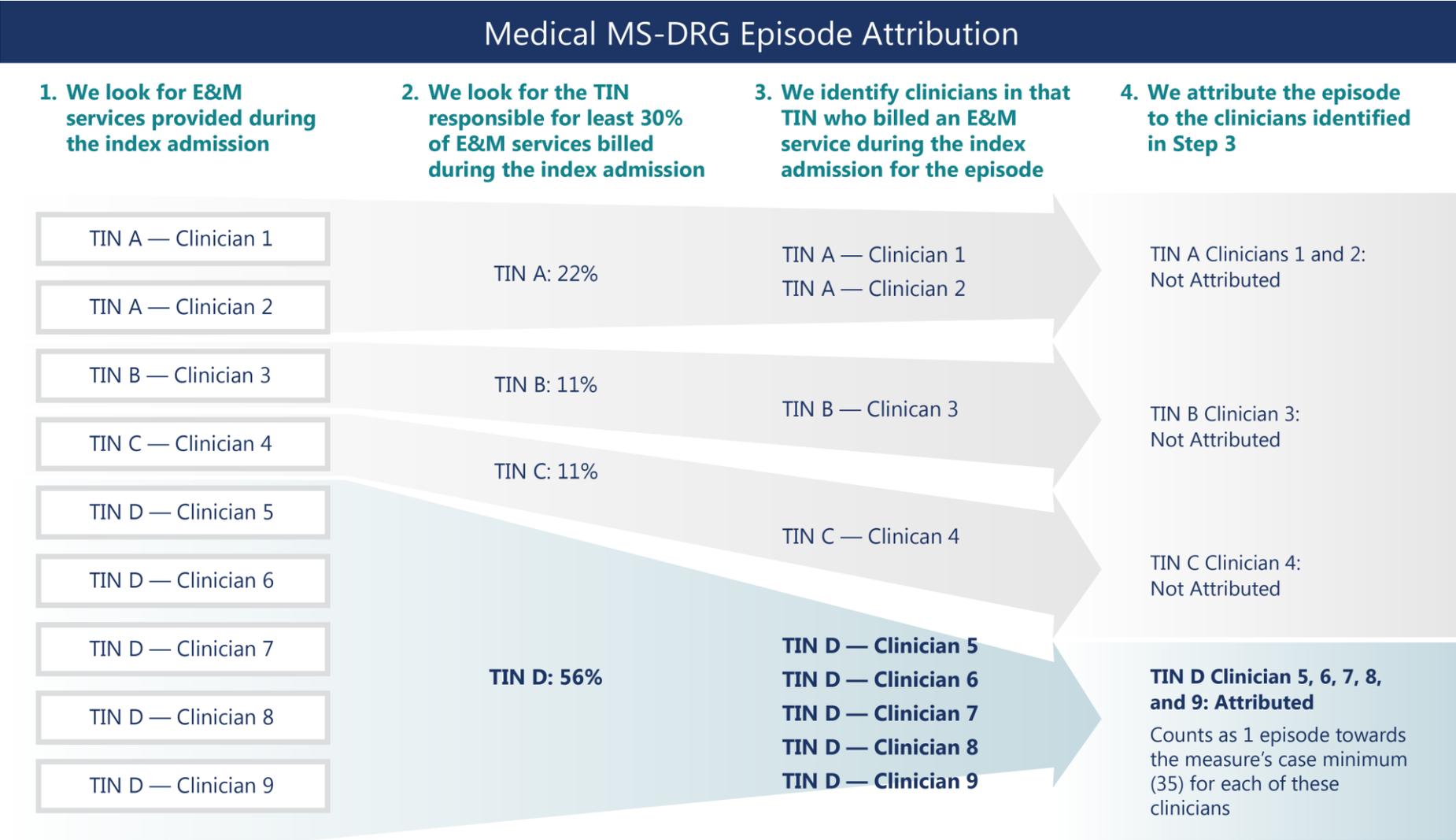
Episodes are classified as either medical or surgical, based on the MS-DRG.

- A **medical episode** is
  - First attributed to the TIN billing at least 30 percent of the inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
  - Then attributed to any clinician in the TIN who billed at least one inpatient E/M service that was used to determine the episode’s attribution to the TIN.
- A **surgical episode** is attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay as well as to the TIN under which the clinician(s) billed for the procedure.

# Get Started with Cost Measures in Four Steps

## Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

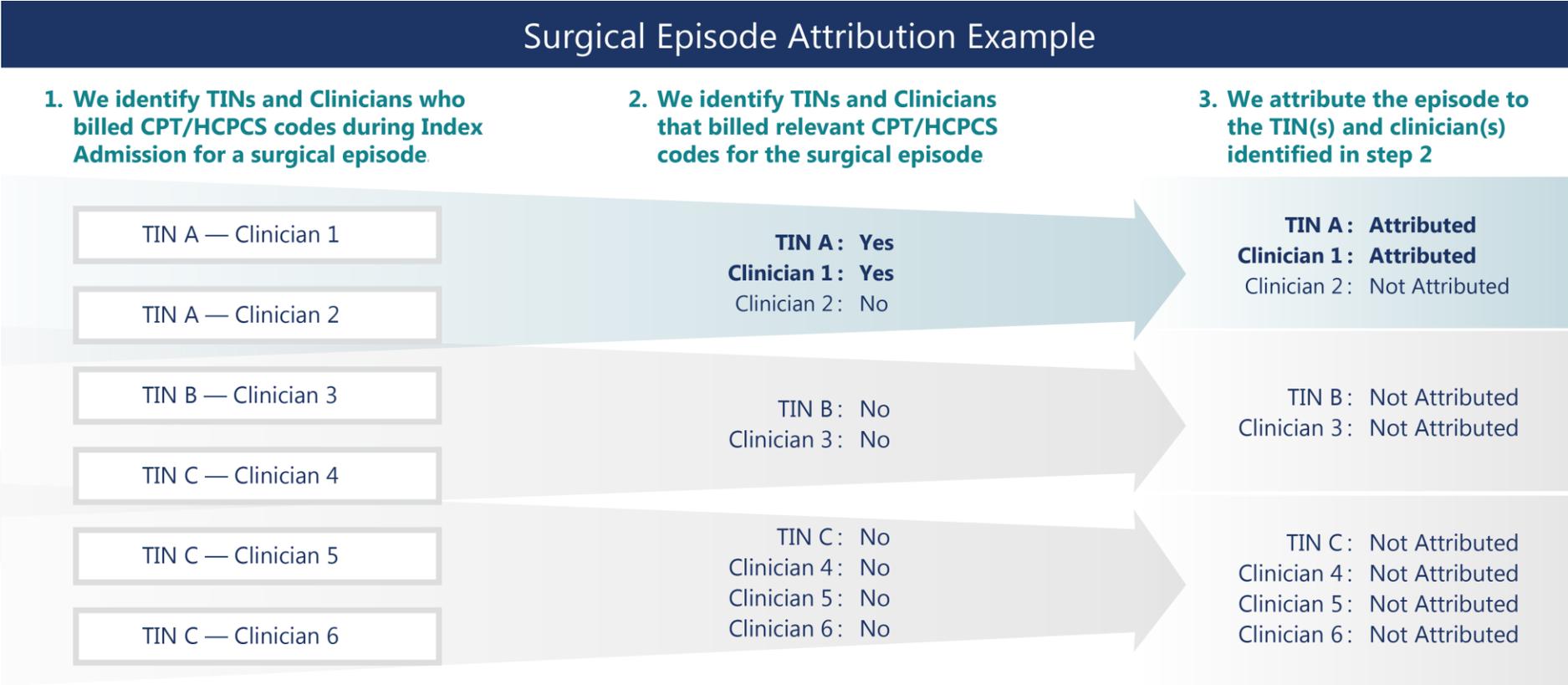
### MSPB Clinician: Medical Episode Attribution Example



# Get Started with Cost Measures in Four Steps

## Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

### MSPB Clinician: Surgical Episode Attribution Example



# Get Started with Cost Measures in Four Steps

## Step 3. Understand How Cost Measures Are Attributed to MIPS Clinicians *(continued)*

### Episode-based Measure Attribution

For **acute inpatient episodes**, an episode is:

- First attributed to the TIN billing at least 30 percent of inpatient E/M services on Part B physician/supplier claims during the inpatient stay.
- Then attributed to any clinician in that TIN who billed at least one inpatient E/M service during the inpatient stay.

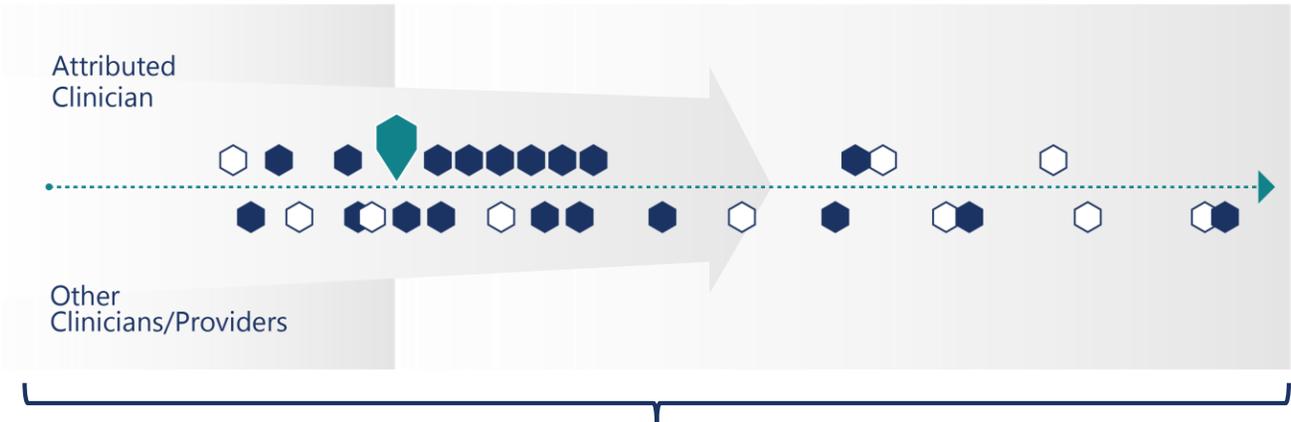
For **procedural episodes**, we attribute the episode to any clinician who bills the code that triggers the episode.

## Episode-based Measure Attribution

**Pre-Trigger Period  
(if applicable)**

**Post-Trigger Period**

**Attribution**



-  Trigger Service
-  Service Assigned to Episode
-  Service Not Assigned to Episode

**Episode Window**

# Get Started with Cost Measures in Four Steps

## Step 4. Understand What Cost Performance Feedback Will Be Available

MIPS eligible clinicians, groups, and virtual groups who meet the case minimum for any of the cost measures will receive category- and measure-level scoring information in their performance feedback. Each measure is scored out of 10 possible points, based on comparison to a performance period benchmark. (There are no historical benchmarks for cost measures.)

You can compare your costs for each measure with the benchmark provided to better understand your performance relative to your peers. To see what performance feedback looked like in previous years, review the cost section of the [2018 Performance Feedback FAQs](#).

We have also provided patient-level reports for viewing and downloading by clinicians and groups who were scored on the TPCC and MSPB Clinician measures and are currently investigating more detailed cost feedback for the 2019 Episode based measures. Visit the [2018 MIPS Performance Feedback Beneficiary-Level Data Reports Supplement](#) on the Resource Library for more information. (Note, this is the most current resource at the time of publication.)

Final performance feedback will be available by July 2021 when you sign in to [qpp.cms.gov](http://qpp.cms.gov).



## Help, Resources, and Version History

# Help, Resources, and Version History

## Where Can You Go for Help?

- Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 AM-8:00 PM ET or by e-mail at: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov).
  - Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.
- Connect with your [local technical assistance organization](#). We provide no-cost technical assistance to **small, underserved, and rural practices** to help you successfully participate in the Quality Payment Program.
- Visit the Quality Payment Program [website](#) for other [help and support](#) information, to learn more about [MIPS](#), and to check out the resources available in the [QPP Resource Library](#).

# Help, Resources, and Version History

## Additional Resources

The [OPP Resource Library](#) houses fact sheets, specialty guides, technical guides, user guides, helpful videos, and more. We will update this table as more resources become available.

Resource	Description
<a href="#">2020 MIPS Quick Start Guide</a>	A high-level overview of the Merit-based Incentive Payment System (MIPS) requirements to get you started with participating in the 2020 performance period.
<a href="#">2020 MIPS Eligibility and Participation Quick Start Guide</a>	A high-level overview and actionable steps to understand your 2020 MIPS eligibility and participation requirements.

# Help, Resources, and Version History

## Version History

If we need to update this document, changes will be identified here.

Date	Change Description
8/28/20	Added disclaimer language regarding changes to 2020 MIPS in response to COVID-19.
3/19/20	Corrected typo from MSPC-C to MSPB Clinician on page 8 and updated the MSPB Clinician measure name throughout
1/7/20	Original posting



## Appendix

## Episode-based Cost Measures for the MIPS 2020 Performance Year

Measure Topic	Measure Type	New in 2020
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	No
Knee Arthroplasty	Procedural	No
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	No
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	No
Screening/Surveillance Colonoscopy	Procedural	No
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Yes
Elective Primary Hip Arthroplasty	Procedural	Yes
Femoral or Inguinal Hernia Repair	Procedural	Yes
Hemodialysis Access Creation	Procedural	Yes
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	Yes
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	Yes
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	Yes
Renal or Ureteral Stone Surgical Treatment	Procedural	Yes
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	No
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	No
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	No
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	Yes
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	Yes