Episode Groups and Cost Performance Evaluation

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Disclosures

• I have no financial interests or relationships to disclose
MIPS Categories In 2019

45% 
Quality Measures (PQRS)

25% 
Promoting Interoperability (EHR MU)

15% 
Clinical Practice Improvement Activities

15% 
Resource Use Cost (VBM)
Cost Performance Evaluation In MIPS

- 15% of MIPS score in 2019 (affecting 2021 payments)
- Metrics derived solely from Medicare Part A and Part B claims data
  - No “reporting”
- Cost score based on three measures
  1. Total per capita cost (TPCC) per beneficiary: mostly primary care
  2. Medicare spending per beneficiary (MSPB): mostly for inpatient care
  3. Cost episode groups: new in 2019
TPCC For All Attributed Beneficiaries

• Total Per Capita Cost: all risk- and specialty-adjusted Medicare Part A and Part B costs per patient for all patients attributed to a TIN-NPI or TIN

• Attribution 2-step process
  1. Attempt to attribute patient to a PCP (identified by 2-digit specialty code) based on plurality of primary care services.

  If no PCP billed primary care services, go to Step 2

  2. Attribute to non-PCP who provided most primary care services, identified by
     • E&M codes (99201-99215)
     • NOT eye visit codes (92002-92014)
Problems with TPCC Patient Attribution

• Use of E&M codes for frequent office visits may result in patient care costs attributed to specialists not responsible for that care
  • Multiple office visits for intravitreal injections or glaucoma
  • Cost of treating COPD, CHF, etc., may be attributed

• Attribution spread over multiple providers – vague methodology

• Ophthalmologists may inappropriately be attributed costs

• Use eye codes (92002-92014) to avoid misattribution of patients
  • Tradeoff for lower reimbursement vs. level 4 and 5 E&M codes
Medicare Spending Per Beneficiary

- Based on inpatient episodes of care
- Average of observed/risk-adjusted expected costs for attributed episodes for each TIN-NPI or TIN
  - Includes costs of claims from 3 days prior to 30 days after hospital discharge
  - Data manipulation: winsorization, exclusion of outliers
- Attribution of episodes based on plurality of part B physician/supplier services during the hospital admission
- Ophthalmologists should not be attributed cases
Cost Episode Groups

- Developed by clinicians, led by Acumen, LLC (consultant to CMS)

- First Wave: Eight Groups
  - Elective Outpatient Percutaneous Coronary Intervention (PCI)
  - Knee Arthroplasty
  - Revascularization for Lower Extremity Chronic Critical Limb Ischemia
  - Routine Cataract Removal with Intraocular Lens (IOL) Implantation
  - Screening/Surveillance Colonoscopy
  - Intracranial Hemorrhage or Cerebral Infarction
  - Simple Pneumonia with Hospitalization
  - ST-Elevation Myocardial Infarction (STEMI) with PCI
Eligible Cases

• *Routine* cataract/IOL surgery: ONLY 66984

• Excluded from the measure:
  • ALL cases that would be excluded in the two cataract PQRS measures
    • 120-day look-back period prior to date of surgery
    • Any PQRS-excluded diagnosis listed anywhere on the claim form
  • Eliminates high-risk cases that would otherwise be difficult to risk-adjust
  • Almost half of 66984 cases

• Minimum eligible cases necessary to generate a score: 10
What Costs Are Included?

• Pre-op costs occurring within 60 days prior to surgery
  • Office visits and tests by any provider with cataract as a primary diagnosis
  • Tests potentially considered part of cataract workup regardless of diagnosis
    • A-scan, optical biometry, topography, tear osmolality, OCT of macula, etc.

• Costs associated with the procedure itself
  • Physician fee, facility fee, anesthesia fee

• Post-op costs occurring within 90 days after surgery
  • Only those billed to CMS (excludes routine postop visits in global period)
  • Includes complications such as retained lens fragments, IOL repositioning or exchange, retinal detachment, endophthalmitis
Subgrouping

• Eliminates effects of costs not under the physician's control
• HOPD vs. ASC
• Unilateral vs. bilateral (within 30 days)
• Compare only similar cases to one another
• Assign subgroup scores based on costs within each subgroup
• Calculate final score based on weighted average of subgroup scores
Additional Risk-Adjustment Factors

Linear regression model applied to control for beneficiary characteristics

- Age
- Proctored resident cases
- New vs. established patients
- End stage renal disease (ESRD) status
- Institutionalized in a long term care facility
- Hierarchical Condition Categories (HCC) data
Summary of Cost Scoring in 2019

• Cost accounts for 15% of MIPS score in 2019, for payment in 2021
  • Increases to 30% no later than 2022 (previously set for 2020)

• Cataract episode group added to TPCC, MSPB measures

• Weighting of episode, TPCC, MSPB, scores for final cost score unknown
  • Ophthalmologists should not have MSPB scores, some may have TPCC scores
    • Avoid misattribution of patients for TPCC by use of eye codes
  • Episode group will likely be sole determinant of cost score for most
  • If no score on any of the three measures, cost component of MIPS shifted to quality

• Cost episode group scores found on CMS’ QRUR website