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Episode Groups and Cost Performance Evaluation

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Disclosures

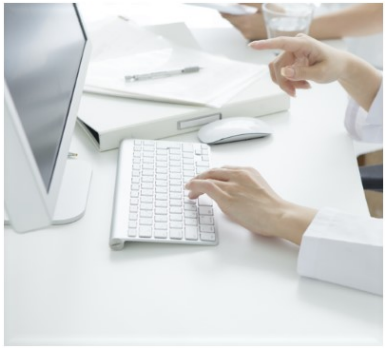
- I have no financial interests or relationships to disclose

MIPS Categories In 2019

45%

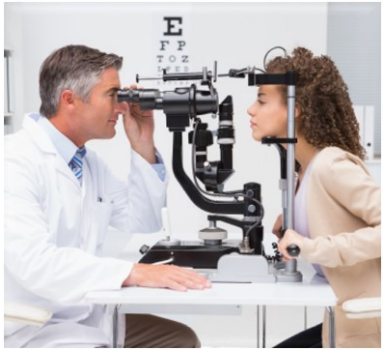
Quality Measures (PQRS)

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

Ophthalmology 2019;126:189