# Understanding the Impact of the MIPS Cost Category

April 11, 2018

# Housekeeping

- If you are experiencing technical difficulties, please dial: **800-422-3623.**

- **Q&A session will be held at the end of the presentation.**
  - Your questions can be submitted via the **Questions Function at any time during the presentation.**

- The **PowerPoint presentation,** as well as the **webinar recording,** will be sent to you within the next 10 business days.

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# About CliftonLarsonAllen

- A professional services firm with three distinct business lines
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  - Outsourcing
  - Audit, Tax, and Consulting
- More than 5,400 employees
- Offices coast to coast
- Serve more than 8,300 health care clients

*Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC.*

# Speaker Introductions

- **Penny Osmon Bahr**

  Penny is a health care principal at CLA with more than 20 years of industry experience and has worked across the continuum with independent physicians practices, accountable care organizations, health systems and health plans. She is an executive level health care operations specialist that works to develop business strategy, navigate regulatory impact and execute improvement across the health care ecosystem

- **Tony Werner**

  Tony specializes in serving hospitals, systems, and physician groups. He has over 30 years of experience in hospital, imaging, and physician group leadership, operations, HIT, revenue cycle and technology management. Tony is called on frequently for revenue cycle and practice assessments and MACRA, PQRS and Meaningful Use assistance.

# Learning Objectives

- At the end of this session, you will be able to:
  - Describe the variety of data available in a QRUR
  - Identify how to use a QRUR to identify Medicare patient leakage
  - Determine where interventions may be necessary across the care continuum
  - Recognize Medicare spending by service categories including: chronic care, acute care, specialist care, and post-acute care

# The Burning Platform was Created for

# Payment Transformation

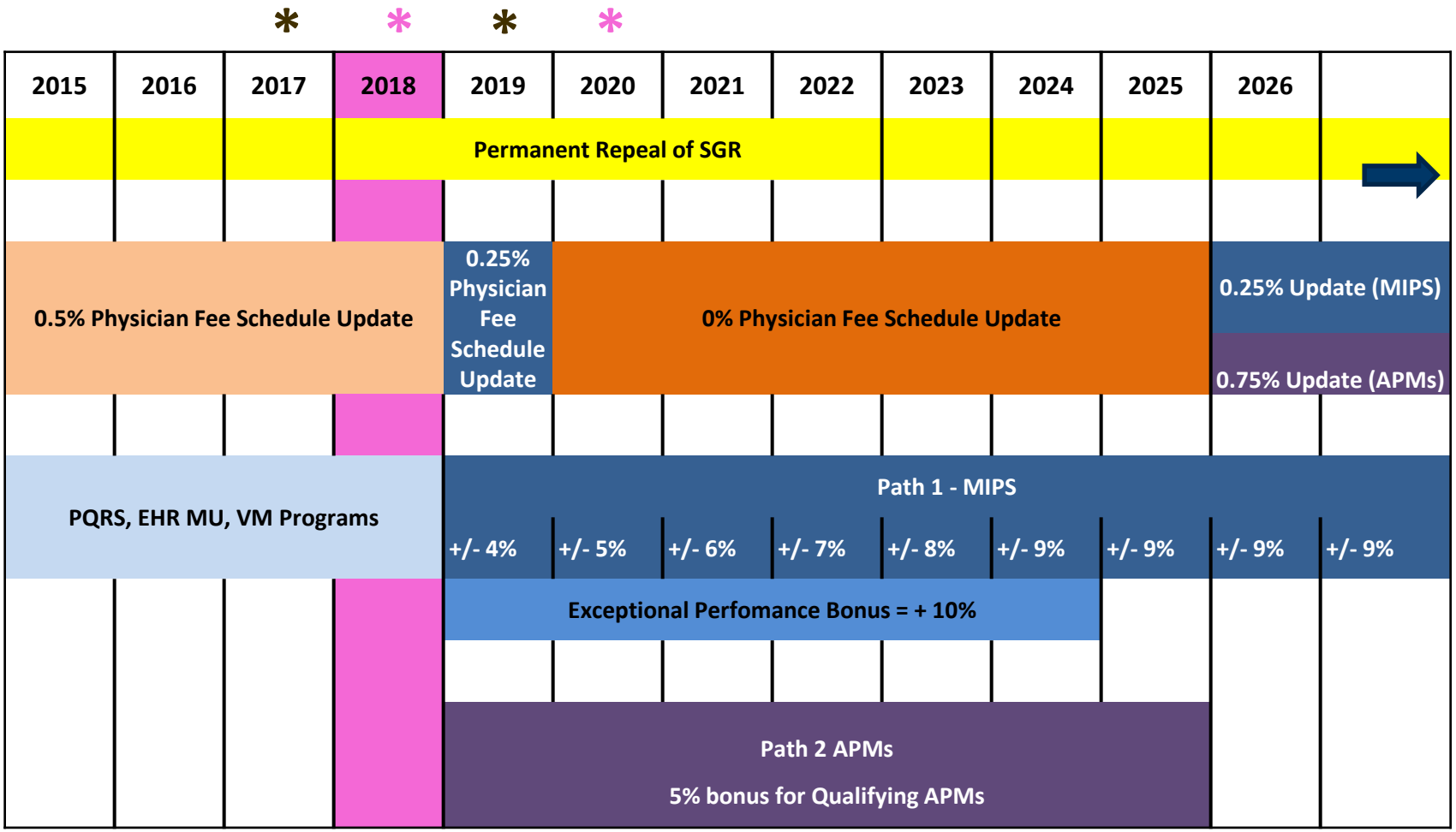
**Volume to Value**

**Quantity vs. Quality**

# MACRA – The MIPS Webinar Series

- **Webinar 1: Quality Payment Program, Year Two — Focus on the Changes**
- **Webinar 2: MIPS Quality Reporting: Choosing the Right Measures**
- **Webinar 3: Understanding the Impact of the MIPS Cost Category**

# MACRA Changes Physician Payment

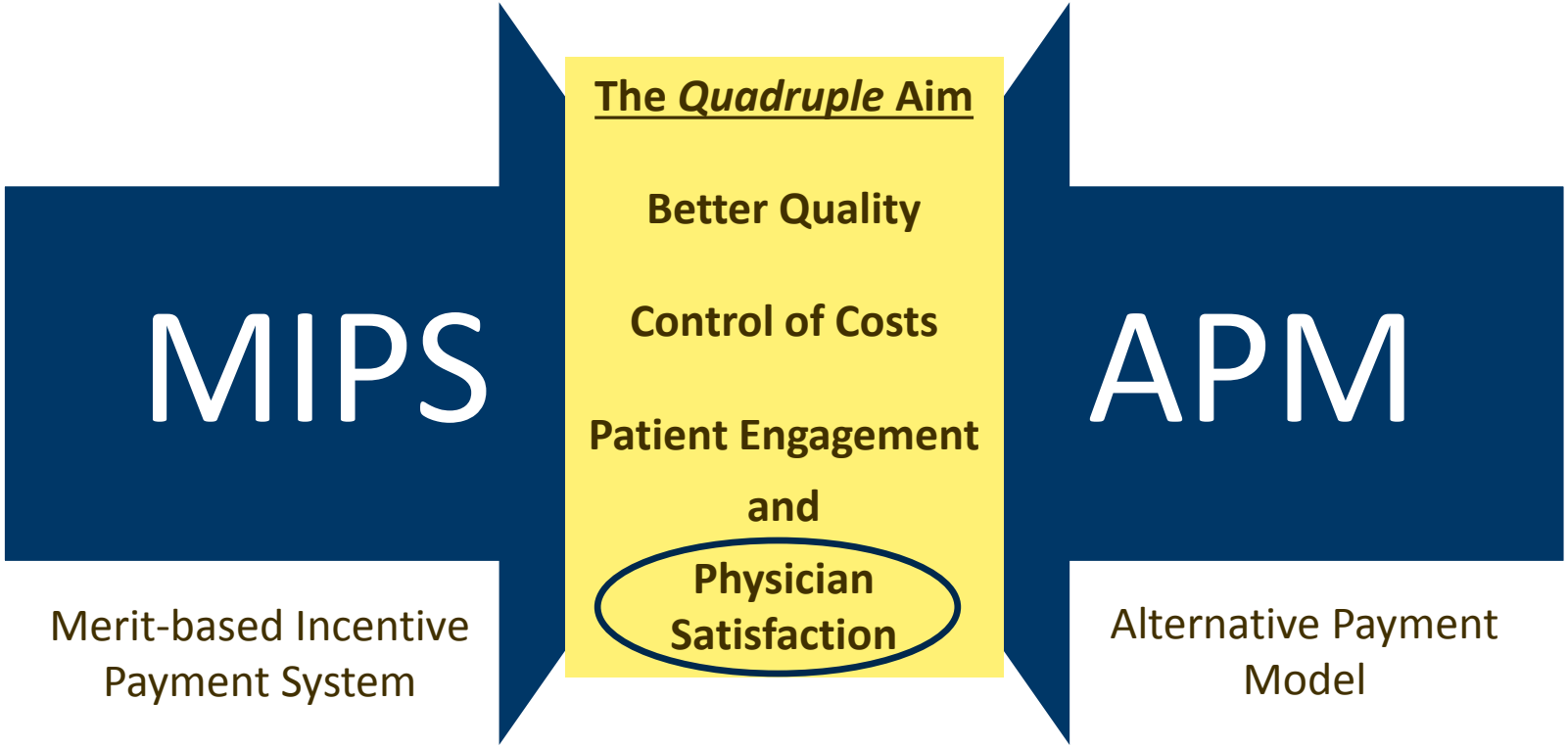



*Measurement year is followed by a year of analysis prior to the payment year. Measure, analyze, apply.

* QPP Year 2.

# MACRA QPP Paths

***Medicare Participating Physicians***




Merit-based Incentive Payment System

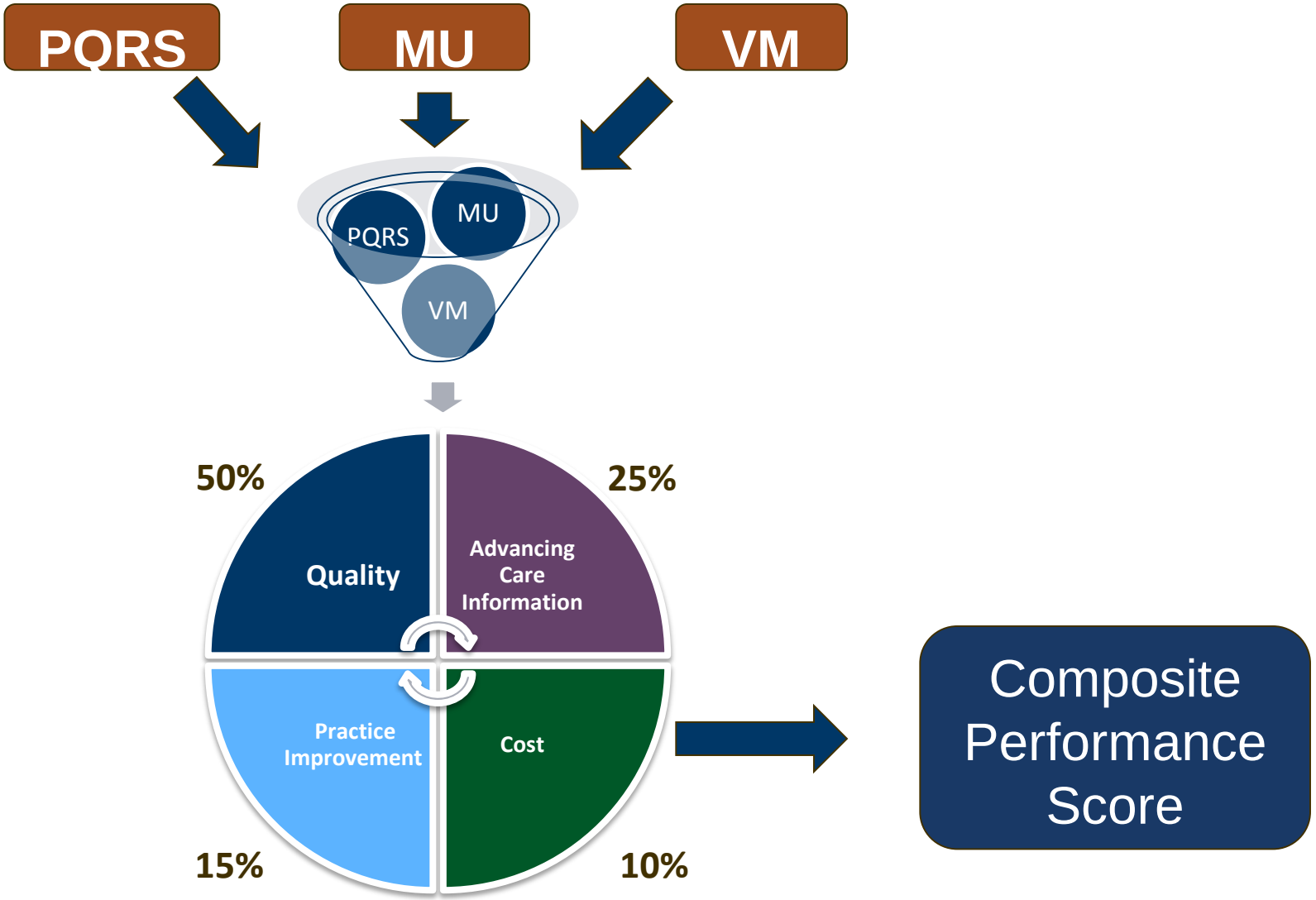
Alternative Payment Model

Complex, yet flexible reporting requirements

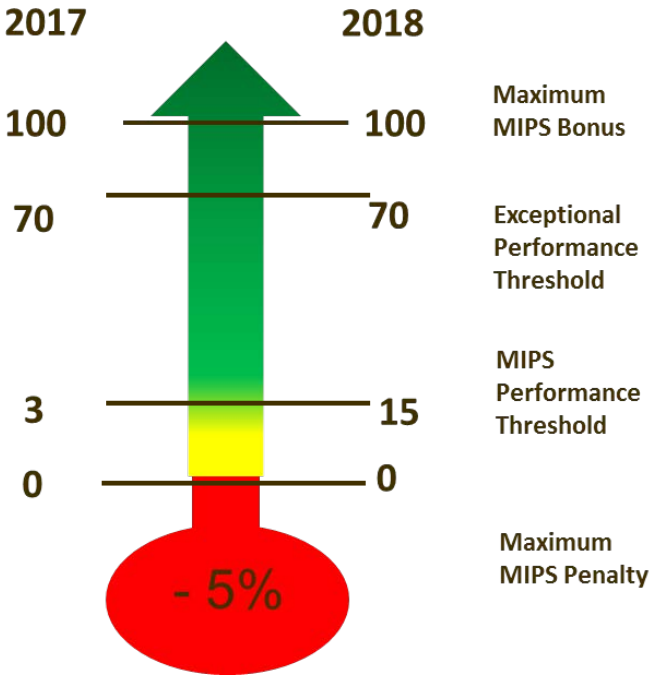
Requires technical infrastructure and appetite for risk

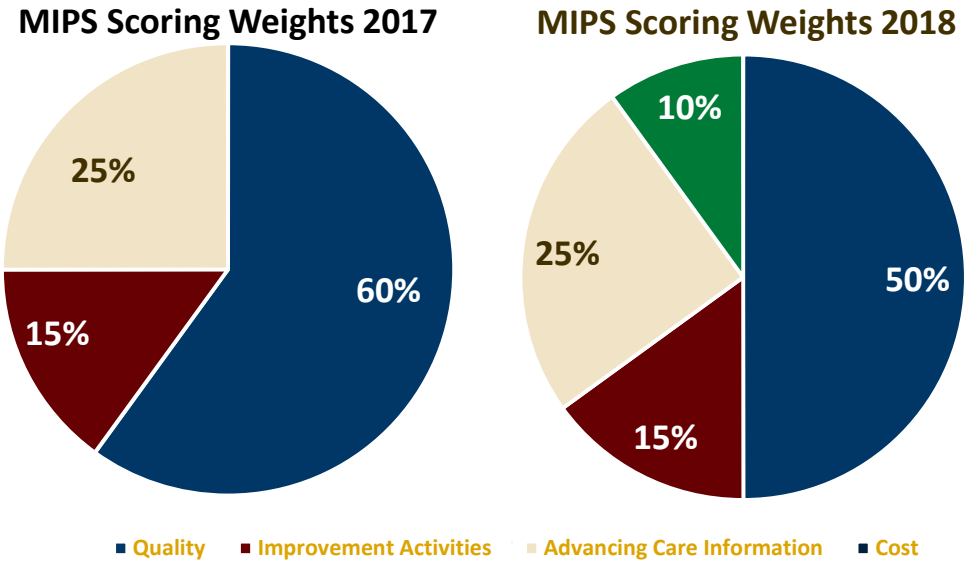
# The Merit-Based Incentive Payment System (MIPS)

# MIPS Components - Review



# MIPS Scoring

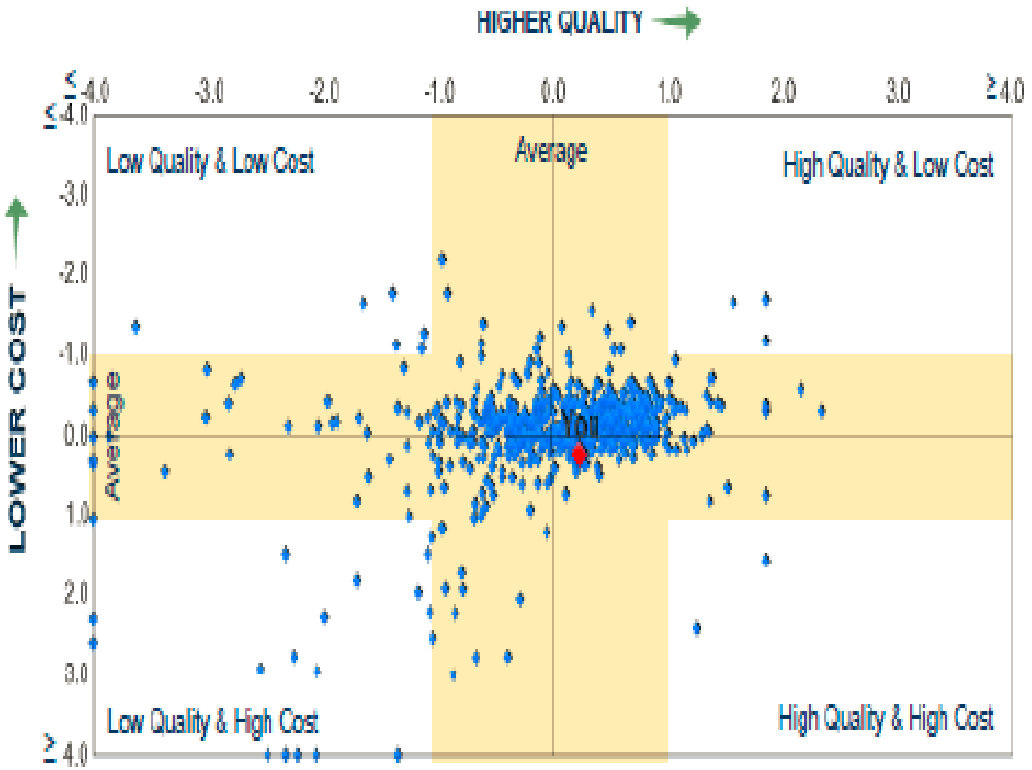



# MIPS Cost Performance

- **CHANGE:** Weighting the MIPS Cost performance category to 10% of your total MIPS final score in 2018 and 30% in 2019.
- CMS will include the **Medicare Spending per Beneficiary** (MSPB) and **Total per Capita Cost** measures to calculate your Cost performance category score for the 2018 MIPS performance period.
  - These two measures carried over from the Value Modifier program and are currently being used to provide feedback for the MIPS transition year.
  - The 10 episode-based measures utilized for the 2017 MIPS performance period have been eliminated in 2018. Episode based cost measures are being tested for 2019.
  - No reporting is required from clinicians, claims data is utilized.
  - More regular feedback with goal of July 2018.

# Quality and Resource Use Reports (QRUR)




## QRUR Data

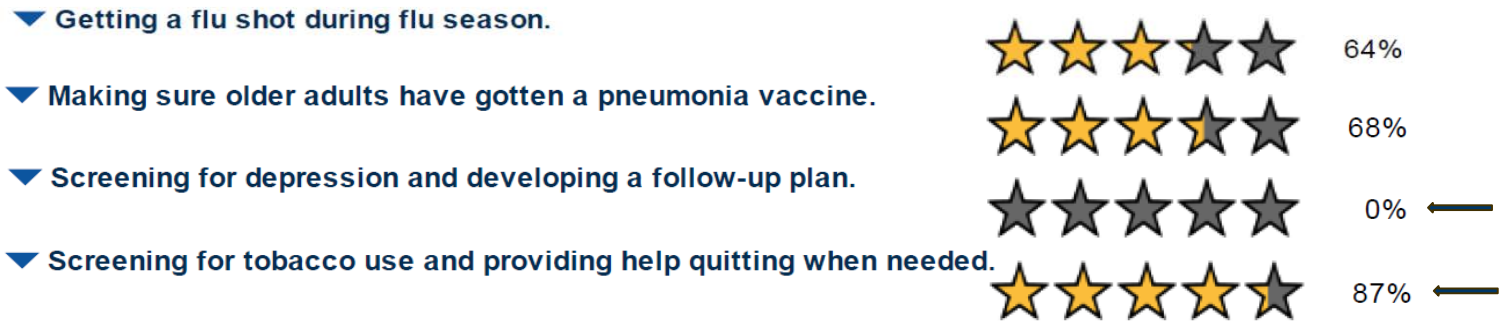
1. Attribution
2. Cost of Chronic Conditions
3. Cost of Acute Conditions
4. Cost of Specialist Care
5. Cost of Post Acute Care
6. Patient Leakage
7. Patient Risk Profile

# CMS Physician Compare

The CMS Physician Compare provides a significant amount of performance data publically and creates a reputational risk for poor performers as well as the financial risk.

## Clinical Quality of Care

Preventive Care:




Patient Experience (CAHPS):


More stars is better.

Data from CMS Physician Compare Website: https://www.cms.gov › Medicare › Physician Compare Initiative.

# Quality – Cost – Revenue Relationships

# Quality Measures

Lower | Average | Better

**Results of Quality Measures Reported to CMS**

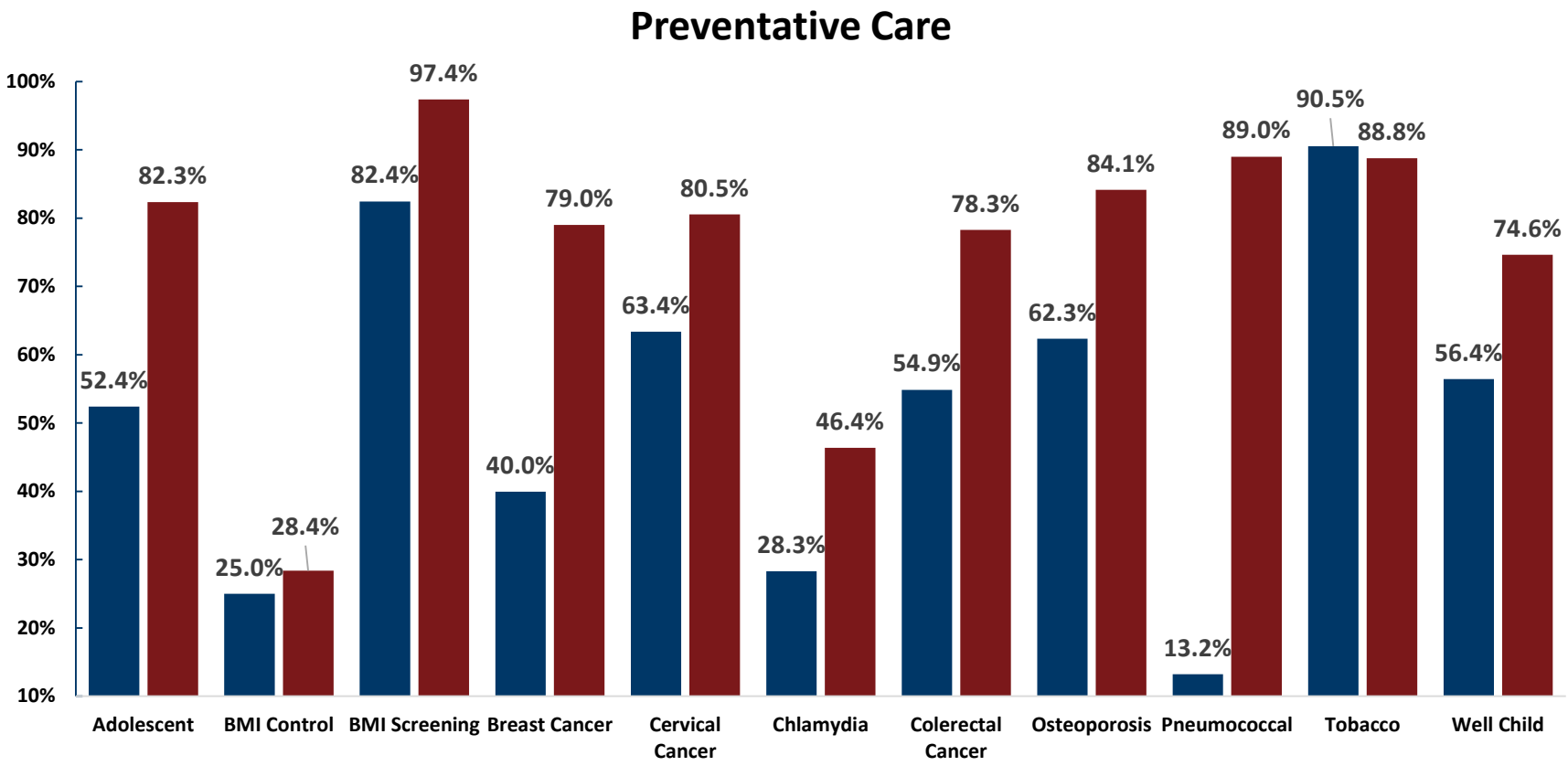
| PQRS Measure # | NQF Measure # | eCQM ID | Measure Title | Measure Satisfactorily | Performance Rate | Inverse Measure? | Decile | Estimated Points | Decile 3 | Decile 4 |
|---|---|---|---|---|---|---|---|---|---|---|
| 110 | 0041 | CMS147v5 | Preventive Care and Screening: Influenza Immunization | Yes | 26.51% | No | 4 | 3.6 | 11.57 - 21.39 | 21.40 - 31.39 |
| 111 | 0043 | CMS127v4 | Pneumonia Vaccination Status for Older Adults | Yes | 28.36% | No | 4 | 3.5 | 12.24 - 24.02 | 24.03 - 36.34 |
| 112 | 2372 | CMS125v4 | Breast Cancer Screening | Yes | 31.06% | No | 4 | 3.5 | 14.49 - 24.52 | 24.53 - 35.70 |
| 113 | 0034 | CMS130v4 | Colorectal Cancer Screening | Yes | 27.15% | No | 4 | 3.5 | 10.08 - 20.68 | 20.69 - 32.73 |

**Table 2: MIPS Benchmark Results**

| Measure_Name | Measure_ID | Measure_Type | Benchmark | Decile 3 | Decile 4 | Decile 5 | Decile 6 | Decile 7 |
|---|---|---|---|---|---|---|---|---|
| Osteoarthritis (OA): Function and Pain Assessment | 109 | Process | Y | 80.92 - 94.14 | 94.15 - 98.67 | 98.68 - 99.99 | -- | -- |
| Preventive Care and Screening: Influenza Immunization | 110 | Process | Y | 11.57 - 21.39 | 21.40 - 31.39 | 31.40 - 41.31 | 41.32 - 51.13 | 51.14 - 62.04 |
| Pneumonia Vaccination Status for Older Adults | 111 | Process | Y | 12.24 - 24.02 | 24.03 - 36.34 | 36.35 - 48.51 | 48.52 - 58.95 | 58.96 - 68.05 |
| Breast Cancer Screening | 112 | Process | Y | 14.49 - 24.52 | 24.53 - 35.70 | 35.71 - 46.01 | 46.02 - 55.06 | 55.07 - 63.67 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 116 | Process | Y | 23.19 - 31.47 | 31.48 - 63.74 | 63.75 - 99.99 | -- | -- |
| Diabetes: Eye Exam | 117 | Process | Y | 86.36 - 97.77 | 97.78 - 99.99 | -- | -- | -- |
| Documentation of Current Medications in the Medical Record | 130 | Process | Y | 96.11 - 98.73 | 98.74 - 99.64 | 99.65 - 99.99 | -- | -- |
| Pain Assessment and Follow-Up | 131 | Process | Y | 75.66 - 95.78 | 95.79 - 99.33 | 99.34 - 99.99 | -- | -- |

Table 2 MIPS Benchmark Results – extracted from CMS Quality Measures Benchmark FAQs

# Tying Quality Measures to Reimbursement




The graph above shows several opportunities for improving preventative care and reimbursement.

# Tying Quality Measures to Reimbursement

**One example of tying quality to reimbursement is obesity.**

**MIPS Measure #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**

**HCPCS code G0447 Face-to-Face Behavioral Counseling for Obesity (15 minutes) reimburses at $26.28 per patient.**

**Approximately 4,000 CLAC patients had an uncontrolled BMI, but we can't tell from this data how many were morbidly obese. If 2,000 patients were morbidly obese and received the 15 minutes of counseling, the financial return is approximately $52,560. This service reimburses $26.28 for 15 minutes of counseling (weight loss goal must be measured at 6 month increment). If a patient went through the full program for the first 6 months, it would be 367.92. 4 visits the first month, 2 visits for months 2-6 and 1 once a month for months 7-12 if weight loss goal achieved. This would result in $73,584 for 200 of the 4,000 uncontrolled patients went through the first 6 months of the program without any weight loss.**

# Care Coordination Visit – Examples

| Providers | Visits |
|---|---|
| DONALD DUCK | 2095 |
| MICKEY MOUSE | 1761 |
| Grand Total | **3856** |

**Total Office CCM, ACP, & MWE, Codes**

| Providers | Visits | Total Billed MCR | Total Paid |
|---|---|---|---|
| DONALD DUCK | 9 | $2,329 | $1,053 |
| G0438 | 1 | $329 | $165 |
| G0439 | 8 | $2,000 | $889 |
| Grand Total | **9** | **$2,329** | **$1,053** |

| Providers | MWE | CCM | TOC | ACP |
|---|---|---|---|---|
| | 40% | 20% | 20% | 40% |
| DONALD DUCK | $94,996 | $21,668 | $66,709 | $68,238 |
| MICKEY MOUSE | $79,851 | $18,213 | $56,074 | $57,359 |
| | **$174,846** | **$39,881** | **$122,783** | **$125,598** |

- Drs. Duck and Mouse had 3,856 unique Medicare patient visits in the claims data extraction during the first 9 months of 2017.
- If the criteria is met, Medicare will pay for simple and complex patient care coordination, Medicare Wellness, advanced care planning, and care transition services (CPT codes).
- During 2017, there was a total of 9 Medicare Wellness visits billed to Medicare for all providers on the table to the left.
- If the Medicare Wellness, Care Coordination, Transition of Care, and Advanced Care Planning visits were increased as a percent (table on right) of all Medicare patients, the table on the left represents additional net payments.

**Comparable data from January 2017 to Sept. 2017 CLA Intuition RCA® - Titan Comparative Data.**

# MIPS 2018: Cost

# MIPS Cost Performance

- **Medicare Spending per Beneficiary** (MSPB).
  - The Medicare Spending Per Beneficiary (MSPB) clinician measure assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode, which comprises the period **immediately prior to, during, and following a patient's hospital stay**.
  - An MSPB episode includes **all Medicare Part A and Part B** claims (allowed charges) falling in the episode "window," specifically claims with a start date between 3 days prior to a hospital admission (also known as the "index admission" for the episode) through 30 days after hospital discharge.
  - **The MSPB measure is attributed to individual clinicians,** as identified by their unique Medicare Taxpayer Identification Number/National Provider Identifier (TIN-NPI). MSPB measure performance may be reported at either the clinician (TIN-NPI) or the clinician group (TIN) level.

# MIPS Cost Performance

- **Medicare Spending per Beneficiary** (MSPB).
  - Clinicians who do not see patients in the hospital will not be attributed to any episodes and not scored on the measure.
  - No longer specialty adjusted.
  - Clinicians must be attributed to at least 35 cases to be scored on this measure.
  - Episodes will be attributed to the clinician who provided the plurality of Medicare Part B services to a beneficiary during an index admission.

# MIPS Cost Performance

- **Calculate Risk-Adjusted Expected MSPB Episode Costs**
  - To estimate the expected cost for each episode, the MSPB methodology uses an *ordinary least squares regression model* to **risk adjust** for beneficiary age and comorbidities.
  - Specifically, expected costs for each episode are calculated using a model based on the **CMS Hierarchical Condition Category** (CMS-HCC) risk adjustment methodology for the Medicare Advantage program.
    - ◊ However there are several differences, for example, in the MSPB methodology a separate risk adjustment model was estimated for episodes within each major diagnostic category (MDC). The MDC is determined by the Medicare Severity Diagnosis Related Group (MS-DRG) of the index hospital stay. The Medicare Advantage Program risk adjustment model includes 24 age/sex variables, while the MSPB methodology does not adjust for sex and includes 12 age categorical variables. In addition, the MSPB methodology includes individual indicator variables for history of ESRD, long-term care status, and whether the beneficiary qualifies for Medicare through disability or age, in contrast to the stratification and interaction variables used in the Medicare Advantage model.

# MIPS Cost Performance

- **Total per Capita Cost** (TPCC).
  - The **Total Per Capita Costs for All Attributed Beneficiaries** (TPCC) measure is a payment-standardized, annualized, risk-adjusted, and *specialty-adjusted* measure that evaluates the **overall cost of care** provided to **beneficiaries attributed to clinicians**, as identified by a unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI).
  - The Total Per Capita Costs for All Attributed Beneficiaries measure can be reported at the TIN or the TIN-NPI level.
    - Attribution Method: **Two-step process**
      1. **Attributed to provider with largest share of primary care services provided by PCPs**
      2. **If beneficiary didn't visit PCP, attribution applied to specialist with plurality of services**

# MIPS Total per Capita Cost Performance

- **Total per Capita Cost – 5 Step Calculation**
  - Step 1: Attribute Beneficiaries to TIN-NPI
  - Step 2: Calculate Payment Standardized Per Capita Costs
  - Step 3: Annualize Costs
  - Step 4: Risk-Adjust Costs
  - Step 5: Specialty-Adjust Costs

# MIPS Cost Performance

- **Risk-Adjust Total Per Capita Costs for all Beneficiaries**
  - Risk adjustment accounts for beneficiary-level risk factors that can affect medical costs, regardless of the care provided. To estimate the expected per capita cost for each beneficiary, the TPCC methodology uses an ordinary least squares regression model to risk adjust for two measures of beneficiary risk. Prior to estimation of the regression model, extreme values of per capita costs are adjusted in a process called Winsorization: **the top and bottom 1 percentile of the distribution of beneficiary costs is replaced with the 99$^{th}$ and 1$^{st}$ percentile value**.
  - The two measures of beneficiary risk used in the risk adjustment algorithm are the beneficiary's CMS-Hierarchical Condition Category (CMS-HCC) risk score and End Stage Renal Disease (ESRD) status. To ensure that the model measures the influence of health status (as measured by diagnoses) on the treatment provided (costs incurred), rather than capturing the influence of treatment on a beneficiary's health status, the risk adjustment model uses prior year (2016) risk factors to predict current year (2017) total per capita costs. The CMS-HCC model generates a risk score for each beneficiary that summarizes each beneficiary's expected cost of care relative to other beneficiaries

# Example of Cost Scoring

- ✓ 8 of 10 points achieved for Cost per Capita
- ✓ 7 of 10 points achieved for MSPB

Category percent score = (8+7) / (2*10) = 15/20 (***75%***)

75% x 10% x 100 = 7.5 MIPS Points for Cost

# MIPS 2018 – QRUR

# QRURs Provide Insight for Opportunities

**The Quality Resource and Utilization Report is packed with useful information in regards to a clinic's Medicare population.**

- QRURs include data on the "Medicare Spend" or costs and insight into the "where, why, and how" these costs are generated.
- Clinics can see the costs to Medicare generated by their providers, as well as other providers and facilities outside their organization.
- QRURs allow for segmentation of costs to the different parts of the health care continuum.

**Having a good understanding of the organizations care costs will be very important for success in the future.**

# Per Capita Costs for all Attributed Beneficiaries



Table 3A. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure

† Indicates terms defined through the hover-over function.

| | Your TIN | | | All TINs in Peer Group† | | |
|---|---|---|---|---|---|---|
| **Service Category** | **Number of Attributed Beneficiaries Using any Service in this Category** | **Percentage of Beneficiaries Using any Service in this Category** | **Per Capita Costs for Attributed Beneficiaries †** | **Benchmark (National Mean) Percentage of Beneficiaries Using Any Service in This Category** | **Benchmark (National Mean) Per Capita Costs** | **How Much Higher or (Lower) Your TIN's Costs Were than TINs in Peer Group** |
| **ALL SERVICES** | 1,610 | 100.00% | $12,857 | 100.00% | $12,380 | $477 |
| **Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)** | **1,610** | **100.00%** | **$1,423** | **100.00%** | **$1,991** | **($568)** |
| **Evaluation & Management Services Billed by Eligible Professionals** | 1,610 | 100.00% | $803 | 100.00% | $1,161 | ($357) |
| **Billed by Your TIN** | 1,610 | 100.00% | $424 | 99.99% | $496 | ($73) |
| Primary Care Physicians | 1,380 | 85.71% | $294 | 61.33% | $341 | ($47) |
| Medical Specialists | 519 | 32.24% | $85 | 17.81% | $55 | $30 |
| Surgeons | 31 | 1.93% | $2 | 7.79% | $22 | ($20) |
| Other Eligible Professionals | 469 | 29.13% | $43 | 22.13% | $78 | ($36) |
| **Billed by Other TINs** | 1,321 | 82.05% | $380 | 81.13% | $664 | ($285) |
| Primary Care Physicians | 174 | 10.81% | $20 | 24.05% | $55 | ($35) |
| Medical Specialists, Surgeons, and Other Eligible Professionals | 1,304 | 80.99% | $359 | 79.21% | $609 | ($250) |

Source: CMS QRUR Report: Table 3A

# Per Capita Costs for all Attributed Beneficiaries



**CLA Clinic's (CLAC) Per Capita Costs for all services provided is higher than the peer benchmark levels.**

- **The overall per capita costs for all beneficiaries is 3% greater than the benchmark costs.**
- **E&M services are 41% lower than the benchmark costs.**
  - **CLAC's E&M per capita costs are 21% lower than the benchmark costs, while the E&M costs for other TIN's was 43% below the benchmark.**
  - **70% of the lower spend for E&M services can be attributed to Medical Specialists outside our TIN.**
  - **CLAC's primary care physicians per capita costs were 27% below the benchmark costs for E&M services.**

**Although the MIPS Cost category is weighted at 10% for 2018, it is good for an organization to understand their cost of care.**

# Per Capita Costs for all Attributed Beneficiaries

**Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure**

| | Your TIN | | | All TINs in Peer Group† | | |
|---|---|---|---|---|---|---|
| **Service Category** | **Number of Attributed Beneficiaries Using any Service in this Category** | **Percentage of Beneficiaries Using any Service in this Category** | **Per Capita Costs for Attributed Beneficiaries †** | **Benchmark (National Mean) Percentage of Beneficiaries Using Any Service in This Category** | **Benchmark (National Mean) Per Capita Costs** | **How Much Higher or (Lower) Your TIN's Costs Were than TINs in Peer Group** |
| **ALL SERVICES** | 1,610 | 100.00% | $12,857 | 100.00% | $12,380 | $477 |
| **Hospital Inpatient Services** | **436** | **27.08%** | **$4,354** | **21.59%** | **$3,604** | **$750** |
| Inpatient Hospital Facility Services | 372 | 23.11% | $3,830 | 18.18% | $3,106 | $724 |
| Eligible Professional Services During Hospitalization | 435 | 27.02% | $524 | 21.38% | $498 | $27 |
| **Billed by Your TIN** | 330 | 20.50% | $204 | 4.40% | $79 | $125 |
| Primary Care Physicians | 289 | 17.95% | $135 | 2.90% | $34 | $101 |
| Medical Specialists | 214 | 13.29% | $65 | 1.24% | $21 | $44 |
| Surgeons | 2 | 0.12% | $1 | 0.44% | $18 | ($18) |
| Other Eligible Professionals | 39 | 2.42% | $3 | 0.50% | $6 | ($3) |
| **Billed by Other TINs** | 426 | 26.46% | $321 | 21.03% | $419 | ($98) |
| Primary Care Physicians | 86 | 5.34% | $31 | 14.44% | $102 | ($71) |
| Medical Specialists, Surgeons, and Other Eligible Professionals | 423 | 26.27% | $290 | 20.27% | $317 | ($27) |
| **Emergency Services Not Included in a Hospital Admission** | **592** | **36.77%** | **$348** | **33.20%** | **$392** | **($44)** |
| Emergency Evaluation & Management Services | 584 | 36.27% | $307 | 32.81% | $346 | ($40) |
| Procedures | 237 | 14.72% | $27 | 11.17% | $23 | $3 |
| Laboratory, Pathology, and Other Tests | 316 | 19.63% | $2 | 13.38% | $2 | $0 |
| Imaging Services | 345 | 21.43% | $12 | 22.53% | $20 | ($8) |
| **Post-Acute Services** | **270** | **16.77%** | **$1,778** | **15.39%** | **$1,878** | **($99)** |
| Home Health | 73 | 4.53% | $155 | 10.76% | $580 | ($425) |
| Skilled Nursing Facility | 217 | 13.48% | $1,303 | 7.29% | $972 | $332 |
| Inpatient Rehabilitation or Long-Term Care Hospital | 20 | 1.24% | $320 | 1.44% | $326 | ($6) |

Source: CMS QRUR Report: Table 3A

# Per Capita Costs for all Attributed Beneficiaries

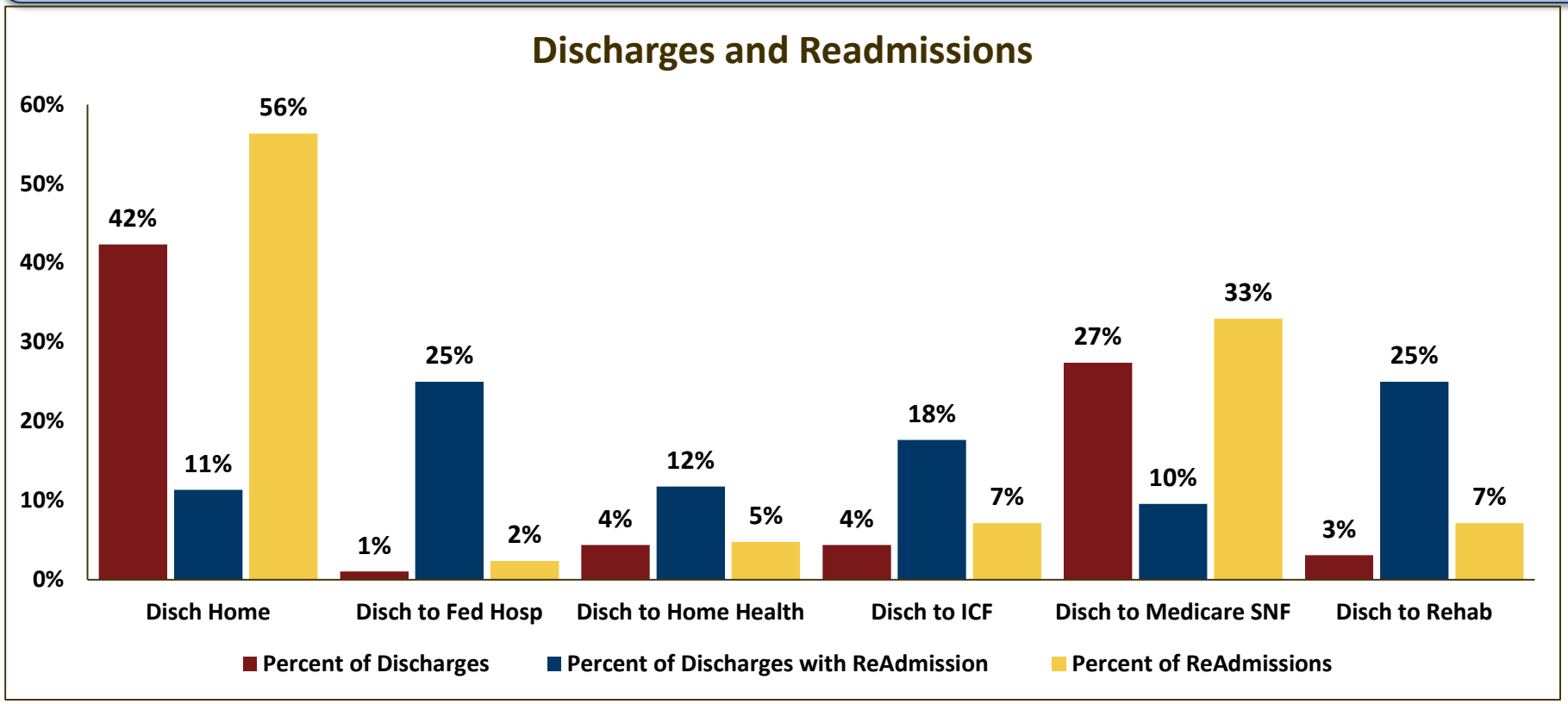


**CLA Clinic's Per Capita Costs for all Inpatient services provided is higher than the peer benchmark levels.**

- **Hospital Inpatient services costs are 21% higher than the benchmark.**
  - **Inpatient hospital facility services are 23% higher than the benchmark.**
  - **CLAC's inpatient services costs were 158% higher than the benchmark while the spend by other TIN's was 23% below the benchmark.**
  - **Costs for Emergency Services not included in a hospital admission were 11% below the per capita costs benchmark.**
- **Post Acute services spend was 5% lower than the benchmark.**
  - **SNF services were 34% more costly than benchmark costs.**
  - **Home Health services were 7% lower cost that benchmark costs.**
  - **The per capita costs for Home Health were 11% of the SNF Costs.**

# Discharges and Admissions

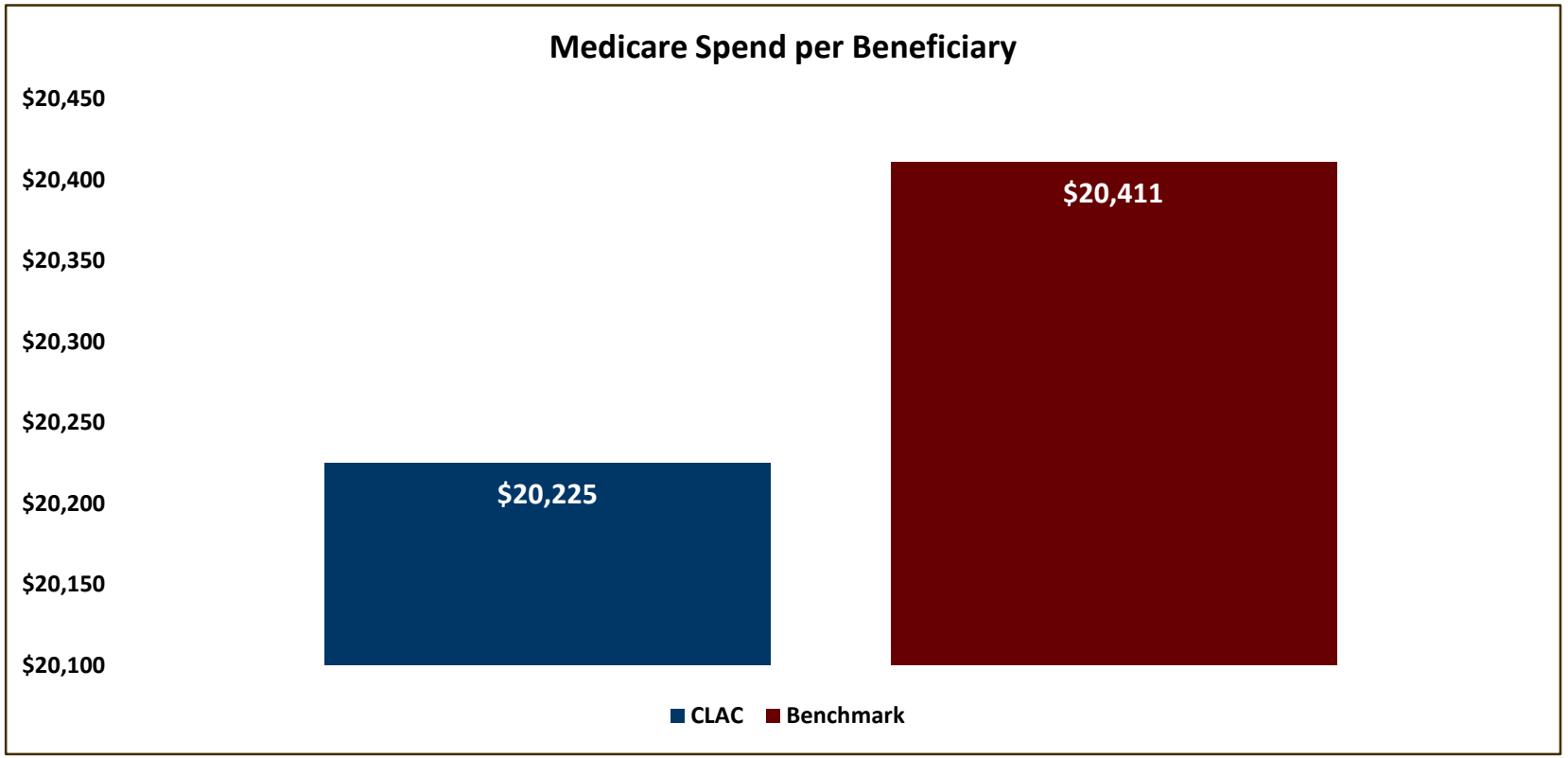
***CLAC discharged 42% of admissions to home, 27% to a SNF and 4% to Home Health. Discharges to Rehab and Federal Hospital facilities had 25% Readmission rates.***




**Readmissions from patients discharged to home were 56% of all readmission, but only 11 percent of discharges had readmissions. Discharges to a SNF, Home, and Home Health had the lowest readmission rates at 10,11, and 12, respectively.**

# Medicare Spend per Beneficiary

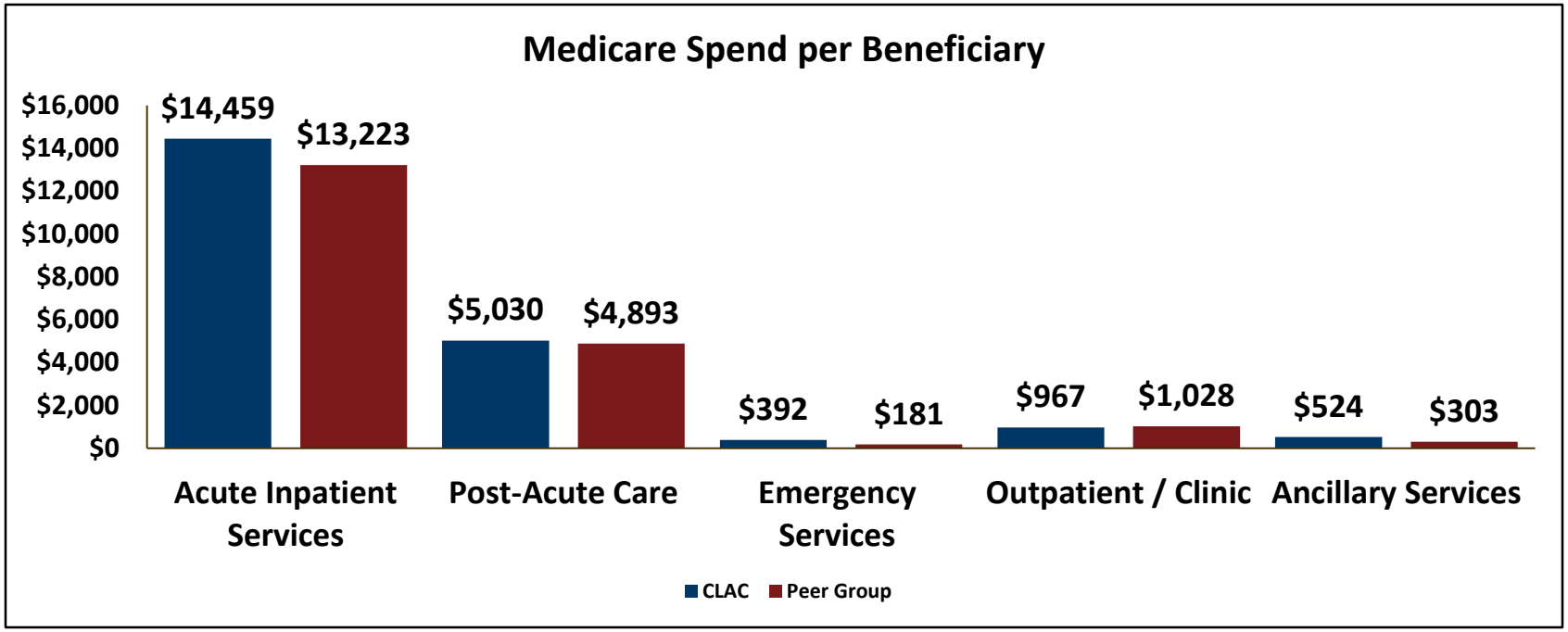
***Overall Medical Spend per Beneficiary (MSPB) is lower that the all other TIN Peer Group.***




**MSPB for combined CLAC is about $200 lower than the peer group or about 1%.**

# Medicare Spend per Beneficiary

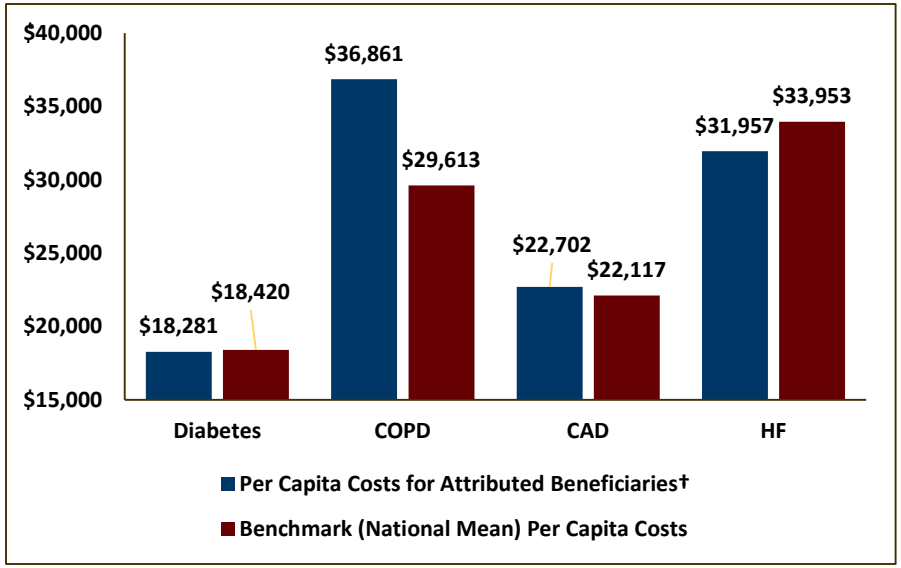
***Medical Spend per Beneficiary (MSPB) for Inpatient services is lower that the Peer Group. All other spend categories CLAC is more costly.***

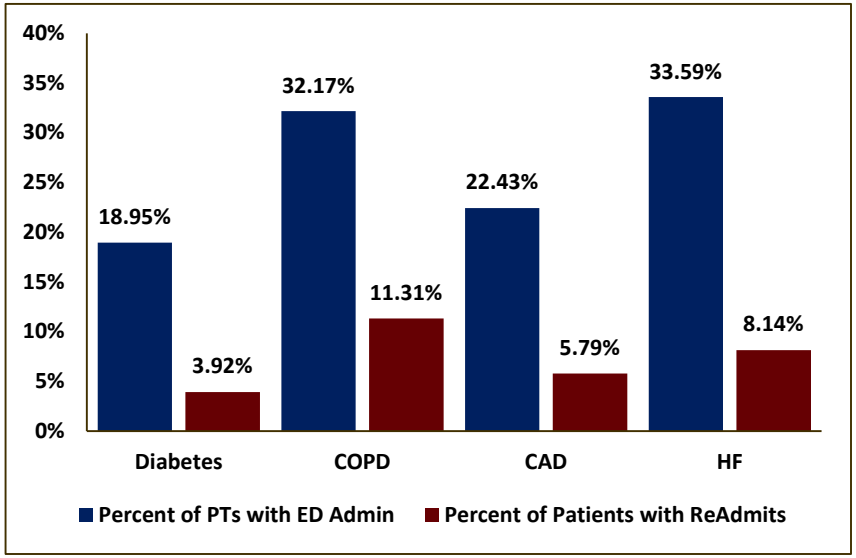



**Inpatient services MSPB for combined CLAC is about $1,200 higher than the peer group or about 10%. The MSPB for Emergency Services is 117% and Ancillary Services is 73% higher than peers, while Outpatient / Clinic services are 7% lower and Post Acute is 3% higher than peers.**

# Resource Use Scores

## Per Capita Costs for All Attributed Beneficiaries Measure with Chronic Conditions.



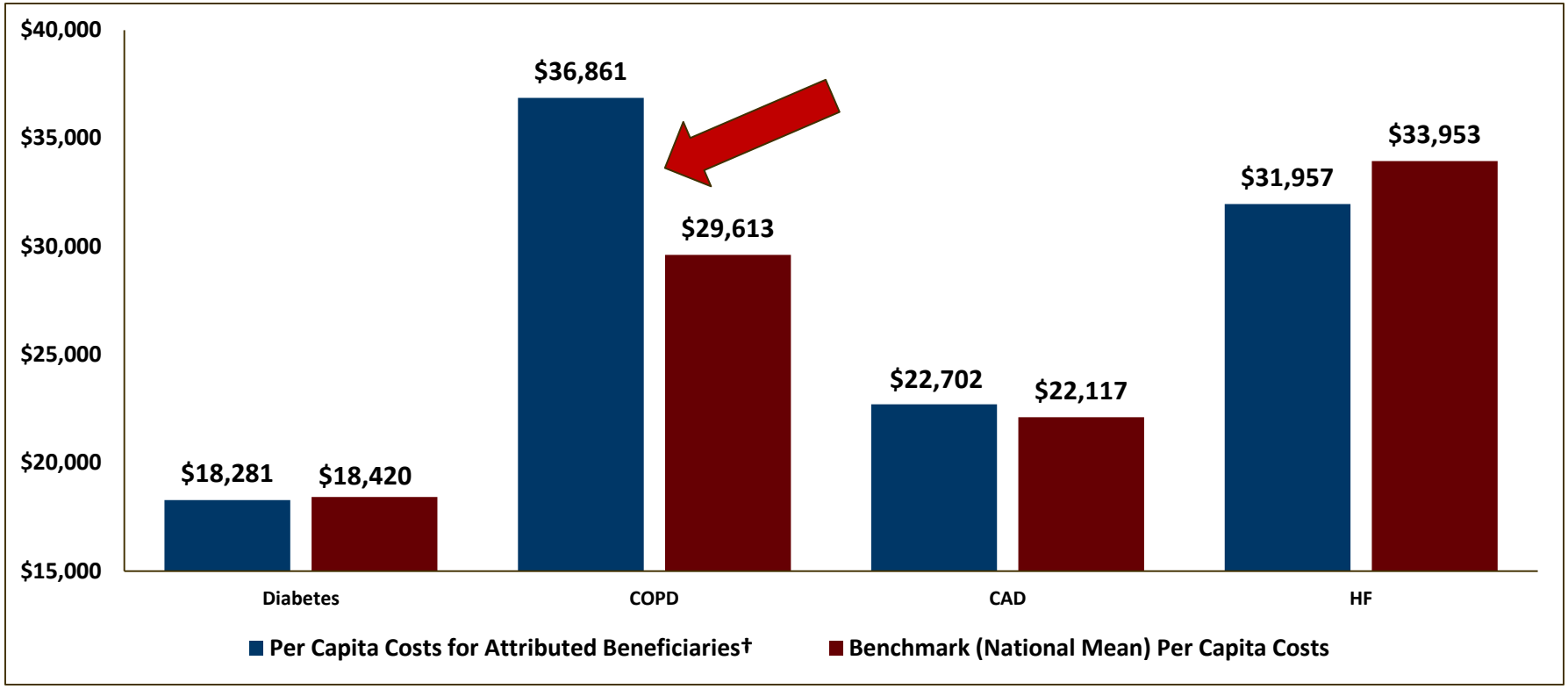




**Utilizing the QRUR results gives a window into performance and can identify areas in need of focused attention.**

| | | |
|---|---|---|
| ReAdmit Home | 21 | 56% |
| ReAdmit SNF | 13 | 29% |
| ReAdmit HH | 2 | 4% |
| ReAdmit Rehab | 4 | 9% |

# Resource Use Scores

## Per Capita Costs for All Attributed Beneficiaries Measure with Chronic Conditions.




**The QRUR results for chronic conditions can identify areas in need of focused attention. Overall per capita costs for all 4 chronic conditions was 4.5% higher than benchmarks. COPD patients have the highest negative spend in comparison to benchmark costs.**

# Per Capita Costs for all Attributed Beneficiaries for Beneficiaries with Chronic Conditions



**CLAC Clinics Per Capita Costs for all services provided is 4.5% higher than the peer benchmark levels.**

- **Hospital Inpatient services spend is 21% higher than the benchmark.**
  - **Inpatient hospital facility services are 23% higher than the benchmark.**
  - **CLAC's inpatient services were 158% higher than the benchmark while the spend by other TIN's were 23% below the benchmark.**
  - **70% of the lower spend for E&M services can be attributed to Medical Specialists outside your TIN.**
- **Post Acute services spend was 5% lower than the benchmark.**
  - **SNF services were 34% more costly than benchmark costs.**
  - **Home Health services were 7% lower cost that benchmark costs.**
  - **Home Health per capita costs were 9% of the SNF post acute costs.**
  - **SNF discharges were 30% of all discharges, 26% of all readmissions, and had a 10% readmission rate.**

# MIPS 2018 – Primary Care

# Primary Care Provider's Managing Costs



**The QRUR reports provide primary care providers insight to their spend, as well as understanding the spend from specialists they utilize and facilities where services are provided.**

- For each "specialist" in or outside their organization they refer, primary care can get an idea of the costs generated.
- Primary care can see where patients are admitted and discharged after admission by their specialists.
- Primary care providers can also see if specialists are keeping patient referrals in preferred facilities.

# Primary Care Provider's Managing Costs

| Beneficiaries and Episodes Attributed to Your TIN for the MSPB Measure | | | | | Apparent Lead Eligible Professional† | | | |
|---|---|---|---|---|---|---|---|---|
| HIC | Gender | DOB | Index† | HCC Percentile Ranking† | NPI | Name | Specialty | Total Payment-Standardized Episode Cost† |
| 023304096A | F | 11/14/1939 | 103899089 | 81 | | | Cardiology | $8,398 |
| 029145632A | M | 09/18/1924 | 5657213 | 83 | | | Internal Medicine | $36,109 |
| 063262533A | F | 07/28/1932 | 9710603 | 90 | | | Internal Medicine | $20,141 |
| 123260332A | F | 01/31/1934 | 17000843 | 97 | | | Internal Medicine | $11,685 |
| 141328175A | F | 09/23/1929 | 19049247 | 63 | | | Cardiology | $26,884 |
| 149380090A | F | 03/09/1950 | 119757919 | 93 | | | Pulmonary Disease | $9,685 |
| 149380090A | F | 03/09/1950 | 119757919 | 93 | | | Pulmonary Disease | $12,315 |
| 149380090A | F | 03/09/1950 | 119757919 | 93 | | | Pulmonary Disease | $8,632 |

Source: CMS QRUR Report: Table 5B

# Primary Care Provider's Managing Costs

| Characteristics of Hospital Admission | | | | Discharge Disposition | | |
|---|---|---|---|---|---|---|
| Date of Admission | Admitting Hospital (Name, CCN, City, State) | Principal Diagnosis† (Code, Description) | | Date of Discharge | Discharge Status† (Code, Description) | |
| 08/29/2016 | HOSPITAL | I481 | Persistent atrial fibrillation | 09/01/2016 | 01 | Disch Home |
| 09/22/2016 | HOSPITAL | M7981 | Nontraumatic hematoma of soft tissue | 09/28/2016 | 89 | Txfr Swing Bed-Planned Readmit |
| 01/09/2016 | HOSPITAL | A419 | Sepsis, unspecified organism | 01/13/2016 | 01 | Disch Home |
| 09/24/2016 | HOSPITAL | N132 | Hydronephrosis with renal and ureteral calculous obstruction | 09/25/2016 | 01 | Disch Home |
| 09/19/2016 | HOSPITAL | I214 | Non-ST elevation (NSTEMI) myocardial infarction | 09/24/2016 | 01 | Disch Home |
| 01/20/2016 | HOSPITAL | J189 | Pneumonia, unspecified organism | 01/28/2016 | 01 | Disch Home |
| 04/01/2016 | HOSPITAL | J9622 | Acute and chronic respiratory failure with hypercapnia | 04/07/2016 | 06 | Disch to Home Health |
| 07/09/2016 | HOSPITAL | J9621 | Acute and chronic respiratory failure with hypoxia | 07/10/2016 | 06 | Disch to Home Health |

Source: CMS QRUR Report: Table 5B

# Costs by Providers outside CLAC Network

## The table below shows cost of services provided by clinicians outside the CLAC Clinically Integrated Network.



**Inside CLAC TIN**

| | Primary | Non-Primary |
|---|---|---|
| All | 2,536 | 2,536 |
| Out | 0 | 0 |
| In | 2,536 | 2,243 | |
| % Out | 0.0% | 0.0% |
| Out | $0 | $0 |
| In | $23,183,764 | $20,353,106 |
| Out | $0.00 | $0.00 |
| In | $9,141.86 | $9,074.06 |

| | |
|---|---|
| Total All Cause Leakage | $0 |
| Total Services Provided | $43,536,870 |

**Outside CLAC TIN**

| | Primary | Non-Primary |
|---|---|---|
| All | 2,536 | 2,536 |
| Out | 1,602 | 1,596 |
| In | 934 | 940 |
| % Out | 63.2% | 62.9% |
| Out | $16,198,398 | $15,826,100 |
| In | $6,985,366 | $7,357,664 |
| Out | $10,111.36 | $9,916.10 |
| In | $7,478.98 | $7,827.30 |

| | |
|---|---|
| Total All Cause Leakage - High | $16,198,398 |
| Total All Cause Leakage - Low | $15,826,100 |

**The QRUR results provide a view of the total Medicare Spend per Beneficiary and provides data relating to "where" services were provided and "who" provided the services. This allows CLAC Clinic to see where there is leakage from the system.**

# MIPS 2018 – Specialist Care

# Specialty Care Costs

**The QRUR reports provide secondary care providers insight to their spend, as well as understanding the spend that will be reported to primary care providers.**

- For each “specialist” in or outside their organization they refer, primary care can get an idea of the MSPB costs generated.
- Primary care can see where patients are admitted and discharged after admission by their specialists.
- Primary can see if specialists are using high quality, low cost facilities.
- Primary care providers can also see if specialist are keeping patients at their preferred partners.

# Per Capita Costs for all Attributed Beneficiaries

**Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure - Orthopedics**

| | Your TIN | | | All TINs in Peer Group† | | |
|---|---|---|---|---|---|---|
| **Service Category** | **Number of Attributed Beneficiaries Using any Service in this Category** | **Percentage of Beneficiaries Using any Service in this Category** | **Per Capita Costs for Attributed Beneficiaries †** | **Benchmark (National Mean) Percentage of Beneficiaries Using Any Service in This Category** | **Benchmark (National Mean) Per Capita Costs** | **How Much Higher or (Lower) Your TIN's Costs Were than TINs in Peer Group** |
| **ALL SERVICES** | 1,610 | 100.00% | $12,857 | 100.00% | $12,380 | $477 |
| **Hospital Inpatient Services** | **436** | **27.08%** | **$4,354** | **21.59%** | **$3,604** | **$750** |
| Inpatient Hospital Facility Services | 372 | 23.11% | $3,830 | 18.18% | $3,106 | $724 |
| Eligible Professional Services During Hospitalization | 435 | 27.02% | $524 | 21.38% | $498 | $27 |
| **Billed by Your TIN** | 330 | 20.50% | $204 | 4.40% | $79 | $125 |
| Primary Care Physicians | 289 | 17.95% | $135 | 2.90% | $34 | $101 |
| Medical Specialists | 214 | 13.29% | $65 | 1.24% | $21 | $44 |
| Surgeons | 2 | 0.12% | $1 | 0.44% | $18 | ($18) |
| Other Eligible Professionals | 39 | 2.42% | $3 | 0.50% | $6 | ($3) |
| **Billed by Other TINs** | 426 | 26.46% | $321 | 21.03% | $419 | ($98) |
| Primary Care Physicians | 86 | 5.34% | $31 | 14.44% | $102 | ($71) |
| Medical Specialists, Surgeons, and Other Eligible Professionals | 423 | 26.27% | $290 | 20.27% | $317 | ($27) |
| **Emergency Services Not Included in a Hospital Admission** | **592** | **36.77%** | **$348** | **33.20%** | **$392** | **($44)** |
| Emergency Evaluation & Management Services | 584 | 36.27% | $307 | 32.81% | $346 | ($40) |
| Procedures | 237 | 14.72% | $27 | 11.17% | $23 | $3 |
| Laboratory, Pathology, and Other Tests | 316 | 19.63% | $2 | 13.38% | $2 | $0 |
| Imaging Services | 345 | 21.43% | $12 | 22.53% | $20 | ($8) |
| **Post-Acute Services** | **270** | **16.77%** | **$1,778** | **15.39%** | **$1,878** | **($99)** |
| Home Health | 73 | 4.53% | $155 | 10.76% | $580 | ($425) |
| Skilled Nursing Facility | 217 | 13.48% | $1,303 | 7.29% | $972 | $332 |
| Inpatient Rehabilitation or Long-Term Care Hospital | 20 | 1.24% | $320 | 1.44% | $326 | ($6) |

Source: CMS QRUR Report: Table 3A

# Per Capita Costs for all Attributed Beneficiaries



**Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure - Orthopedics**

| | Your TIN | | | All TINs in Peer Group† | | |
|---|---|---|---|---|---|---|
| Service Category | Number of Attributed Beneficiaries Using any Service in this Category | Percentage of Beneficiaries Using any Service in this Category | Per Capita Costs for Attributed Beneficiaries† | Benchmark (National Mean) Percentage of Beneficiaries Using Any Service in This Category | Benchmark (National Mean) Per Capita Costs | How Much Higher or (Lower) Your TIN's Costs Were than TINs in Peer Group |
| **ALL SERVICES** | 506 | 100.00% | $11,270 | 100.00% | $12,380 | ($1,110) |
| **Hospital Inpatient Services** | **62** | **12.25%** | **$2,590** | **21.59%** | **$3,604** | **($1,014)** |
| Inpatient Hospital Facility Services | 43 | 8.50% | **$2,186** | 18.18% | **$3,106** | ($920) |
| Eligible Professional Services During Hospitalization | 62 | 12.25% | $403 | 21.38% | $498 | ($94) |
| **Billed by Your TIN** | 15 | 2.96% | $84 | 4.40% | $79 | $5 |
| Primary Care Physicians | 0 | 0.00% | $0 | 2.90% | $34 | ($34) |
| Medical Specialists | 0 | 0.00% | $0 | 1.24% | $21 | ($21) |
| Surgeons | 15 | 2.96% | $80 | 0.44% | $18 | $61 |
| Other Eligible Professionals | 7 | 1.38% | $5 | 0.50% | $6 | ($1) |
| **Billed by Other TINs** | 59 | 11.66% | $319 | 21.03% | $419 | ($100) |
| Primary Care Physicians | 48 | 9.49% | $100 | 14.44% | $102 | ($2) |
| Medical Specialists, Surgeons, and Other Eligible Professionals | 53 | 10.47% | $219 | 20.27% | $317 | ($97) |
| **Emergency Services Not Included in a Hospital Admission** | **121** | **23.91%** | **$309** | **33.20%** | **$392** | **($84)** |
| Emergency Evaluation & Management Services | 120 | 23.72% | **$266** | 32.81% | **$346** | ($80) |
| Procedures | 56 | 11.07% | $25 | 11.17% | $23 | $2 |
| Laboratory, Pathology, and Other Tests | 31 | 6.13% | $1 | 13.38% | $2 | ($1) |
| Imaging Services | 87 | 17.19% | $17 | 22.53% | $20 | ($4) |
| **Post-Acute Services** | **26** | **5.14%** | **$510** | **15.39%** | **$1,878** | **($1,367)** |
| Home Health | 23 | 4.55% | **$321** | 10.76% | **$580** | ($259) |
| Skilled Nursing Facility | 2 | 0.40% | $5 | 7.29% | $972 | ($966) |
| Inpatient Rehabilitation or Long-Term Care Hospital | 4 | 0.79% | **$184** | 1.44% | **$326** | ($143) |

Source: CMS QRUR Report: Table 3A

# Questions?

# Questions/Opportunities?

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