Regulatory Reporting Update

3-Part Series:

Promoting Interoperability – February 14th

Value Pathways & Quality – February 21st

Cost & Improvement Activities – February 28th

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Today's Presenter

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Executive Director

Oklahoma Foundation for Medical Quality (OFMQ)

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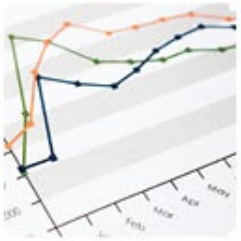
Regulatory Reporting Update 2024

Part 3: Cost & Improvement Activities

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Topics Covered

Reporting Basics

Objectives & Measures

Requirements for 2024

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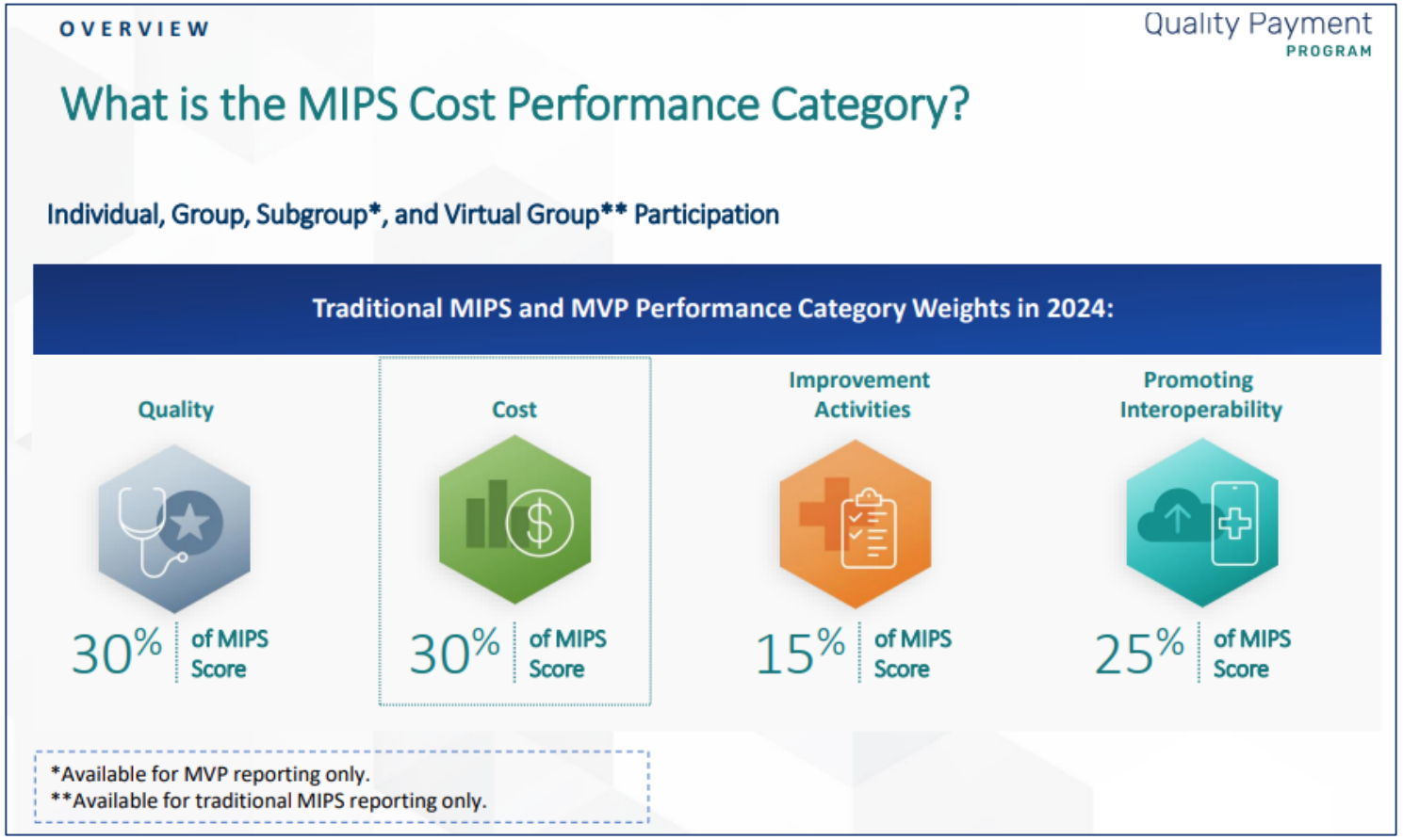
Cost & Improvement Activities



2024CostQuickStartGuide.pdf

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Cost Reporting

30 % of your Final Score

12-month reporting period (January 1, 2024 – December 31, 2024)

No reporting requirement. CMS retrieves your cost data from administrative claims

To be scored on a cost measure, you or your group must have enough attributed cases to meet or exceed the case minimum requirement for that cost measure

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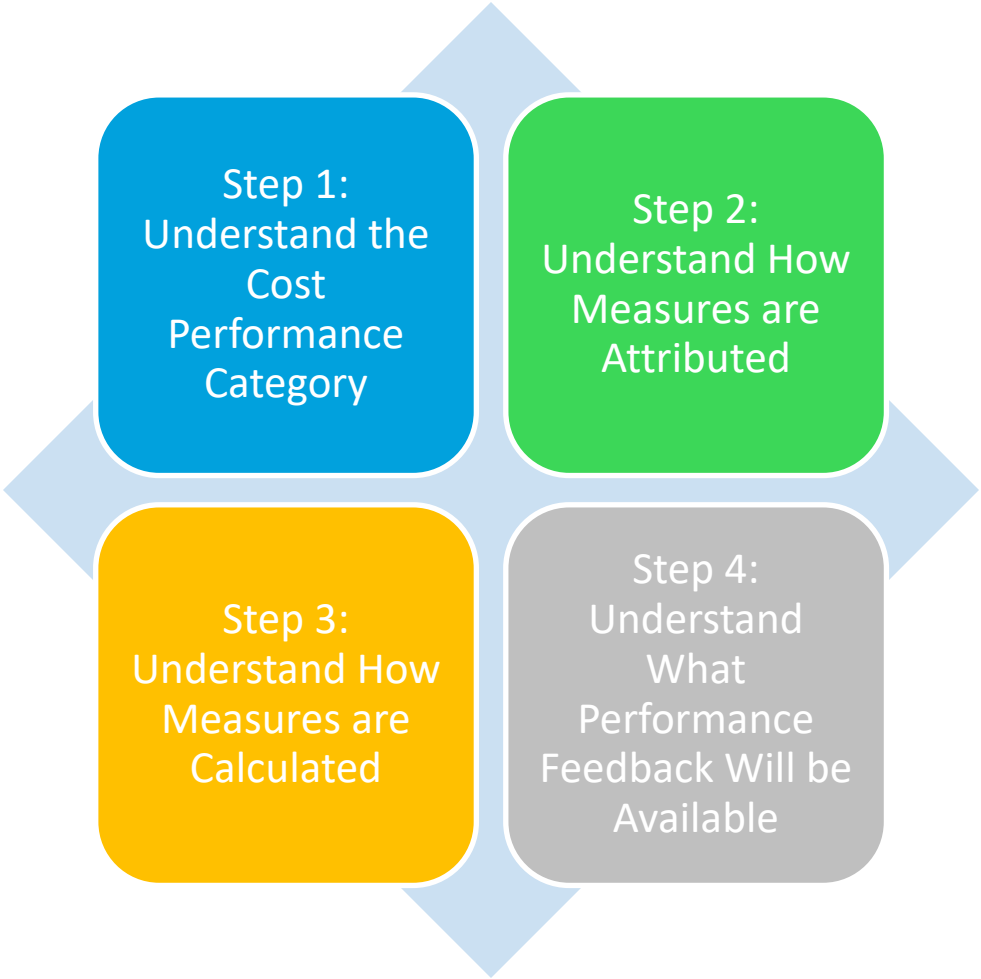
Cost Basics



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Step 1: Understand the Cost Performance Category Measures

Types of Cost Measures:

➢ **Episode Based**

- Patient condition groups, defined by:
  -Chronic conditions requiring ongoing management of a long-term health condition.
- Care episode groups, defined by:
  -Procedures of a defined purpose or type. These can be performed in different settings depending on the specific measure's intended focus (e.g., outpatient, inpatient).
  -Acute inpatient medical conditions requiring a hospital stay. These can represent treatment for a self-limited acute illness or treatment for a flare-up or exacerbation of a condition.
- Care setting groups, defined by:
  -Treatment received in a specific setting (e.g., emergency department).

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Step 1: Understand the Cost Performance Category Measures

Types of Cost Measures:

- Population Based
  - 2 measures: Medicare Spending Per Beneficiary (MSPB) Clinician and Total Per Capita Cost (TPCC).

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Step 1: Understand the Cost Performance Category Measures

The are 29 total cost measures for 2024

Measure Name/Type	Description	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	This population-based measure assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.	20 Medicare patients	Medicare Parts A and B claims data
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	This measure assesses the cost of care for services related to qualifying inpatient hospital stays (immediately prior to, during, and after) for a Medicare patient.	35 episodes	Medicare Parts A and B claims data
15 procedural episode-based measures	Assess the cost of care that's clinically related to a specific procedure provided during an episode's timeframe.	10 episodes for all procedural episode-based measures **except** the Colon and Rectal Resection measure which has a case minimum of 20 episodes	Medicare Parts A and B claims data
6 acute inpatient medical condition episode-based measures	Assess the cost of care clinically related to specific acute inpatient medical conditions and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode-based measures	Medicare Parts A and B claims data (all acute inpatient condition episode-based cost measures), Medicare Part D claims (Sepsis episode-based cost measure)
5 chronic condition episode-based measures	Assess the cost of care clinically related to the care and management of patients' specific chronic conditions provided during a total attribution window divided into episodes.	20 episodes for chronic condition episode-based measures	Medicare Parts A, B and D claims data
1 measure focusing on care provided in the emergency department setting (Emergency Medicine)	Evaluates a clinician's risk-adjusted cost to Medicare for patients who have an emergency department (ED) visit during the performance period.	20 episodes	Medicare Parts A and B claims data

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2024-mips-summary-cost-measures (3).pdf

Step 1: Understand the Cost Performance Category Measures

Cost Measure Examples for 2024

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 30 days	Patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance period.	Ambulatory/office-based care centers, outpatient hospitals, Ambulatory surgical centers (ASCs)
Knee Arthroplasty	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who receive an elective knee arthroplasty during the performance period.	Acute inpatient (IP) hospitals, hospital outpatient department (HOPDs), ambulatory/office-based care centers, and ASCs
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance period.	ASCs, HOPDs, and acute IP hospitals
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	• Pre-Trigger Period = 60 days • Post-Trigger Period = 90 days	Patients who undergo a procedure for routine cataract removal with intraocular lens implantation during the performance period.	ASCs and HOPDs
Screening/Surveillance Colonoscopy	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 14 days	Patients who undergo a screening or surveillance colonoscopy procedure during the performance period.	ASCs, ambulatory/office-based care, HOPDs
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 30 days	Patients who receive an inpatient dialysis service for acute kidney injury during the performance period.	Acute IP hospitals

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Step 1: Understand the Cost Performance Category Measures

Cost Measure Examples (continued) for 2024

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Diabetes	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients who receive medical care to manage and treat diabetes during the performance period.	The most frequent settings in which a Diabetes episode is triggered include: Office, skilled nursing facility (SNF), and OP hospital.
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients who receive medical care to manage and treat asthma or COPD during the performance period.	The most frequent settings in which an Asthma/COPD episode is triggered include: Office, SNF, and OP hospital.
Depression	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients receiving medical care to manage and treat depression. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Depression episode.	The Depression measure focuses on the care provided by clinicians practicing in non-inpatient hospital settings for patients with depression. The most frequent settings in which a Depression episode is triggered include: Office, nursing facility, SNF, and OP hospital.
Heart Failure	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients receiving medical care to manage and treat heart failure. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Heart Failure episode.	The Heart Failure measure focuses on the care provided by clinicians practicing in non-inpatient hospital settings for patients with heart failure. The most frequent settings in which a Heart Failure episode is triggered include: office, OP hospital, and SNF.
Low Back Pain	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 120 days	Patients receiving medical care to manage and treat low back pain. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Low Back Pain episode.	The most frequent settings in which a Low Back Pain episode is triggered include: office, OP hospital, and ASC.
Emergency Medicine	Care Setting	• Pre-Trigger Window: 0 days • Post-Trigger Window: 14 days	Patients who have emergency department (ED) visit during the performance period.	Emergency department

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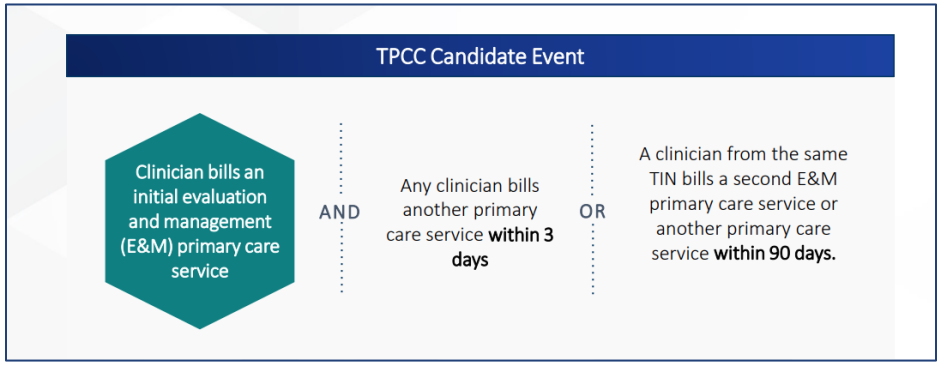
Step 2: Understand How Measures are Attributed

TPCC attribution begins with a "candidate event," defined as a pair of services billed by the clinician to the patient within a short period of time. A candidate event marks the start of a primary care relationship between a patient and a clinician.



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Step 2: Understand How Measures are Attributed

TPCC Attribution

- A risk window is a year-long window that begins on the date of a candidate event, during which time a clinician is responsible for a patient's costs.
- The performance period is a static calendar year that is divided into 13 4-week blocks called beneficiary months. Beneficiary months that occur during a risk window and the performance period are counted towards a clinician’s (or clinician group’s) measure scores. These beneficiary months are attributed to the TIN billing the initial E&M “primary care” service.
- For TIN-NPI-level attribution, only the TIN-NPI responsible for the largest share of candidate events provided to the patient within the TIN is attributed the beneficiary months.

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Step 2: Understand How Measures are Attributed

MSPB Attribution

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

Step 2: Understand How Measures are Attributed

Medical MSPB Clinician Episode

- First attributed to a TIN if that TIN billed at least 30% of the 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.

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Step 2: Understand How Measures are Attributed

- Acute episode-based measures
- Procedural episode-based measures
- Chronic condition episode-based measures
- Emergency Medicine

These measure are based on (some of the following):

- ✓ First attributed to the TIN billing at least 30% of inpatient E&M services on Part B physician/supplier claims during the inpatient stay
- ✓ Any clinician who bills the code that triggers the episode.

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Step 3. Understand How Cost Measures are Calculated

- Earn up to 10 points
- CMS compares a clinician or group's performance (expressed as a dollar amount) on each Cost measure to the performance period benchmark(s) and then assigns points to each measure based on that comparison

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Step 3. Understand How Cost Measures are Calculated

TPCC Example

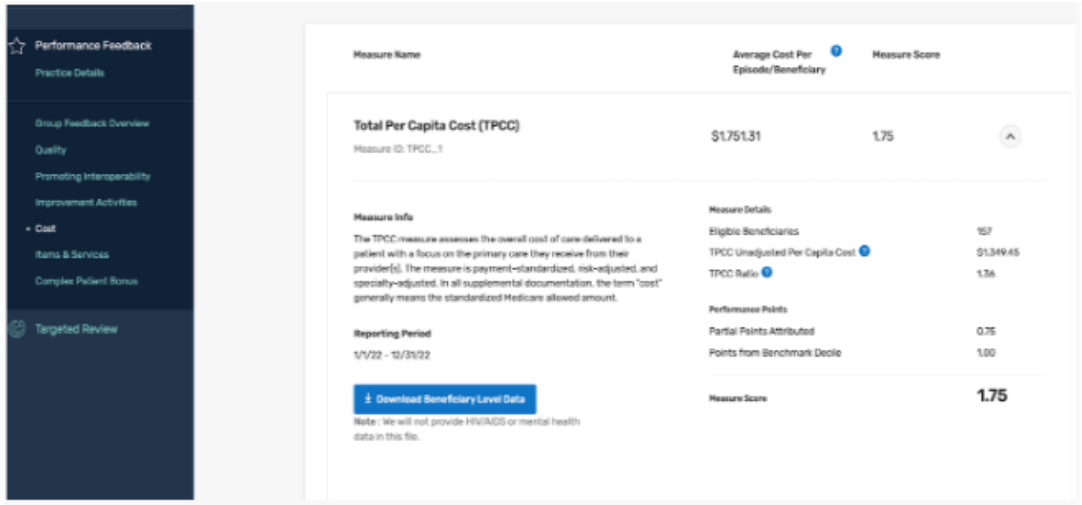
Step	Description/Additional Information
1. Identify candidate events	This is the start of a primary care relationship between a clinician and Medicare patient.
2. Apply service category and specialty exclusions	This excludes candidate events for certain clinicians. For example, clinicians whose candidate 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 beneficiary 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 payment-standardized monthly observed costs	This sums the cost of all services billed for the Medicare patient during a given month. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
6. Calculate risk-adjusted monthly costs	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
7. Apply specialty adjustment to risk-adjusted costs	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 beneficiary-months where the risk window overlaps with the performance year.

Step 3. Understand How Cost Measures are Calculated

TPCC Example

Cost Measure	Average Cost Per Beneficiary/Episode	National Average Per Capita Cost	Measure Score
Total Per Capita Cost (TPCC)	$1,751.31	$1,284.88	1.75/10 pts

The performance feedback for all Cost measures will show this information in more detail, including the number of Medicare beneficiaries who contributed to the Cost measure calculation:



Step 4. Understand What Cost Performance Feedback Will be Available

- Each measure is scored out of 10 points that meets case minimum
  - This is based on comparison to performance period benchmark
- Measure, Category and Patient level reports will be available **(QPP sign in required)**

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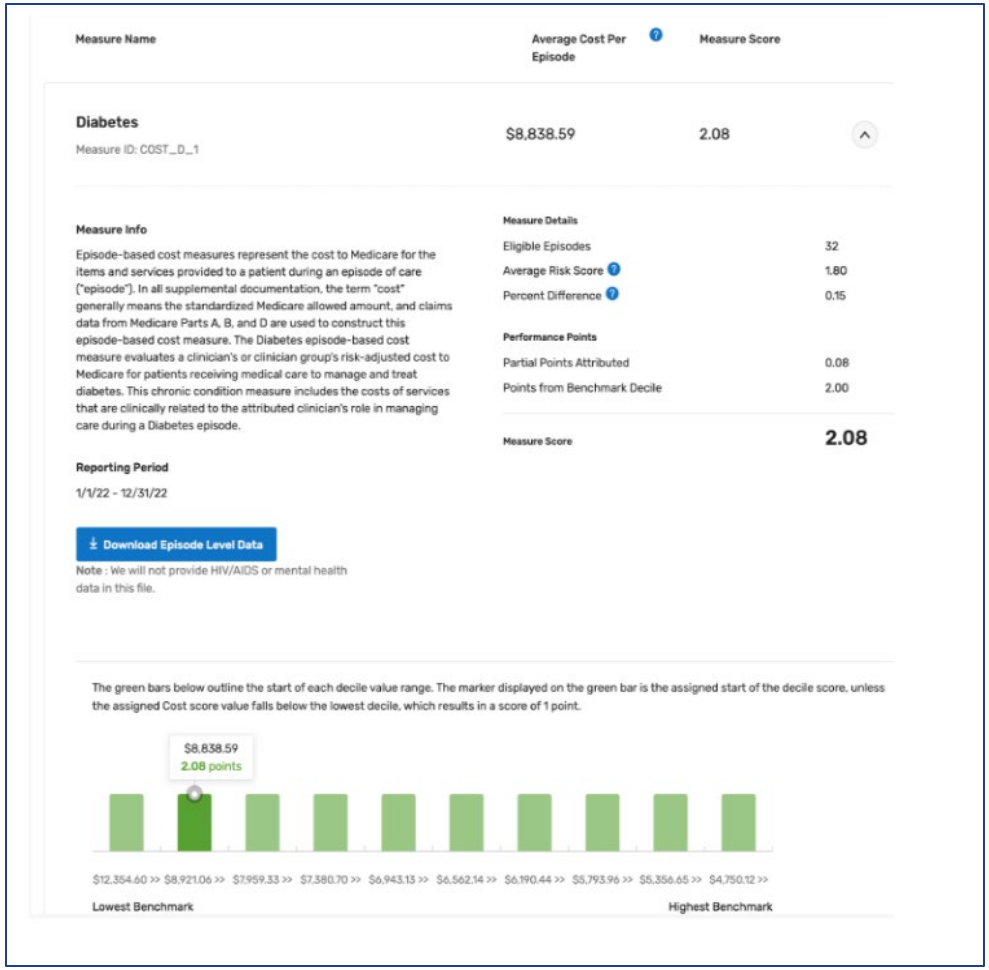
Cost Feedback Report Example



Measure Name

Average Cost Per Episode

Measure Score

Diabetes

Measure ID: COST_D_1

$8,838.59

2.08

Measure Info

Episode-based cost measures represent the cost to Medicare for the items and services provided to a patient during an episode of care ("episode"). In all supplemental documentation, the term "cost" generally means the standardized Medicare allowed amount, and claims data from Medicare Parts A, B, and D are used to construct this episode-based cost measure. The Diabetes episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage and treat diabetes. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Diabetes episode.

Reporting Period

1/1/22 - 12/31/22

Measure Details

Eligible Episodes	32
Average Risk Score	1.80
Percent Difference	0.15

Performance Points

Partial Points Attributed	0.08
Points from Benchmark Decile	2.00

Measure Score **2.08**

Download Episode Level Data

Note : We will not provide HIV/AIDS or mental health data in this file.

The green bars below outline the start of each decile value range. The marker displayed on the green bar is the assigned start of the decile score, unless the assigned Cost score value falls below the lowest decile, which results in a score of 1 point.

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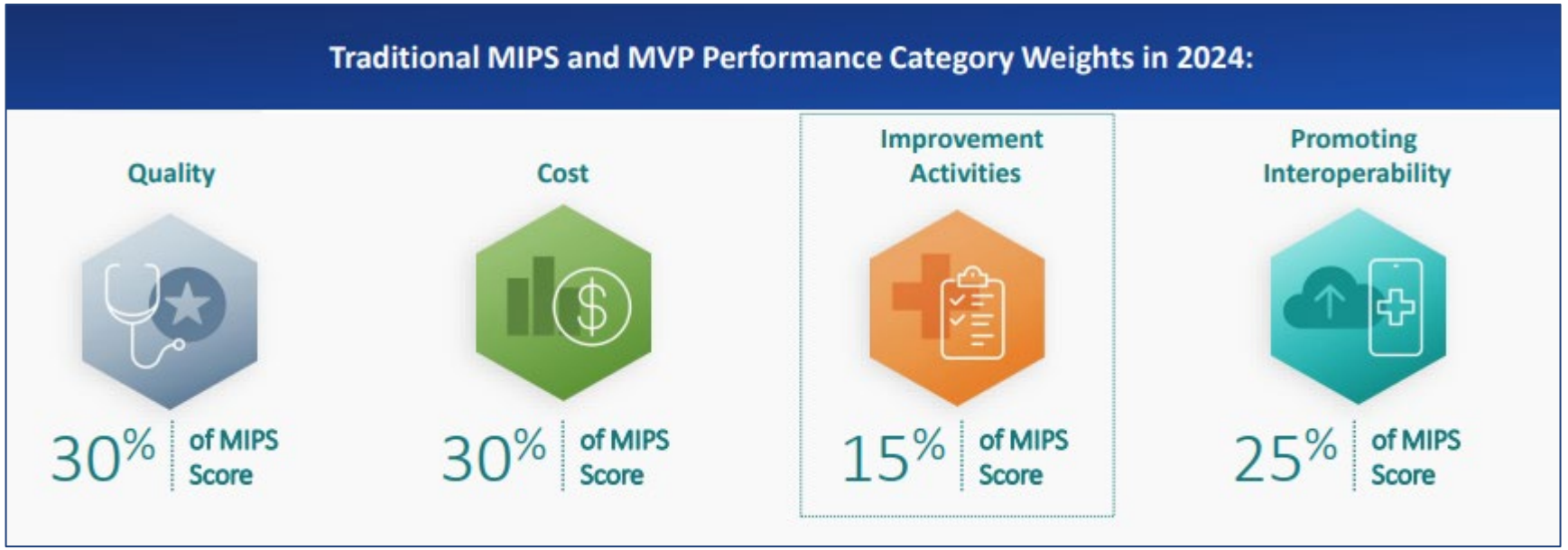
Improvement Activities



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What New with Improvement Activities for 2024

5 new activities

- Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention
- Practice-Wide Quality Improvement in MIPS Value Pathways (IA_MVP)
- Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women (IA_BMH_14)
- Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults (IA_BMH_15)

3 removed activities

- Implementation of co-location PCP and MH services (IA_BMH_6)
- Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication Assisted Treatment [MAT] for Opioid Use Disorder (IA_BMH_13)
- Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging (IA_PSPA_29)

1 modified activity

- Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools—and standardized treatment protocols to manage workflow on the care team to meet patient needs (IA_PSPA_16)

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Step 1. Understand Improvement Activity Reporting Requirements

Most clinicians must implement and submit 2 to 4 improvement activities

Maximum score of 40 points

Each improvement activity is classified as either medium-weighted or high-weighted

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Reporting Requirements

Traditional MIPS	MVPs
Clinicians, groups, virtual groups, and APM Entities with **certain special statuses (small practice, rural, health professional shortage area (HPSA), non-patient facing)** select (from **over 100 activities**) and perform: • **2 medium-weighted activities** (20 points each) **OR** • **1 high-weighted activity** (40 points)	**N/A – there are no reduced reporting requirements for special status designations**
All other MIPS eligible clinicians select (from over 100 activities) and perform: • **2 high-weighted activities** (20 points each) **OR** • **1 high-weighted and 2 medium-weighted activities** (10 points each) **OR** • **4 medium-weighted activities**	**All MVP participants** select (from the **activities available within the MVP**): • **2 medium-weighted activities** (20 points each) **OR** • **1 high-weighted activity** (40 points)

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Step 2. Select and Plan to Implement Your Improvement Activities

Resources

- ✓ 2024 Improvement Activity Inventory (106 activities)
  - https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2644/2024ImprovementActivitiesInv.zip

Step 2. Select and Plan to Implement Your Improvement Activities

Plan to implement each improvement activity for a minimum of a continuous 90-day period, unless otherwise stated in the activity description, in calendar year (CY) 2024 (activities don't have to be performed concurrently).

If you're reporting traditional MIPS as a group, virtual group, or APM Entity, at least 50% of the clinicians in the group, virtual group, or APM Entity must perform the same activity for a continuous 90-day period (but don't have to perform the activity concurrently) for the group, virtual group, or APM Entity to attest and receive credit for that activity.

If you're reporting an MVP as a group, subgroup, or APM Entity, at least 50% of the clinicians in the group, subgroup, or APM Entity must perform the same activity for a continuous 90-day period (but don't have to perform the activity concurrently) for the group, subgroup, or APM Entity to attest and receive credit for that activity.

You can attest to improvement activities you performed during the 2023 performance period again unless otherwise indicated in the activity description.

The last continuous 90-day period to perform an improvement activity begins October 3, 2024.

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Step 3. Implement Your Activities and Compile Documentation Supporting Your Work

Review the **2024 MIPS Data Validation Criteria** document (ZIP) for examples of individual improvement activity documentation requirements

- Ensure that each activity selected and attested to is completed and documented accurately and in accordance with the guidance provided in the MIPS Data Validation document.
- Maintain documentation for each activity you attested to for a period of 6 years as evidence of completion in the event of a CMS audit.

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2666/2024MIPSDataValidationCriteria.zip

Step 3. Implement Your Activities and Compile Documentation Supporting Your Work

Common examples of documentation may include, but are not limited to:

- Screenshot or digital capture of relevant information supporting the attestation.
- Improvement plans and/or outlines supporting the interventional strategies/processes implemented to meet the intent of the improvement activity.
- Electronic Health Record Report: Retain a copy of documentation relevant to the chosen improvement activity as evidence of attestation

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Step 4. Data Submissions

- Log-in to the QPP or HQR site
- Attestation options:
  - Manually enter data – numerator/denominator and yes/no measures
  - Upload a QRDA file
  - Have a 3rd Party intermediary submit data on your behalf
- Data can be updated until the submission window is closed

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Resources

- QPP Resource Library
  - https://qpp.cms.gov/resources/resource-library
- Cost Programs Resource Library
  - https://qpp.cms.gov/mips/cost
- Improvement Activity Programs Resource Library
  - https://qpp.cms.gov/mips/improvement-activities
- OKSHINE – Oklahoma HIE
  - https://oklahoma.gov/ohca/okshine/overview.html
  - MyHealth Application
    - https://go.myhealthaccess.net/MyHealth-Application

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Questions

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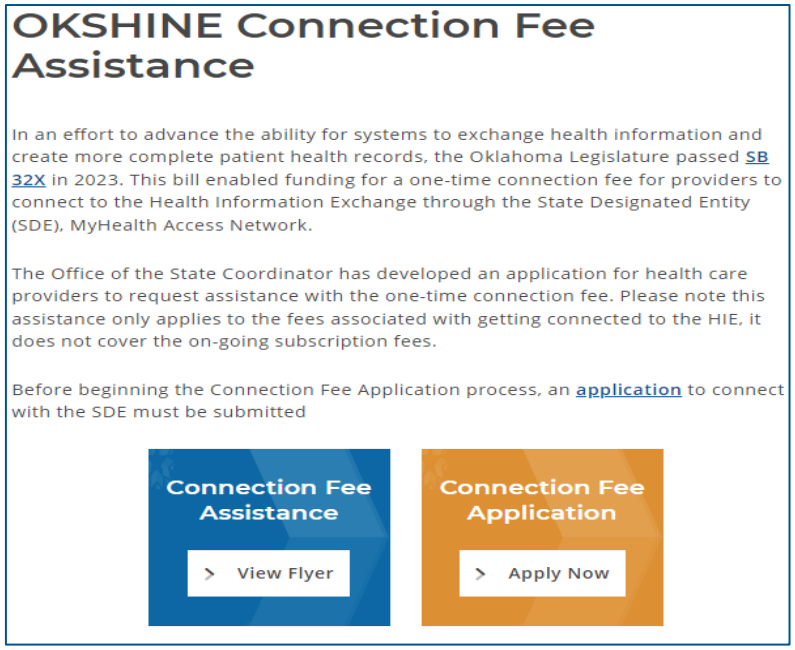
Upcoming Events

- Join us_____, to learn more about OKSHINE Speaker: Lindsey Wiley, MHA, Executive Director, OFMQ



Register Now!!!

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