

Resource Utilization (Cost)

Background

The CMS value equation is equal to quality divided by cost. Assessing and attributing costs to physicians, however, is not a straight forward task. Beginning in 2018, CMS will attribute 10% (10 points) of the total Merit-Based Incentive Payment System (MIPS) score to cost or resource utilization. In this section, we will discuss resource utilization and attribution within the Quality Payment Program (QPP)

Long before MACRA, CMS developed the [Quality Resource Utilization Report \(QRUR\)](#). Every practice has [access](#) to this report on an annual basis. The QRUR reflects the performance of a medical group (via Taxpayer Identification Number, TIN) on quality and cost metrics, as compared to all other TINs. As a result, the QRUR can provide a sense of a group's overall performance, including strengths and/or weaknesses to consider when preparing for QPP participation.

The QRUR, while not perfect, seeks to develop a "score" based upon physician group resource use, adjusted for risk assessment. The QRUR is based upon CMS claims data. Because this report analyzes cost based on TINs, the information is aggregated on a group-wide basis, other than for solo practitioners.

The QRUR has 3 components:

1. **Total Cost Per Capita for Medicare Parts A & B costs** (excluding Part D costs). This is a risk- and specialty-adjusted measure that assigns costs to physicians (groups) who provided the most primary care services to the patient. Costs include *all Part A & B annual costs*, even those not performed by the attributed physician. Some patients are excluded from this calculation, including patients who were not enrolled in both Part A & B, were part of a Medicare Advantage Plan or who resided outside of the US for some time during the year. Notably, primary care services can be attributed to PCPs and to specialists—whomever provides the plurality of primary services. These services are defined as new and follow-up outpatient E/M codes, home care and nursing home visits and annual wellness visits. Charges for patients who die during the year are annualized (for example, if a patient incurs costs of \$1,000 and dies on June 30th, his or her annualized costs attributed to the physician would be \$2,000).
2. **Total Cost Per Capita for Disease Specific Conditions**. This measurement includes costs associated with overall care of four specific conditions, including diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), heart failure (HF), and coronary artery disease (CAD). As above, these are annualized, risk- and specialty-adjusted measures and include the entirety of Medicare Parts A & B costs for patients with these conditions (with the same parameters as above). Patients are again attributed to a single physician (or medical group). Only patients that had a primary care service (as defined above) within the

year are eligible and these costs are again attributed to the physician or group that provided the plurality of services (charges). As above, it is possible for a patient to be attributed to specialists, rather than PCPs.

3. **Medicare Spending per Beneficiary for Hospitalizations.** This measurement evaluates “episodes” of inpatient care and includes both Parts A & B costs from 3 days prior to 30 days post discharge (adjusted by DRG, patient risk and specialty composition of the group). Currently, this requires 125 total hospitalizations per group. These charges are also attributed to the physician (group) that is responsible for the plurality of services.

QRUR: 5 Cost Measures

Total Per
Capita Costs

Condition-
Specific Per
Capita Costs

Cost Categories	Your Medical Group Practice's Performance			Performance of All 1032 Groups with at least 100 Eligible Professionals		
	Number of Eligible Cases	Per Capita Costs Before Risk Assessment	Per Capita Costs After Risk Assessment	Benchmark Per Capita Costs (Risk-Adjusted)	Average Range Benchmark -1 Standard Division	Benchmark +1 Standard Division
Per Capita Cost for All Attributed Beneficiaries (Domain Score ==+ 1.02)						
All Beneficiaries	7,313	\$11,523	\$11,835	\$10,265	\$8,722	\$11,808
Per Capita Cost for Beneficiaries with Specific Conditions (Domain Score ==+ 0.73)						
Diabetes	1,697	\$15,287	\$16,244	\$14,788	\$12,379	\$17,198
COPD	759	\$26,700	\$27,214	\$24,153	\$19,840	\$28,466
Coronary Artery Disease	2,854	\$17,740	\$19,123	\$17,265	\$14,415	\$20,115
Heart Failure	833	\$29,417	\$30,582	\$28,013	\$21,237	\$30,788

Only groups' risk adjusted costs are compared

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By combining the cost component with PQRS and non-PQRS quality outcomes, CMS developed the Value-based Payment Modifier (VBPM). Based upon cost and quality, participating medical groups were eligible for either a small payment bonus or penalty.

Risk adjustment is a key aspect of this program. CMS provides a list of Hierarchical Condition Categories (HCC) which are diseases and conditions that affect overall health. Several of the HCCs listed are frequent comorbidities found in nephrology patients. Some of these conditions include diabetes, hepatitis, vascular disease, drug/alcohol abuse, heart failure and ESRD. Clinicians should be mindful of the effect of precise documentation accounting for the presence of these and other HCCs in order to accurately define their specific patient population.

Currently, CMS publishes the QRUR twice a year. The mid-year report is for informational purposes only and does not directly affect physician payment. The annual report, becomes available in the fall following the performance year (i.e. Fall 2018 for 2017 performance). Groups can access their QRUR on the CMS website at



<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>. Access requires an Enterprise Identity Management System (EIDM) account.

Changes under MACRA

Moving forward, MACRA doubles down on quality and resource utilization for physicians with a goal to “compare resources used to treat similar care episodes and clinical condition groups across practices.” CMS has previously noted that “Although an estimated 80 percent of overall health care costs are attributable to the decisions made by clinicians, these same clinicians are often not aware of how their care decisions influence the overall costs of care. The cost category of MIPS provides an opportunity for informing clinicians on the costs for which they are directly responsible, as well as the total costs of their patients’ care.”

For performance year 2018 (payment year 2020), cost measures will account for 10% of the total MIPS score. In performance year 2019 and beyond (payment years 2021 and beyond), resource utilization accounts for 30% of the MIPS score.

While the current QRUR and Value Modifier Program are not the exact means of scoring for the merit-based incentive payment system, they do for the foundation. There is no data reporting or action required by clinicians as CMS will calculate the cost measures and performance.

Based upon the above attribution criteria and building the QRUR/VM resource subsets, physician groups will be accountable for the following costs within MIPS: Total cost per capita (Medicare Parts A & B) and Medicare Spending per Beneficiary. In 2018, episode-specific conditions will not count towards resource utilization, though this section will likely count in future years (and is included here for future reference). CMS is currently developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures fall 2018.

1. **Total Cost Per Capita for Medicare Parts A & B.** This remains essentially unchanged compared to QRUR/VM with slight changes to the attribution process, still requiring two steps. Similar to the QRUR with attribution typically following the physician with primary responsibility for the patient’s overall care (Primary Care or Primary Physician) and is based upon the volume of billing charges of outpatient E/M codes. Minor changes include better alignment with Medicare Shared Savings and will include codes billed for Chronic Care Management (CCM) and Transition of Care Management (TCM) codes.
2. **Medicare Spending per Beneficiary for hospitalizations.** This measure will continue to evaluate care around hospitalizations, adjusted by DRG and patient risk. However, there are two adjustments compared to QRUR/VM. The minimum number of cases will decrease from 125 to 20 cases and the specialty adjustment will be removed.
3. **Total Cost Per Capita for Episode-Specific Conditions (for future reference, not applicable in 2018).** This category could eventually expand with new episode groups and clinical conditions. Attribution of these costs would require a minimum number of patients with a given condition. Episode groups and clinical conditions would like include acute episodes (triggered by and admission/DRG), chronic conditions (triggered by E/M code combined with ICD-10 diagnosis) and procedures (triggered by ICD procedure codes or HCPCS). For



acute episode-specific conditions, attribution will likely include all clinicians (groups) that bill at least 30% of the inpatient E/M visits. Therefore, a single event may be attributed to more than one entity.

CMS has developed 5 criteria for these episode-specific measures:

- A. **Define the Episode Group:** Three types of episodes include: Acute inpatient medical condition, chronic condition and procedural.
- B. **Assign costs to the episode.** Includes pre-op and anesthesia for a surgery. Includes Complications, readmissions, ER visits etc. Some costs would not be assigned to the episode. For example costs associated with the ongoing care associated with a chronic condition that occurs within an entirely different acute condition or procedure (i.e. dialysis for ESRD patient admitted for appendicitis).
- C. **Attribute the episode to 1 or more clinicians:** Assigned first to a principal, managing physician. Other costs attributed to physicians responsible for a part of the care.
- D. **Risk adjust** based upon type of beneficiary including geography, severity, risk, age, comorbidities, possibly based upon hierarchical condition categories (HCC).
- E. **When possible, align costs associated with an episode with indicators of quality** (hospitalization, readmission, complications). This includes outcomes, processes of care, functional status and patient experience.

CMS expects to propose new cost measures in future rulemaking and solicit feedback on episode-based measures before they are included in MIPS.

MIPS Scoring

What does that mean for nephrologists in 2018 and beyond? Each measure will be converted into points (1-10, based upon performance percentile). Physicians and groups will vary in the number of measures that qualify, due to case volume. For this reason, the equation will be: Total points received / total available points x 100.

In general, nephrologists may be responsible for patients falling into each of the categories above:

1. **Category 1:** Patients for whom the nephrology office has billed the plurality of outpatient E/M codes may be attributed to the nephrologist. This will also include the TCM/CCM codes, even if the patient has a Primary Care Physician. These payments are risk-adjusted based on a CMS algorithm that includes age, sex, Medicaid status and medical history (ICD-9/10). Additionally, outlier patients with costs in the bottom 1% or top 99% are expected to be excluded.
2. **Category 2:** Depending on overall charges, it is possible that ESRD patients who become hospitalized for dialysis-related conditions could fall into this category. It is unclear what role hospitalist-related charges will have, as those providers rarely care for these patients in the post-discharge timeframe.

Notably, there are several medical conditions that aid in risk adjustment. Among others, they include diabetes, liver failure, drug/alcohol dependence, congestive heart failure (CHF), acute kidney injury (AKI), and ESRD. For these reasons, it is exceedingly important to document patient conditions thoroughly.

Aside from receiving points for absolute resource utilization benchmarks, CMS will also offer improvement scoring based upon statistically significant changes at the measure level. CMS will grant practices up to 1 percentage point



for improvement in cost savings. CMS will only consider extra points for cost improvement when there is sufficient data to measure such improvement. For example, a MIPS eligible clinician uses the same identifier in two consecutive performance periods and is scored on the same cost measures. Clinicians who change practices or geographies, therefore, may not qualify for these “improvement points.”

Hardship Exemption

CMS has recognized that unforeseeable events and natural disasters can alter the way physicians practice and can highly impact clinical outcomes and cost of care. For hurricanes and other unanticipated events, the CMS will offer a hardship exception. The application deadline for this will be December 31, 2018.

