

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 attributed 10% (10 points) of the total Merit-Based Incentive Payment System (MIPS) score to cost or resource utilization. For 2019, this percentage rises to 15% of the total score. 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 previously had [access](#) to this report on an annual basis. The QRUR reflected the performance of a medical group (via Taxpayer Identification Number, TIN) on quality and cost metrics, as compared to all other TINs. The final performance period for the Value Modifier and Physician Quality Reporting System (PQRS) programs was 2016 and the final payment adjustment year was 2018. Therefore, the Quality and Resource Use Reports (QRURs) and PQRS Feedback Reports are no longer be available.

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 Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the Value Modifier and PQRS programs. For 2019, MIPS uses cost measures that assess the beneficiary's total cost of care during the year, or during a hospital stay, and/or during 8 episodes of care.

Utilization metrics

As noted above, the MIPS Resource Utilization score has 3 components:

1. **Total Cost of care during the year, also known as *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 (typically defined as outpatient E & M codes). 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 of care during hospitalizations, also known as 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). These charges are attributed to the physician (group) that is responsible for 30% or more of the inpatient E & M services for a given hospitalization.
3. **Total cost of eight pre-specified episodes of care, also known as Total Cost Per Capita for Disease Specific Conditions.** This measurement includes costs associated with overall care of eight specific conditions (see table below from CMS QPP 2019 Final Rule). These are annualized, risk- and specialty-adjusted measures and include the entirety of Medicare Parts A & B costs for patients with these conditions. Patients may be either attributed to a single physician, multiple physicians or medical group(s). The minimum number of cases is 10 for procedural episodes and 20 for acute inpatient medical condition episodes. Episode groups and clinical conditions 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 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.

Measure Topic	Measure Type
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural
Screening/Surveillance Colonoscopy	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition
Simple Pneumonia with Hospitalization	Acute inpatient medical condition
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition

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

- **Define the Episode Group:** Three types of episodes include: Acute inpatient medical condition, chronic condition and procedural.
- **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 (e.g., dialysis for ESRD patient admitted for appendicitis).



- **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.
- **Risk adjust** based upon type of beneficiary including geography, severity, risk, age, comorbidities, possibly based upon hierarchical condition categories (HCC).
- **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.

Physicians and practices are not responsible for tabulating these costs. Rather, CMS will use claims data to calculate cost measure performance.

Benchmarking and Risk Stratification

Resource utilization points are subsequently determined by comparing performance on a measure to a benchmark. Fortunately, these benchmarks utilize comparative data from the performance period (2019), rather than historical data. Costs will only be calculated and utilized for this measure if a benchmark exists and if a physician has adequate patient volume to support statistical analysis. Improvement in resource utilization will not be a metric in the 2019 performance year, but will be a factor in the future.

Additionally, 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.

MIPS Scoring

What does that mean for nephrologists in 2019 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-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.”

Eligibility

General eligibility requirements for the resource utilization score mirror eligibility for MIPS participation in general, including minimum reimbursement and patient claims. In 2019, a new group of facility-based physicians are also eligible for points in this section.

- A facility-based clinician is attributed to the hospital at which he or she provides services to the most Medicare beneficiaries.
- A facility-based group is attributed to the hospital at which a plurality of its facility-based clinicians are attributed.
- If there is an equal number of Medicare beneficiaries treated at more than one facility, the value-based purchasing score for the highest scoring facility is used.
- If CMS is unable to identify a facility with a Hospital VBP Program score to attribute a clinician’s performance, that clinician is not eligible for facility-based measurement and will have to participate in MIPS via other methods.
- Benchmarks for facility-based measurement are those that are adopted under the Hospital VBP program of the facility for the year specified.

Hardship Exemption

CMS has previously 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 has offered hardship exceptions in both performance years 2017 and 2018. As of January, CMS had not yet indicated whether or not they would offer this exemption in 2019.

