***PowerPoint***

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**QUALITY PAYMENT PROGRAM Cost Performance Category VIDEO**

**SLIDE 1**

**What is the Merit-based Incentive Payment System?**



**SCRIPT**

The Merit-based Incentive Payment System or MIPS is one of two participation paths of the new Quality Payment Program or QPP. The Quality Payment Program, contained within MACRA, the Medicare Access and CHIP Reauthorization Act of 2015, is part of a broader effort by CMS, the Centers for Medicare and Medicaid Services, to shift from a volume based payment system, to one which rewards clinicians demonstrating high quality and value by penalizing those who are not. The QPP replaces and consolidates several legacy Medicare programs, combining them into a single program with flexibility that allows participants to choose the activities and measures which are most meaningful. MIPS consolidates the Physician Quality Reporting System or PQRS, now the Quality performance category of MIPS, the Value-modifier program, now the Cost performance category, the Medicare EHR Incentive Program, now the Advancing Care Information performance category and adds a new fourth performance category called Improvement Activities.

**SLIDE 2**

**Weights assigned to each category based on a 1 to 100 point scale**



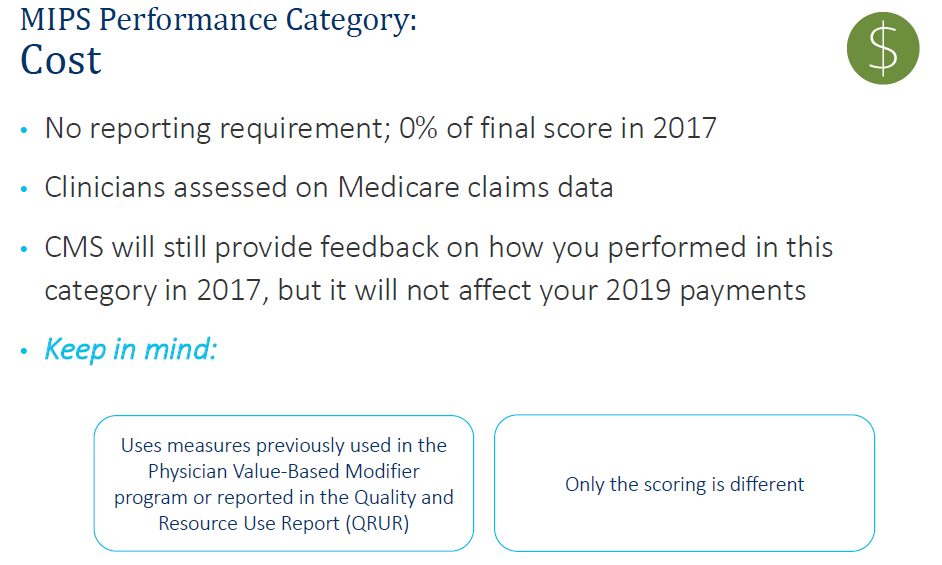
**SCRIPT**

The performance of MIPS participants, referred to as Eligible Clinicians or ECs, is measured across the four weighted performance categories on a 100 point scale, called the Final Score, which is then compared against an annual performance threshold, with Medicare Part B reimbursement rates adjusted based on program performance. In the first Transition Year of the program, to give participants additional time to prepare, clinicians will not be assessed using the Cost performance category, thus only 3 of the 4 MIPS performance categories will be used in 2017. In this initial year of the program, the Quality performance category is worth 60% of the Final Score, the Improvement Activities performance category is worth 15% of the Final Score, and the Advancing Care Information performance category is worth 25% of the Final Score.

**SLIDE 3**

**MIPS Performance Category: Cost**

* No reporting requirement; 0% of Final Score in 2017
* Clinicians assessed on Medicare claims data
* CMS will still provide feedback on how clinicians performed in this category in 2017, but it will not affect 2019 payments
* For this performance category, keep in mind:

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**SCRIPT**

Although the Cost performance category of MIPS is weighted at 0% in 2017 and thus will not be assessed in the first performance year, when it IS utilized in future years of the program, there is no reporting requirement. Clinicians will be assessed in this performance category based on Medicare Part B claims data. Although Medicare reimbursement rates won’t be adjusted based on Cost performance in the first year, CMS will still provide feedback on how clinicians performed in this category, allowing participants time to become acclimated to how cost measures work and how they may affect reimbursement rates in future program years. For this performance category, keep in mind that it uses measures previously used in the Value-based Modifier program and reported in Quality and Resource Use Reports or QRURs. Only the scoring is different.

**SLIDE 4**

**What is a Cost Measure?**

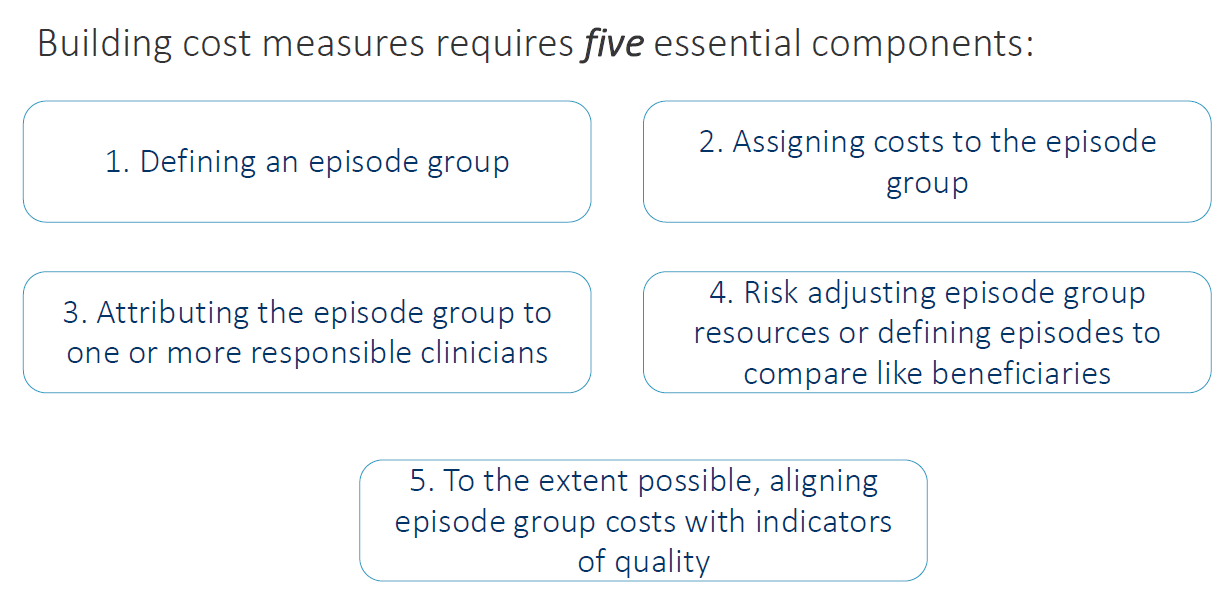
* Generally stated, a cost measure represents the Medicare payments (for example, payments under the Physician Fee Schedule, IPPS, etc.) for the items and services furnished to a beneficiary during an episode of care.
* The episode of care is the basis for identifying items and services through claims that are furnished to address a condition within a specified timeframe.
* The goal is that cost measures should also be aligned with quality of care assessments so that patient outcomes and smarter spending can be pursued together.

**SCRIPT**

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**SLIDE 5**

**What is a Cost Measure?**

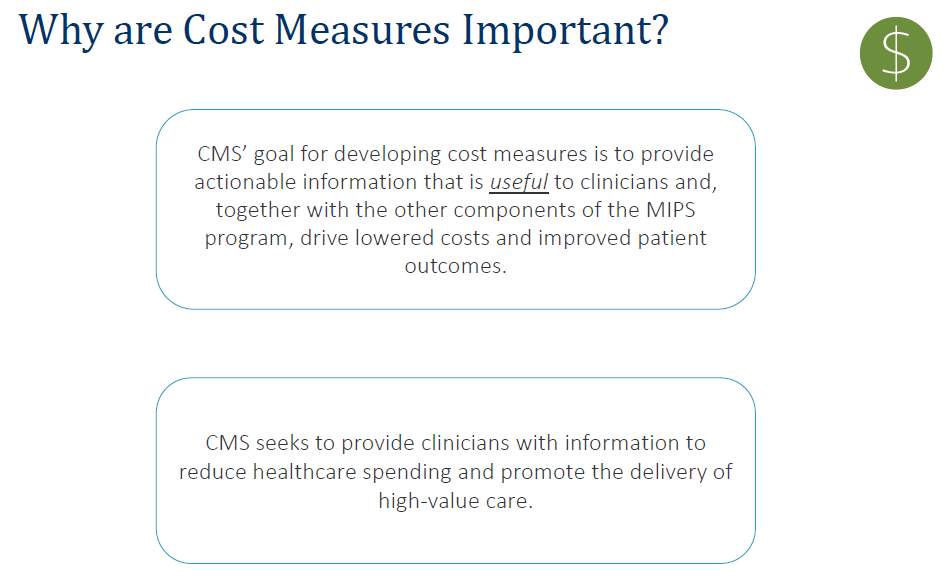


**SCRIPT**

When developing cost measures, CMS considers five essential components. First, defining an episode group. An episode group is a certain type of procedure such as aortic valve replacement or hip fracture surgery. In general, there are 3 different types of episode groups which CMS intends to further develop with significant healthcare community feedback, Chronic Condition Episode Groups, Acute Inpatient Medical Condition Episode Groups and finally, Procedural Episode Groups. Through further development and stakeholder feedback, CMS will be developing additional cost measures which will be used in future years of the program when this performance category is actually used to calculate MIPS Final Scores. The second component in developing a cost measure deals with assigning costs to the episode group. Both direct and indirect costs are considered here and assigned appropriately. Number 3 is attributing the episode group to one or more responsible clinicians. Number 4, risk adjusting the episode group resources or defining episodes to compare like beneficiaries, which is needed to ensure there is an apples-to-apples comparison to the greatest extent possible. And finally five, aligning episode group costs with indicators of quality, so that clinicians can pursue high quality and lower costs concurrently.

**SLIDE 6**

**Why are Cost Measures Important?**

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**SCRIPT**

Why are cost measures important? CMS’ goal for developing cost measures is to provide actionable information that is USEFUL to clinicians and, together with the other components of MIPS, drive lowered costs and improved patient outcomes. Overall, CMS seeks to provide clinicians with information to reduce healthcare spending and promote the delivery of high-value care.

**SLIDE 7**

**In Summary  
MIPS Performance Category: Cost**

* Replaces the Cost portion of the Value Modifier program
* 0% of Final Score in 2017
* Weight will increase in subsequent years, eventually being equally weighted with the Quality category (30%)
* No additional data reporting requirements; calculated from claims data
* Cost measures represent payments for the items and services furnished to a Medicare beneficiary during an episode of care
* CMS’ goal in developing cost measures and providing actionable data to clinicians is to reduce healthcare spending and promote the delivery of high-value care

**SCRIPT**

In summary, the Cost performance category of MIPS replaces the cost portion of the Value Modifier program. To give participants more time to become acclimated with this category and to give additional time for cost measure development by CMS with stakeholder feedback, Cost is not being assessed in 2017, although clinicians will still receive feedback in this area. The weight of this performance category will increase in subsequent years, eventually being equally weighted with the Quality category at 30% each. No additional data reporting is required in this category as measurement is calculated from claims data. Cost measures represent payments for the items and services furnished to a Medicare beneficiary during an episode of care. And CMS’ goal in developing cost measures and providing actionable data to clinicians is to reduce healthcare spending and promote the delivery of high-value care.