Shared Data Across Cost Measurements

Cost measures assess the cost effectiveness of an individual clinician or clinician group's role in managing a patient's care. Within a single cost measure, multiple clinicians involved in a single patient's care are each measured individually to ensure joint accountability of the patient's management. To ensure fair and accurate comparisons, individual claims are used in the separate measurements of clinicians providing concurrent care.

Across different cost measures, each measure will assess the specific role of the clinician care for the defined scope. As patients receive care across these different scopes, claims relevant to each measure will again be used in both measurements to accurately characterize the care for the individual cost measure.

This document presents infographics to illustrate how claims data is shared within and across cost measures. These illustrations show how the reconciliation of each measure and the final Merit-based Incentive Payment System (MIPS) score are constructed to avoid "double counting," or the multiple weighting of costs in a clinician's measurement. Specifically:

(1) The sharing of data during overlapping periods of responsibility (i.e. attribution) across clinicians, using an episode-based cost measure as an example (single cost measure); and
(2) The sharing of data across 2 cost measures that assess differing scopes of the patient's care, using a Total Per Capita Cost (TPCC) measure and an episode-based cost measure as examples (2 separate cost measures).

(1) Within a Single Cost Measure

Figures 1a and 1b provide an illustrative example of a patient's care within an episode-based cost measure, where 2 separate clinicians are attributed individual episodes that overlap. As shown in this example, the patient visits Clinician A for a groin hernia repair (service 1), along with other services (2-3). However, the patient returns after some time and sees Clinician B for an office visit (service 4), along with other services (5-8). Services 4-7 overlap between Clinicians A and B's episode windows and are clinically related to each clinician's care of the patient, and thus attributed to both clinicians' episodes.

Figure 1a. Overlap within an Episode-Based Cost Measure

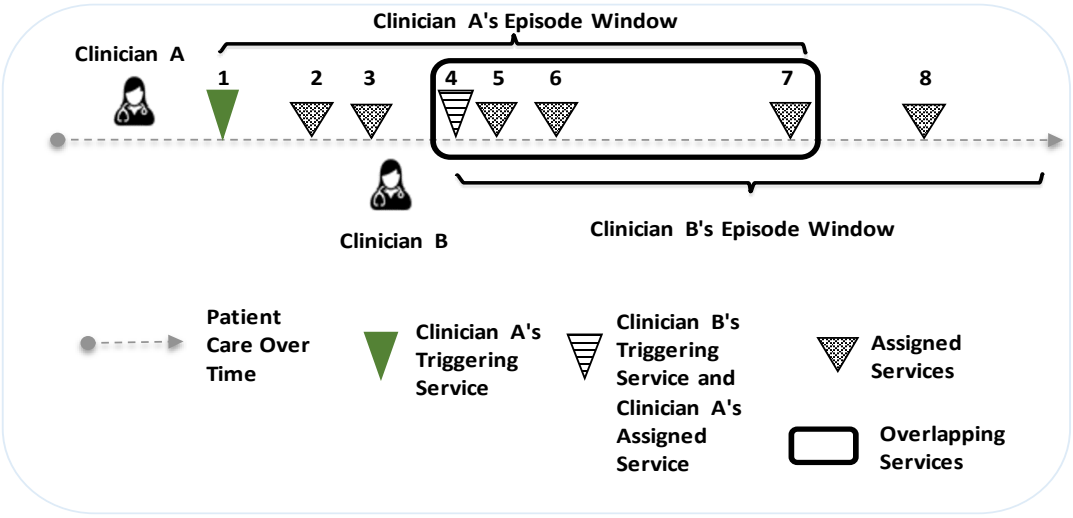
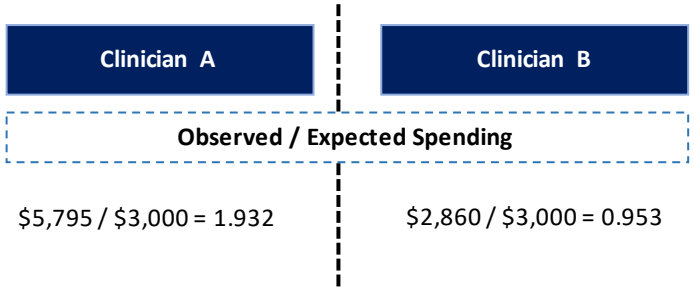


Figure 1b. Assigned Services for Overlap within an Episode-Based Cost Measure

Service #	Assign to Episode		Example Service Cost	Service
	Clinician A	Clinician B		
1	Yes	No	$2,800	Repair of groin hernia
2	Yes	No	$200	Anesthesia for lower abdominal hernia repair
3	Yes	No	$10	Complete blood cell count
4	Yes	Yes	$75	Office or other outpatient visit
5	Yes	Yes	$2,500	Repair of trapped groin hernia
6	Yes	Yes	$200	Anesthesia for lower abdominal hernia repair
7	Yes	Yes	$10	Complete blood cell count
8	No	Yes	$75	Office or other outpatient visit

Figure 1c illustrates how each clinician's observed to expected spending ratio is measured separately and in direct relation to the patient. The concern about double counting in this example is addressed by the fact that the measure calculation risk adjusts each clinician's observed costs for the patient with the same observable characteristics among their peers, rather than to a pre-defined standard. By comparing clinicians to their peers, who are all attributed in the same way, and measuring all clinicians who are responsible for the patient's care, we can expect this comparison to be fair.

Figure 1c. Clinicians A and B's Observed to Expected Spending Ratio



The same scenario could be applied if the measure was reported at the group level rather than the individual clinician level, where Clinicians A and B would instead be separate clinician groups.

(2) Between 2 Separate Cost Measures

Figures 2a and 2b provide an illustrative example of a patient's care with overlapping attribution between 2 measures, the TPCC measure and an episode-based cost measure. In this example, the patient visits a clinician who provides primary care services for routine health maintenance (services 1-4). The patient returns after some time when she notices new symptoms and is seen by the same clinician, who now provides inpatient services for the patient's newly discovered pneumonia condition (services 5-8). The overlapping services (5-8) are counted once in each separate measure since each measure has a distinct scope: the TPCC measure captures broader healthcare costs influenced by primary care clinicians, while the episode-based cost measure includes costs solely related to a specific acute condition.

Figure 2a. Concurrent TPCC Measure and Episode-Based Cost Measure Episodes (Individual Level)

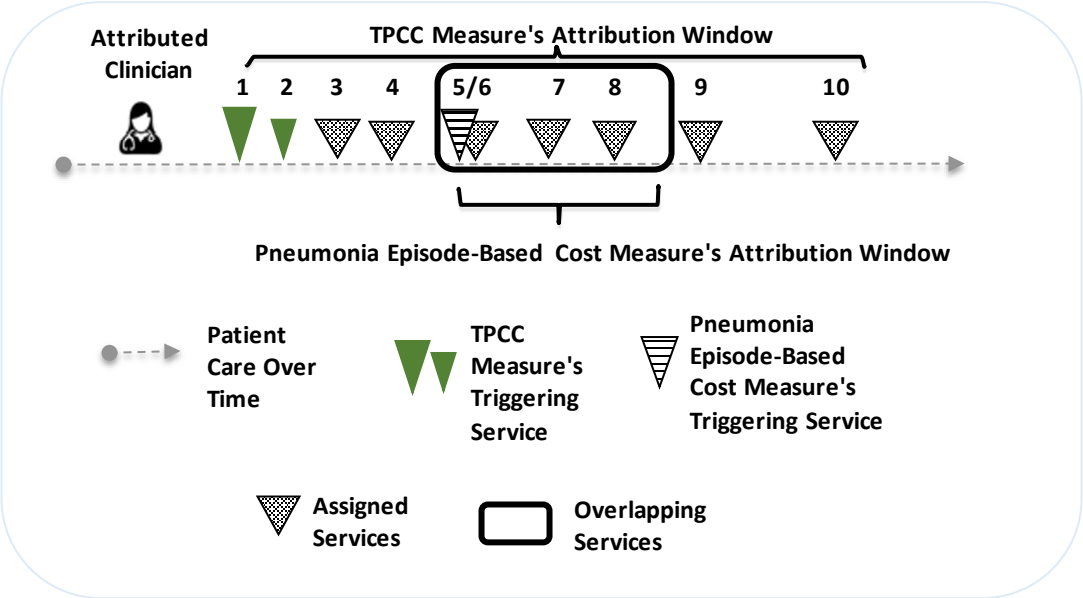
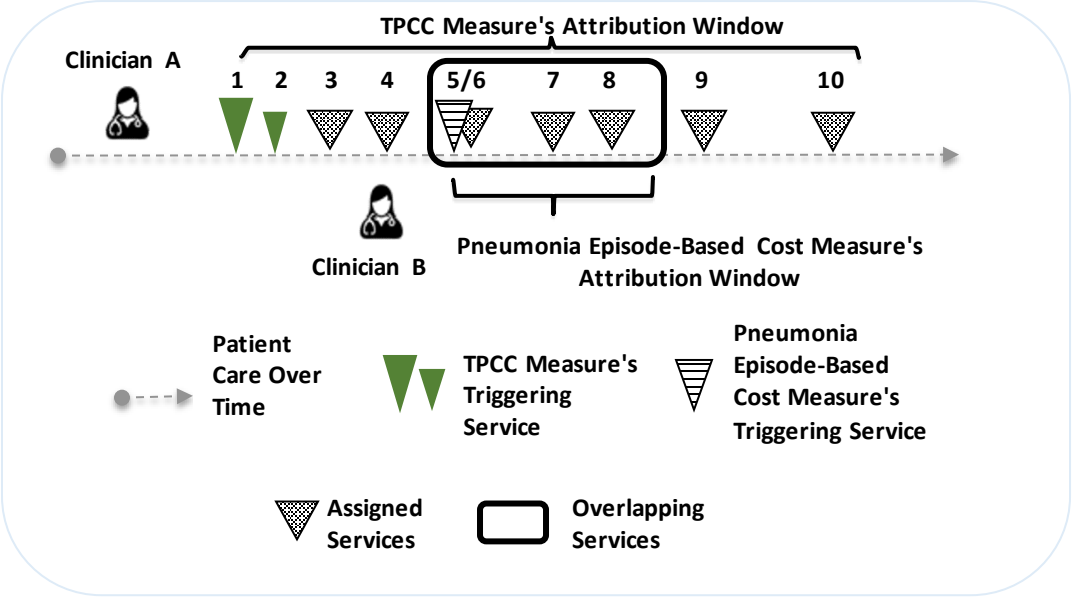


Figure 2b. Assigned Services for Concurrent TPCC Measure and Episode-Based Cost Measure Episodes

Service #	Assign to Episode		Example Service Cost	Service
	TPCC Measure	Pneumonia Episode-Based Cost Measure		
1	Yes	No	$80	Home visit, evaluation and management
2	Yes	No	$80	Home visit, evaluation and management
3	Yes	No	$11	Blood cell count
4	Yes	No	$40	Routine chest scan
5	Yes	Yes	$5,540	Simple pneumonia and pleurisy inpatient admission
6	Yes	Yes	$110	Inpatient, evaluation and management
7	Yes	Yes	$37	Outpatient Computed Tomography chest scan
8	Yes	Yes	$11	Blood cell count
9	Yes	No	$40	Routine chest scan
10	Yes	No	$80	Home visit, evaluation and management

The same scenario could be applied if the measure was reported at the group level rather than the individual clinician level, where Clinicians A and B would be part of the same clinician group (Figure 2aa). In this example, Clinician A is a primary care clinician who provides primary care services attributed to the TPCC measure, and Clinician B is a specialist who provides care at the inpatient level for pneumonia. The overlapping services (5-8) would be included in both the TPCC measure and the episode-based cost measure without double counting because the services are included once in each measure. Having both the primary care clinician and specialist share responsibility over the patient helps align incentives of providers across care settings through the patient care continuum.

Figure 2aa. Concurrent TPCC Measure and Episode-Based Cost Measure Episodes (Group Level)



As illustrated in Figure 2c, the concern about double counting is mitigated as these measures are calculated separately (the risk-adjusted spending for the TPCC measure is calculated amongst clinicians who are attributed TPCC measure episodes; while the risk-adjusted spending for the episode-based cost measure is calculated amongst clinicians who are attributed episode-based cost measure episodes), and then averaged into a single score for the MIPS Cost performance category. In the aggregation of a MIPS Cost performance category score, the relative impact of a high- or low- cost patient in each cost measure is averaged for a given clinician or clinician group, rather than counted twice. This avoids compounding good or poor results, and allows the measure to accurately reflect clinician performance within the context of each individual measure.

Figure 2c. Measure Calculation