Total Per Capita Cost (TPCC) Measure Clinician Group (TIN) Field Test Report

Sample TIN Name, AR[1]
Last four digits of your Taxpayer Identification Number (TIN): XXXX
Measurement Period: October 1, 2016 – September 30, 2017

Your TIN's TPCC Field Test Report Measure Score:

	TPCC measure
Your TIN's score	$891.95
National median	$755.38
Percentile rank	17

The TPCC measure score above, and the information contained in this report are for field testing ONLY. The information in this report does not affect any scoring or payment adjustments in the Merit-based Incentive Payment System (MIPS). This report has been provided for the October 2018 field testing as part of ongoing measure maintenance and reevaluation to gather stakeholder feedback.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS's discretion, including but not limited to, circumstances in which an error is discovered.

[1] For TINs practicing across multiple states, you are assigned the state in which the plurality of your standardized costs were accrued. The state-level values do not impact your TIN's TPCC measure calculation and are included only to provide meaningful comparisons. In cases where state information is unavailable, a TIN is simply assigned "N/A" as state, and state comparisons will be to other TINs categorized as "N/A".

1 RESULTS

Your TIN's TPCC measure score

This section details your TIN's performance on the re-evaluated Total Per Capita Cost (TPCC) measure for field testing only. The TPCC measure assesses your TIN's performance for episodes overlapping the period October 1, 2016 to September 30, 2017, inclusive. Only clinicians and clinician groups with at least 20 TPCC beneficiaries have received a confidential Field Test Report. After reviewing your report, you may provide feedback via the 2018 MACRA Field Testing Feedback Survey.

For more information on the field testing TPCC measure, please see Section 2.

Table 1 displays your TIN's measure score during the measurement period, as well as your TIN's percentile rank nationally. A lower measure score indicates that your episode cost is lower than or similar to the expected for the particular patients and episodes included in the calculation, and a higher measure score indicates the opposite. The percentile rank indicates the percentage of TINs that received the same or higher TPCC measure scores than your TIN. Table 1, titled "TPCC Measure," follows immediately.

Table 1: TPCC Measure

	TPCC measure
Your TIN's score	$891.95
National median	$755.38
Percentile rank	17

Detailed TPCC Measure Statistics

Tables 2-4 below provide detailed breakdowns of your TIN's episode cost to help you understand the factors driving your TIN's score. Table 2 compares your TIN's TPCC episode cost by claim type to the state and national average, Table 3 compares your TIN's TPCC episode cost by specialty to the state and national average, and Table 4 shows how different categories of service (e.g., acute inpatient services or post-acute services) contribute to your episode cost.

Table 2 shows your TIN's average episode cost by claim type compared to the state and national average. The first column presents your TIN's average episode cost by claim type, and the second column provides this as a percentage of total cost for the average episode. The final two columns provide the percentage of total cost by claim type for the average TIN in your state and nationally. Table 2, titled "TPCC Cost Breakdown by Claim Type," follows immediately.

Table 2: TPCC Cost Breakdown by Claim Type†

Claim Type	Your TIN		State*	National
	Cost per Episode	Percentage of Cost†	Percentage of Cost†	Percentage of Cost†
Home Health Agency	$72.67	4.90%	4.18%	4.86%
Hospice	$26.25	1.77%	1.20%	1.27%
Inpatient	$531.01	35.78%	33.38%	30.20%
Outpatient	$342.28	23.06%	22.58%	21.88%
Skilled Nursing Facility	$50.88	3.43%	4.37%	4.99%
Durable Medical Equipment	$40.63	2.74%	2.93%	2.53%
Carrier	$420.43	28.33%	31.36%	34.27%

* Your TIN is assigned the state in which the plurality of its standardized costs were accrued.

† Percentages reported in this table may not add up to 100% due to rounding.

Table 3 breaks down your TIN's TPCC episodes by specialty type. As most TPCC episodes are attributed to primary care physicians and non-physician practitioners, figures for these two categories are further broken down by specialty. The first column indicates the share of your TIN's TPCC episodes attributed to each specialty type, while the second column indicates the share of your TIN's TPCC cost attributable to each specialty type. The third and fourth columns provide the state and national average percentages. Table 3, titled "TPCC Cost Breakdown by Specialty Type," follows immediately.

Table 3: TPCC Cost Breakdown by Specialty Type†

Primary Care Service or Specialty	Your TIN		State*	National
	Percentage of Episodes†	Percentage of Cost†	Percentage of Cost†	Percentage of Cost†
Primary Care Physicians	100.00%	100.00%	25.07%	21.09%
General Practice	0.00%	0.00%	1.19%	0.61%
Family Practice	100.00%	100.00%	17.43%	8.95%
Internal Medicine	0.00%	0.00%	6.10%	11.34%
Geriatric Medicine	0.00%	0.00%	0.35%	0.19%
Non-physician Practitioners	0.00%	0.00%	9.13%	8.02%
Clinical Nurse Specialist	0.00%	0.00%	0.24%	0.11%
Nurse Practitioner	0.00%	0.00%	7.21%	5.08%
Physician Assistant	0.00%	0.00%	1.69%	2.84%
Medical Specialists	0.00%	0.00%	22.96%	27.04%
Surgeons	0.00%	0.00%	7.27%	9.86%
Other Physicians	0.00%	0.00%	4.75%	6.27%
Other Practitioners	0.00%	0.00%	0.00%	0.01%
Multi-Specialty Episodes	0.00%	0.00%	30.81%	27.70%

* Your TIN is assigned the state in which the plurality of its standardized costs were accrued.

† Percentages reported in this table may not add up to 100% due to rounding.

Table 4 breaks down per episode cost by service category. The first two columns indicate the number of episodes that contain any costs in the service category as a count and as a percentage of your TIN's total number of episodes. The third column shows the average episode cost for each category of service. The subsequent two columns present the national average percentage of episodes with costs in the category and the national average for cost per episode in the category. The final column indicates how much higher or lower your average episode cost was than the national average for each service category. Table 4, titled "TPCC Breakdown by Categories of Service," follows immediately.

Table 4: TPCC Breakdown by Categories of Service

Service Category	Your TIN			National		Percentage Difference Between TIN's Average Cost per Episode and the National Average Cost per Episode
	Number of Episodes with Costs in this Category	Percentage of Episodes with Costs in this Category*	Average Cost per Episode	Percentage of Episodes with Costs in This Category*	Average Cost per Episode	
ALL SERVICES	3,130	64.47%	$1,484.16	76.42%	$1,288.88	9.72%
Acute Inpatient Services	170	3.50%	$427.20	3.49%	$403.77	5.03%
Acute Inpatient Hospital Stay	134	2.76%	$367.05	2.97%	$348.88	5.35%
Physician or Supplier Part B Services Billed During Any Hospitalization	170	3.50%	$60.15	3.45%	$54.89	3.03%
Post-Acute Care	291	5.99%	$287.44	6.63%	$178.06	47.95%
Home Health	218	4.49%	$72.67	4.63%	$62.70	-0.05%
Skilled Nursing Facility	63	1.30%	$50.35	2.12%	$75.09	-37.02%
Inpatient Rehabilitation or Long-Term Care Hospital	33	0.68%	$164.42	0.17%	$40.27	281.10%
Emergency Services Not Included in a Hospital Admission	306	6.30%	$48.25	6.26%	$40.18	20.09%
Emergency Evaluation & Management Services	301	6.20%	$44.78	6.16%	$35.14	27.42%
Procedures	44	0.91%	$1.79	1.47%	$2.73	-34.45%
Laboratory, Pathology, and Other Tests	24	0.49%	$0.05	2.13%	$0.23	-76.31%
Imaging Services	162	3.34%	$1.63	3.80%	$2.08	-21.76%

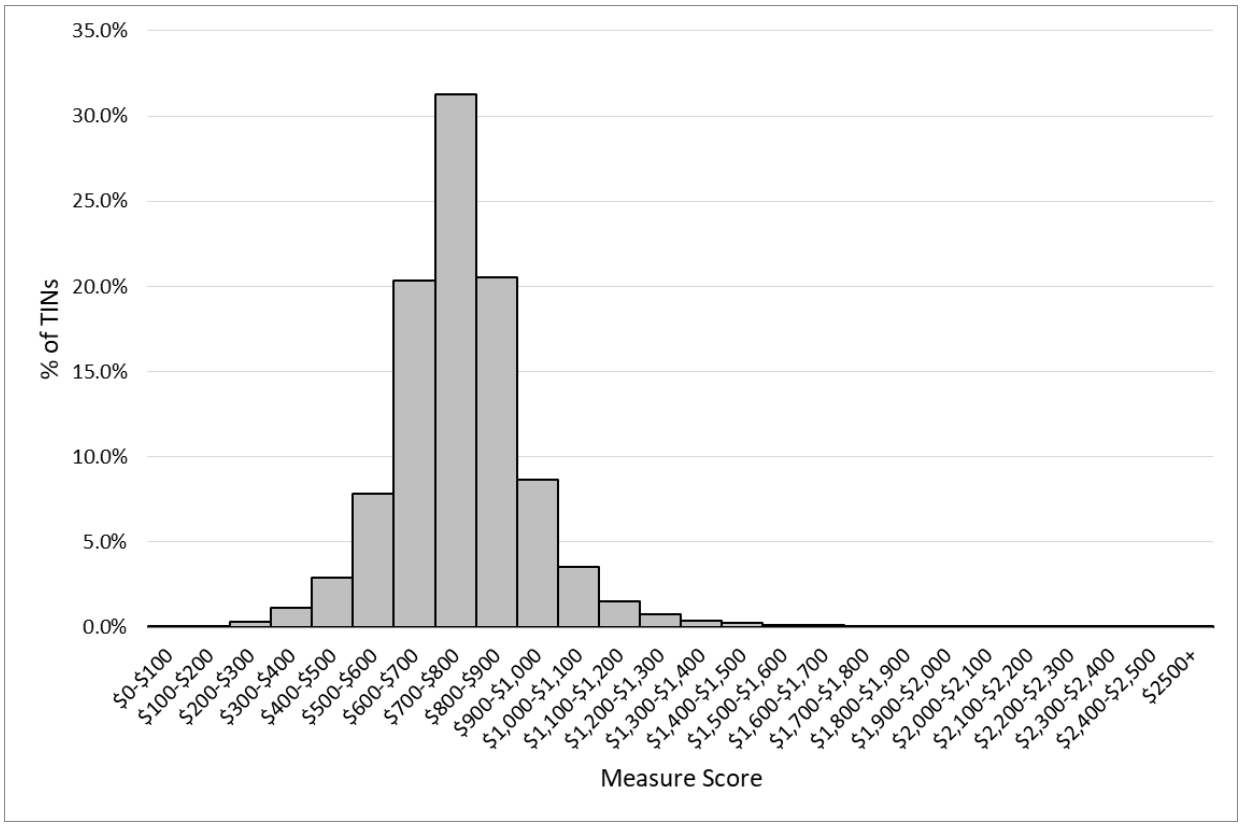
Service Category	Your TIN			National		Percentage Difference Between TIN's Average Cost per Episode and the National Average Cost per Episode
	Number of Episodes with Costs in this Category	Percentage of Episodes with Costs in this Category*	Average Cost per Episode	Percentage of Episodes with Costs in This Category*	Average Cost per Episode	
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	2,932	60.39%	$323.11	67.75%	$331.28	-8.47%
Physical, Occupational, or Speech and Language Pathology Therapy	149	3.07%	$19.04	5.46%	$20.54	-31.38%
Evaluation and Management Services	2,775	57.16%	$136.90	63.36%	$136.74	-3.50%
Major Procedures	142	2.92%	$76.56	2.99%	$77.15	-7.31%
Ambulatory/Minor Procedures	855	17.61%	$90.61	24.33%	$96.85	-11.55%
Ancillary Services	2,429	50.03%	$148.65	53.01%	$138.60	0.12%
Laboratory, Pathology, and Other Tests	1,918	39.51%	$50.88	40.26%	$47.69	6.49%
Imaging Services	909	18.72%	$57.14	20.75%	$58.34	-1.69%
Durable Medical Equipment and Supplies	632	13.02%	$40.63	12.45%	$32.57	-5.94%
Hospice	29	0.60%	$26.25	0.71%	$16.34	-0.54%
All Other Services	915	18.85%	$223.26	24.77%	$180.64	21.86%
Ambulance Services	126	2.60%	$23.17	2.74%	$20.61	7.27%
Chemotherapy and Other Part B-Covered Drugs	332	6.84%	$116.48	8.62%	$99.05	17.15%
Dialysis	92	1.89%	$65.79	1.32%	$37.28	74.97%
Anesthesia Services	157	3.23%	$8.15	4.18%	$9.24	-16.52%
All Other Services Not Otherwise Classified	428	8.82%	$9.67	12.24%	$14.46	-37.45%

* Because an episode may not contain any associated costs, the percentage of episodes with costs in ALL SERVICES may be lower than 100%.

National Distribution of TPCC Measure Scores

Figure 1, which follows immediately, displays a histogram of the national distribution of TPCC measure scores across all TINs.

Figure 1: National Distribution of TPCC Measure Scores



2 ABOUT THE TPCC MEASURE CLINICIAN GROUP (TIN) REPORT

Overview of this report

The TPCC field testing score was calculated with episodes overlapping the period between October 1, 2016 and September 30, 2017, inclusive. Only clinicians and clinician groups with at least 20 TPCC beneficiaries have received a confidential field test report.

This section provides an overview of the TPCC measure, a description of the supplementary data file that accompanies this report, and links to additional resources.

What is TPCC?

The re-evaluated TPCC measure assesses the cost performance of clinicians providing primary care management of Medicare beneficiaries. The TPCC measure has been part of the MIPS cost performance category since the 2017 MIPS performance period. Prior to its use in MIPS, CMS used a version of the TPCC measure in the Value Modifier Program and reported it in annual QRURs until CMS phased out the Value Modifier program. The measure currently used in MIPS is a payment-standardized, risk-adjusted, and specialty-adjusted cost measure focused on clinicians/clinician groups performing primary care services. Specifically, the measure is an average of per capita costs across all attributed beneficiaries, and includes all Medicare Part A and B costs across all attributed beneficiaries.

As part of measure maintenance and re-evaluation, a re-evaluated TPCC measure is now being field tested. The TPCC measure has been re-evaluated with substantial stakeholder feedback and represents a refinement of the TPCC measure that is in use for MIPS. This re-evaluated measure will be field tested in October 2018 and will not affect payment adjustments. It is separate from the reporting of the MIPS TPCC measure for the 2017 and 2018 MIPS performance periods.

What is field testing?

Field testing is a voluntary opportunity for clinicians and other stakeholders to provide feedback on the draft measure specifications for the cost measures, the field test report format, and the supplemental documentation. We will be field testing cost measures, including the re-evaluated TPCC measure, to seek clinician and other stakeholder feedback by:

- Posting confidential clinician field test reports for group practices and solo practitioners who meet the minimum number of cases[2] for each measure on the CMS Enterprise Portal.
- Posting mock reports, draft measure specifications, and supplemental documentation on the MACRA Feedback page.[3]

[2] A case is defined as a beneficiary for the TPCC measure, but can vary for other measures.
[3] CMS, "Episode-based cost measures," *MACRA Feedback Page,* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html.

Supplemental data file

In addition to this report, your TIN has received a beneficiary-level data file in Comma Separated Value (CSV) format. This data file provides detailed information on every beneficiary used to calculate your measure score. Your TIN can use the information contained in this file to perform more detailed analysis of how individual beneficiaries are contributing to your measure score.

Additional Resources

For more information on the TPCC measure, please visit the MACRA Feedback Page.[4]

If you have further questions, please call 1-866-288-8292 (TTY 1-877-715-6222), Monday through Friday, 8:00 AM-8:00 PM ET or email QPP@cms.hhs.gov.

[4] CMS, "Episode-based cost measures," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html

Appendix A – TPCC Measure Score Calculation Breakdown

Table 5 provides more information on your TIN's performance. This table allows you to see summary statistics on items related to your TIN's measure score, and to compare your score to state and national averages. Table 5, titled "Statistics of Your TIN's TPCC Performance," follows immediately.

Table 5: Statistics of Your TIN's TPCC Performance

Row	Statistic	Your TIN	State Average*	National Average
1	Number of Episodes	4,855.00	6,520.00	4,851.00
2	Average Standardized Cost per Episode	$1,484.16	$1,219.62	$1,288.88
3	Average Normalized Risk Score per Episode	1.08	0.91	1.00
4	TPCC Measure Score: Average Risk-Adjusted Episode Cost	$891.95	$840.76	$799.30

* Your TIN is assigned the state in which the plurality of its standardized costs were accrued.

Your TIN's TPCC measure score is calculated as follows:

1. Calculate the standardized observed cost of a TPCC episode by summing all payment-standardized Medicare claims payments during the episode. Costs for partial episodes are pro-rated to cover the entire four-week period.
    - Please see the payment standardization section of Appendix B for more information.
2. Calculate the risk-adjusted cost of that TPCC episode using the risk adjustment model.
    - Please see the risk adjustment section of Appendix B for more information.
3. Average the standardized episode costs across all of your TIN's TPCC episodes (the number of episodes in Table 5, row 1), to calculate the average standardized costs per episode (Table 5, row 2).
4. Calculate the average normalized risk score by averaging the raw risk score across all of your TIN's TPCC episodes, and then dividing by the national average risk score for all TPCC episodes (Table 5, row 3).
5. Calculate the TPCC measure score, the average risk-adjusted episode cost, which, in addition to adjusting for beneficiary risk, trims outlier costs to mitigate the impact of extremely high-cost episodes on the total measure and adjusts for the number of TINs a beneficiary is simultaneously attributed to for the same episode window[5] (Table 5, row 4).

[5] Because outlier trimming and adjusting for the count of TINs simultaneously caring for a beneficiary are done at the episode-level after risk adjustment, the effect of these two adjustments is summarized only in the final measure score. The final measure score cannot be calculated using information from rows 1 through 3 alone.

Appendix B – Glossary

ATTRIBUTION

Attribution is the process of determining which clinician (or clinicians) is responsible for a month of a beneficiary's costs. A month of a beneficiary's costs is attributed to a TIN if a risk window associated with the TIN and beneficiary overlaps the month. More details on the attribution process can be found in the TPCC measure methodology documentation on the MACRA feedback page.

ELIGIBLE CLINICIAN[6]

MIPS eligible clinicians include:

- Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors;
- Physician assistants (PAs);
- Nurse practitioners (NPs);
- Clinical nurse specialists;
- Certified registered nurse anesthetists; and
- Any clinician group that includes one of the professionals listed above.

EPISODE

An episode is a 4-week interval or partial interval associated with a particular beneficiary and attributable to a clinician based on overlap with a risk window.

PAYMENT STANDARDIZATION

The TPCC measure is payment standardized to take into account payment factors that are unrelated to the care provided (such as add-on payments for medical education and geographic variation in Medicare payment amounts)[7]. The standardized payment methodology achieves the following:

- Eliminates adjustments made to national allowed payment amounts to reflect differences in regional labor costs and group expenses (measured by hospital wage indexes and geographic practice cost indexes).
- Eliminates payments to hospitals for larger program goals, including: graduate medical education and indirect medical education (IME); serving a disproportionate population of poor and uninsured (i.e., disproportionate share payments (DSH)); and payments associated with incentive payment programs.
- Substitutes a national amount for services paid on the basis of state fee schedules.

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[6] Please note that the definition of eligible clinicians may be subject to change through rulemaking. For more information on MIPS eligibility, please see About MIPS Participation on the QPP website: https://qpp.cms.gov/participation-lookup/about

[7] For more information, please refer to the "CMS Price (Payment) Standardization - Basics" and "CMS Price (Payment) Standardization - Detailed Methods" documents posted on QualityNet: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic/Page/QnetTier4&cid=1228772057350

- Maintains differences in actual payments resulting from the choice of setting in which a service is provided, the choice of who provides the service, and the choice of whether to provide multiple services in the same encounter.

PRIMARY CARE SERVICES (PCS)

The PCS category includes two distinct types of service. First, it includes evaluation and management (E&M) services provided in office and other non-inpatient and non-emergency-room settings, as well as initial Medicare visits and annual wellness visits. Second, it includes non-E&M services that are commonly associated with E&M visits and considered to be directly related to the provision of primary care.

RISK ADJUSTMENT

Risk adjustment accounts for beneficiary-level risk factors that can affect medical costs, regardless of the care provided. The measure of beneficiary risk used is the beneficiary's risk score from the CMS Hierarchical Condition Category Version 22 (CMS-HCC V22) 2016 Risk Adjustment model. To ensure that the model measures the influence of health status (as measured by diagnoses) on the treatment provided (costs incurred), rather than capturing the influence of treatment on a beneficiary's health status, the risk adjustment model uses prior year risk factors.

The CMS-HCC V22 model generates a risk score for each beneficiary that summarizes the beneficiary's expected cost of care relative to other beneficiaries. Separate CMS-HCC models exist for new enrollees, continuing enrollees, and enrollees in long-term institutional settings:

- The new enrollee model accounts for each beneficiary's age, sex, disability status, original reason for Medicare entitlement (age or disability), and Medicaid eligibility, and is used for beneficiaries with less than 12 months of Medicare medical history.
- The community model is used for beneficiaries with at least 12 months of Medicare medical history. The community model includes the same demographic information as the new enrollee model but it also accounts for clinical conditions as measured by HCCs.
- The institutional model is used for beneficiaries in long-term institutional settings. The institutional model includes demographic variables, clinical conditions as measured by HCCs, and various interaction terms.

RISK WINDOW

The risk window for TPCC begins on the date a beneficiary receives a qualifying visit for an E&M service, and spans an entire year from that date. This term refers to the period of time a beneficiary is considered to be under primary care management by attributed clinician groups, and is not related to risk adjustment. All Medicare Part A and B services provided to a beneficiary during four-week intervals (i.e. episodes) overlapping a risk window are attributable to the TIN associated with the overlapping risk window. More details on what is considered a qualifying visit can be found in the TPCC measure methodology documentation on the MACRA feedback page.