

# MIPS Cost Performance Category



The Cost component is one of the four Merit-Based Incentive Payment System (MIPS) performance categories under which participating MIPS eligible clinicians, including psychiatrists, will be assessed for potential adjustments to their Medicare Part B payments. **This is the only category that the Centers for Medicare and Medicaid Services (CMS) calculates entirely. Psychiatrists and other eligible clinicians have nothing to report for this category.** The MIPS program is part of the Quality Payment Program (QPP), along with incentives for “Advanced” alternative payment models.

## How Much Does Cost Count in my MIPS Score?

For the 2017 performance year, the MIPS Cost category will NOT be counted in your MIPS Composite Score. The Cost category will account for 10% of your MIPS composite score for the 2018 performance year. Then starting with the 2019 performance year, CMS plans to count the Cost category as 30% of your MIPS Composite Score.

## How Does the MIPS Cost Category Compare to the Value-Based Payment Modifier?

The MIPS Cost category replaces the Value-Based Payment Modifier (VM). 2016 was the last year for reporting for the VM, and 2018 is the last year of VM adjustments.

Like the VM, the MIPS Cost category is designed to reward physicians for cost-effective care and efficient use of Medicare resources. Both are designed to capture Part A and B (fee-for-service) spending for Medicare patients, attribute a portion of those costs to the right physicians, and then see how those costs measure up against those of their peers. However, there are some differences:

- The VM only applies to physicians. MIPS eligible clinicians include physician assistants and advance practice nurses. In the future, psychologists, social workers, and other non-physician practitioners are likely to be added to the MIPS program.
- Unlike MIPS Cost scoring, the VM uses six cost measures and a “quality tiering” analysis.
- The Centers for Medicare and Medicaid Services (CMS) will measure the MIPS Cost category (and other categories) at both the NPI (National Provider Identification) and TIN (Tax Identification Number) level. The VM attributes costs only at the TIN level.

## Are Psychiatrists Subject to the VM in 2017 and 2018?

Psychiatrists should also be aware that in 2017 and 2018, Medicare Part B payments for their services may include VM payment adjustments. Depending on the level of resources used by their patients, psychiatrists could receive either a VM bonus, no VM payment adjustment, or possibly a VM penalty. Fortunately, CMS has lowered the penalties for 2018, and unsuccessful reporters under the Physician Quality Reporting System (PQRS) will no longer receive an automatic VM penalty. VM bonuses can range up to 2% for small practices (up to 10 physicians) and up to 4% (for larger practices). In prior years, most physicians and practices were considered “average” and received no VM payment adjustment. Unfortunately, although assessment under the VM requires risk adjustment, VM penalties have tended to go to practices caring for sicker, more disadvantaged patients.

Individual physicians and practices can see how they did under the VM analysis in their annual “Quality and Resource Use Report” (QRUR). CMS has a dedicated web page entitled “How to obtain a QRUR” with detailed instructions, at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>. The CMS Enterprise Portal, which is found at <https://portal.cms.gov/wps/portal/unauthportal/home/>, has a Payment Adjustments and Reports Lookup feature that shows which reports are available for your practice. An Enterprise Identity Management (EIDM) account is required for participants to obtain their annual QRURs.

## What Do I Need to Report for the MIPS Cost Category?

The MIPS Cost category has no separate reporting requirements. However, in future years, Medicare Part B claims for services performed by psychiatrists (and other clinicians) will need to include a code selected for each of the following three categories.

- (1) **Patient Condition Groups:** Different codes will describe the patient’s clinical history at the time of the service, including chronic conditions, health status, recent history, etc. CMS is still developing codes for this category.
- (2) **Care Episode Groups:** These codes will reflect each patient’s clinical conditions or diagnoses, principal procedures or services, inpatient hospitalizations, etc. CMS is still developing codes for this category.

**(3) Patient Relationship Categories:** These self-identified codes are designed to describe the level of each psychiatrist's (or other clinician's) involvement with, and responsibility for, a particular patient: X1: Continuous/Broad; X2: Continuous/Focused; X3: Episodic/Broad; X4: Episodic/Focused; and X5: Only as ordered by another clinician. The "Broad" codes are mostly for primary care providers, while the X5 code is for diagnostic services by, e.g., pathologists and radiologists (rather than patient care). Psychiatrists will likely use the X2 and X4 codes. There are no set definitions for "Continuous" or "Episodic" and these can vary from one encounter to the next, for the same patient. CMS has issued five codes for this category, which can be reported on claims voluntarily, starting in January 2018. CMS plans to require their use in the future, perhaps after further changes.

## How is the MIPS Cost Category Scored?

For performance year 2017, there is no MIPS Cost score. For 2018, CMS will review the Medicare administrative claims data for MIPS eligible clinicians. To calculate MIPS Cost scores, CMS will apply two types of cost measures. Both measures are adjusted for geographic payment rate and beneficiary risk factors (using the HCC/Hierarchical Condition Categories). Additional adjustments are indicated below.

- **Medicare Spending per Beneficiary (MSPB):** This measure attributes patients to the physician or clinician who provided the plurality of Medicare Part B charges during a particular ("index") hospital admission, adjusted by diagnosis-related group (DRG). There is a minimum of 35 cases for this measure to apply.
- **Total per capita cost measure:** This measures the total per capita cost for all attributed beneficiaries, adjusted by specialty. Skilled nursing facility codes are excluded. There is a minimum of 20 cases for this measure to apply.

The scores for both measures are averaged. If only one measure can be scored, that is the score for the whole category. Given the minimum case thresholds of the two measures, some psychiatrists and their practices may not qualify for either cost measure. In that case, CMS may decrease the weight of the Cost category to zero, and increase the weight of other MIPS performance categories.

Starting with performance year 2019, CMS plans to add a third type of cost measure.

- **Episode-based cost measures:** CMS is developing these with input from physicians and other stakeholders. Each measure will define an episode of care for a particular condition and include

related services within a certain time frame. Similar measures, for particular procedures and medical conditions, were used for calculating the VM. CMS plans to set a minimum of 20 cases for each episode-based cost measure to apply.

## What Can I Do to Prepare for this Category?

Psychiatrists who can conserve Medicare resources without negatively impacting the quality of patient care may be rewarded with higher MIPS Cost scores, which can potentially help them earn a MIPS bonus or avoid a penalty. In MIPS Cost scoring, the correct attribution of patient costs to psychiatrists may prove a challenge. The APA wants to ensure that psychiatrists avoid being attributed costs for care that their patients receive, which is unrelated to their services. And those who care for sicker, economically disadvantaged patients should not be penalized for providing these valuable services to vulnerable populations. Since only you or your practice have access to your individual feedback report (QRUR), we recommend reviewing your annual reports as these are made available and letting us know if you see any issues or problems.

## RESOURCES

### Where can I find other APA resources?

- The APA Payment Reform Toolkit has additional fact sheets about the Quality Payment Program (QPP), MIPS reporting, the MIPS performance categories, and incentives for participating in Advanced APMs. The Toolkit is available at [psychiatry.org/PaymentReform](https://psychiatry.org/PaymentReform).
- Information about the APA mental health registry, PsychPRO, including how to sign up, is available at <https://www.psychiatry.org/psychiatrists/registry>.

**What CMS resources are available about the MIPS cost category?** CMS has many resources on the Quality Payment Program website (<https://qpp.cms.gov>) including:

- **QPP Resource Library:** <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html>
  - **2018 QPP Final Rule Overview Fact Sheet:** <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf>

- **2018 QPP Final Rule Executive Summary:** <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf>
- **CMS Cost Measures Fact Sheets:** <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Measures.zip>

#### **What CMS resources are available about the Value-Based Payment Modifier?**

- **Value-Based Payment Modifier webpage:** <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.
- For questions about the 2018 Value Modifier, you may contact the CMS Physician Value Help Desk at 888-734-6433 (select option 3) or [pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov).

#### **What if I still have questions?**

- APA members may consult APA staff experts by sending an email to [qualityandpayment@psych.org](mailto:qualityandpayment@psych.org), or by calling the Practice Management Helpline at 1-800-343-4671.
- CMS has a QPP Service Center that accepts questions from the public at [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 1-866-288-8292.