The Cost component is one of the four Merit-Based Incentive Payment System (MIPS) performance categories under which 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 have nothing to report for this category.**

**How Much Does Cost Count in My MIPS Score?**
For the 2017 performance year, Cost will account for 0% of your total MIPS score. For 2018, Cost will count 10%. Then starting with the 2019 performance year, it will account for 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 is the last year for reporting for the VM, and VM adjustments end after 2018.

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, while MIPS eligible clinicians include PAs, NPs, CNSs, and in the future, psychologists, social workers, etc.
- Unlike MIPS Cost scoring, the VM uses six cost measures and a “quality tiering” analysis.
- MIPS will measure Cost (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.

**Will Psychiatrists be Subject to the VM in 2017 & 2018?**
In 2017 and 2018, all Medicare Part B (fee-for-service) payments to psychiatrists are subject to potential VM adjustments. Psychiatrists who failed to successfully report under PQRS in 2015 and 2016 will also...
receive the highest VM penalty—about 2% for small practices (of up to 10 clinicians) and about 4% for larger practices. Depending on the level of resources used by their patients, psychiatrists who were successful PQRS reporters could receive a VM bonus, no VM payment adjustment, or possibly a VM penalty. Individual physicians and practices can see how they did under the VM analysis in their annual “Quality and Resource Use Report” (QRUR). 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.

**What Do I Need to Report?**

The Cost category has no separate reporting requirements. However, starting in 2018, all Medicare Part B claims for services performed by psychiatrists (and other clinicians) will need to include a code selected for each of the following categories. CMS will provide a list of codes for each category.

- **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.
- **Care Episode Groups**: These codes will reflect each patient’s clinical conditions or diagnoses, principal procedures or services, inpatient hospitalizations, etc.
- **Patient Relationship Categories**: These codes will describe the level of each psychiatrist’s (or other clinician’s) involvement with, and responsibility for, that particular patient. These may range from being the main provider of ongoing care, to providing services as needed, or in response to requests or orders of other clinicians.

**How is the Cost Category Scored?**

CMS will review the administrative claims data for MIPS eligible clinicians, including the codes indicated for patient condition, care episode, and patient relationship category. To calculate MIPS Cost scores, CMS will apply three types of Cost measures. All three 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 clinician who provided the plurality of Medicare Part B charges during the 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.

• **Episode-based measures**: The current ten episode-based measures all relate to surgical or diagnostic procedures; none relate to evaluation and management or mental health services. More will be added in the future. There is a minimum of 20 cases for this measure to apply.

Given the minimum case thresholds of the first two measures – and the procedural nature of the current episode-based measures – many psychiatrists and their practices may not qualify for all (or even any) of these Cost measures. Under the MACRA, CMS may decrease the weight of a MIPS category (even to zero) when there are not sufficient measures, and increase the weight of other categories.

**What Else Should 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, and potentially earn a MIPS bonus or avoid a penalty. In MIPS scoring, correct attribution of patient costs to psychiatrists may prove a challenge. The APA wants to ensure that psychiatrists are not attributed resources that are clearly not related to their services—and those who care for sicker, economically disadvantaged patients are not penalized for providing these valuable services to vulnerable populations. Since only you or your practice have access to your individual feedback report, we recommend reviewing your report and letting us know if you see any issues or problems. In 2017, CMS and the APA will provide information about the new categories and codes to be included in Medicare claims.

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Note: The scatter plot reflects the performance of a representative sample of your peers.

**Position of an ideal hypothetical provider**

RESOURCES

Where can I find other APA Resources?
Additional APA resources are available at: psychiatry.org/PaymentReform

What should I do if I have questions or issues regarding the MIPS Cost performance category?
APA members can submit questions by email to APA staff at: qualityandpayment@psych.org.

What other resources are available?
- CMS Fact Sheet (12 pages):
- CMS Executive Summary (24 pages):
- CMS Quality Payment Program Website: https://qpp.cms.gov/