MIPS Program: 2018 Cost Category

The 2018 Quality Payment Program (QPP) – Year Two final rule continues to implement the programs authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). For 2018 performance, to impact 2020 payment, CMS agreed with ASCRS and medical community recommendations to continue the transition period for MIPS and provide a pathway for practices implementing the program to meet the MIPS final score threshold and avoid the 5% penalty in 2020 by submitting minimal data.

CMS set the 2018 MIPS final score threshold at 15 points, up from 3 points in 2017. To avoid the 5% penalty, physicians must earn at least 15 MIPS points.

The threshold can be met in a variety of ways, such as:

- Full participation in the Improvement Activities category, such as submitting one high-weighted activity or two medium-weighted activities for small practices, or two high-weighted activities, four medium-weighted activities, or a combination of both high- and medium-weighted activities;
- The Advancing Care Information (ACI) category base score and one quality measure meeting the measure threshold, or data completeness, but not benchmarks;
- ACI base score and one medium-weighted improvement activity; or
- Six quality measures meeting data completeness, but not measure benchmarks.

This guide summarizes the final Cost performance category of MIPS, which is based on the previous Value-Based Payment Modifier (VBPM) program. ASCRS also has developed guides on the other three categories of MIPS. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

Cost Category Weight – 10% for 2018 Performance Year

Despite ASCRS and medical community recommendations that the Cost category weight remain at 0% for 2018 to impact 2020 payment, CMS raised the category weight to 10% of a physician’s or group’s final MIPS score.

We continue to oppose the flawed attribution methodology CMS will use to calculate the cost measures and their lack of risk-adjustment, and believe that CMS should develop episode-based cost measures as an alternative to the current measures. CMS will not include any of the previously finalized episode-based measures or ones currently under development for the 2018 performance year. CMS has made draft feedback reports on the eight episode measures under development, including cataract surgery, available to physicians and groups. ASCRS has provided input on the development of the cataract measure and will continue to seek refinements to improve readability and actionability of the reports.

The weight for this category will increase to 30% in 2021, based on 2019 performance, and continue at 30% in future years.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider’s quality performance score to make up the difference. If a physician or group does not have any cost measures attributed, the 10% weight in 2018 will be reassigned to the Quality category.
Cost Reporting Requirements

Physicians do not need to submit separate data for the Cost category. Similar to the Value-Based Payment Modifier (VBPM), CMS will determine cost scores through administrative claims.

Cost Measures

CMS will measure providers’ resource use by using the two cost measures from the VBPM. For the 2018 performance period, CMS will calculate the two cost measures, total per capita cost, and Medicare spending per beneficiary (MSPB) and compare physicians’ score relative to a benchmark set at the beginning of the performance period. Total per capita costs include all payments under Medicare Parts A and B but exclude payments under Part D. MSPB includes costs 3 days before and 30 days after an inpatient hospitalization.

CMS will not calculate several episode-based cost measures previously finalized for 2017 performance, including cataract surgery. CMS and its contractor Acumen have been developing new episode-based cost measures with physician input. ASCRS has a physician serving on a technical expert panel advising CMS and Acumen on the development of a cataract episode measure. These measures are still in the test phase, and will not be included in 2018 performance. Physicians and groups can download test reports on their performance from the CMS Enterprise Portal.

Patient Attribution

CMS will attribute patients to the cost measures through the same flawed VBPM two-step attribution process. First, a beneficiary will be assigned to a Tax Identification Number (TIN), combined with a National Provider Identifier (NPI), if the beneficiary receives a plurality of primary care services from a primary care provider. For beneficiaries who did not receive any eligible primary care services from a primary care physician during the reporting period, the beneficiary will be assigned to the TIN/NPI combo that provided the plurality of E/M services to the beneficiary. Due to this attribution method, ophthalmologists may be attributed costs of care they did not provide.

CMS has set the attribution threshold at 20 beneficiaries for scoring on the total per capita and 35 beneficiaries on the Medicare Spending per Beneficiary (MSPB) measures.

Cost Category Score

Beginning in 2018, the MACRA statute requires CMS to incorporate improvement into a physician’s or group’s Cost score. The total Cost category score will be the sum of cost measure achievement divided by total possible points in the category, plus up to 1 percentage point of for improvement.

Cost Achievement Score

To determine a provider’s Cost achievement score, CMS will assign 1 to 10 points to each measure attributed to the physician or group based on performance relative to the established benchmark. The benchmark for each measure will be determined based on cost data from the performance period. CMS would award points for each measure depending on how a provider scored in relation to overall performance.

The total category points possible for a performance year depend on how many measures the provider is attributed. The Cost category achievement score is determined by adding the points scored on each measure and dividing by the total possible points available. For example, if an ophthalmologist is only attributed the total per capita measure, then the total possible points for the category would be 10. If he or she scores 9 on the total per capita measure, the 9 points earned would be divided by the 100 possible points for an achievement score of 90%.

If a provider does not have any attributed measures, the Cost category will not be scored, and the Quality category will be re-weighted to 60%.
Cost Improvement Score

Even though Cost was not included in 2017 MIPS scores, CMS will calculate improvement scores as part of physicians’ and groups’ 2018 Cost category scores. To calculate the improvement score, CMS will determine whether physicians or groups were attributed each of the cost measures for the current and prior performance periods. For any measure attributed in both years, CMS will determine if there was a statistically significant rate of improvement or decline for the measure.

CMS will add a maximum of one percentage point for improvement to the Cost category percent score.
- If a physician has both cost measures attributed, he or she will earn 0.5% for each measure with significant improvement.
- If a physician has only one measure attributed, he or she will earn 1% if there is significant improvement on the measure.

No physician or group can earn fewer than zero improvement points. Failure to demonstrate significant improvement or not have measures attributed in consecutive years will not result in a penalty. If a physician or group does not have the same measure attributed in two consecutive years, no improvement score will be calculated.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.