MIPS Program: 2017 Resource Use (Cost) Category

On October 14, 2016, CMS released the final rule on the Quality Payment Program, which includes both the Merit-Based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (APMs). The final rule establishes regulations on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law in April 2015. The new law changes the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models.

This guide summarizes the final Resource Use performance category of MIPS, which is based on the current Value-Based Payment Modifier (VBPM) program. ASCRS also has developed guides on the other three categories of MIPS.

Resource Use Category Weight – 0% for 2017 Performance Year

For 2017, the first performance year of MIPS, a provider’s Resource Use score will not factor into the overall MIPS composite score. Due to the flawed attribution methodology proposed by CMS to calculate the cost measures and lack of risk-adjustment, ASCRS and the medical community recommended the category weight be lowered to 0% so that physicians are not penalized for the cost of care they did not provide. CMS agreed to that recommendation. Therefore, CMS will calculate the proposed cost measures based on the 2017 performance period for informational purposes only. This guide summarizes the policies CMS finalized to calculate the informational resource use scores for 2017.

The weight for this category will increase in future years to 10% in 2020, based on 2018 performance, and 30% for payment year 2021 and beyond.

In some cases, CMS may determine 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.

Resource Use Reporting Requirements

Physicians do not need to submit separate data for the Resource Use category. Similar to the current Value-Based Payment Modifier (VBPM), CMS will determine resource use through administrative claims.

Resource Use Measures

CMS will measure providers’ resource use by using two cost measures from the VBPM and several episode-based measures, including cataract surgery. For the 2017 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. Condition-based measures previously used in the VBPM will not be used for the Resource Use category.

CMS will also measure cost through several episode-based measures, including lens and cataract procedures. Episode-based measures attempt to measure the total cost of care for particular acute episodes, specific procedures, or chronic conditions. ASCRS opposed the inclusion of the cataract episode measure in our comments on the final rule, since CMS has not provided sufficient information on how the episodes are constructed and scored. In addition, we have concerns that the attribution process continues to hold physicians accountable for costs that are beyond their control, and that the measures are not risk-adjusted. We continue to advocate for more transparency in the development and use of these measures, and are participating in several technical expert panels to provide feedback on their development. CMS will also calculate the episode-based
measures on 2017 performance, for informational purposes. Previously, CMS calculated these measures for physicians, based on 2014 and 2015 data, for informational purposes. Physicians can review their performance on these measures for 2014 and 2015 by downloading their Supplemental Quality and Resource Use Report from the CMS 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.

For episode-based measures, beneficiaries will be attributed to the provider who bills a Medicare Part B claim with a trigger code during the trigger event. In the case of the cataract episode, the triggering event is when a CPT code—66984 or 66982 for cataract—is billed. If more than one eligible professional bills a triggering claim during the triggering event, the episode is attributed to both providers. In the case of co-management, the episode is attributed to the physician performing the specific procedure, such as cataract surgery.

A physician must have 20 attributed episodes to be scored on an episode-based measure.

### Resource Use Score

To determine a provider’s Resource Use category score, CMS will assign 1 to 10 points to each measure based on performance relative to the established benchmark. The benchmark for each measure would 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 points possible for a performance year depend on how many measures the provider is attributed**. The Resource Use category 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 and the cataract episode, then the total possible points for the category would be 20. If he or she scores 10 on the total per capita measure and 6 on the cataract episode measure, the 16 points earned would be divided by the 20 possible points for a score of 80%. In future years, the Resource Use category score will then be weighted as part of the total MIPS score.

If a provider does not have any attributed measures, the Resource Use category will not be scored, and the Quality category will be re-weighted.

### Additional Resources

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