
On April 27, 2016, CMS released a proposed rule on the Quality Payment Program, which includes the Merit-Based Incentive Payment System (MIPS). The proposed rule is CMS’ first attempt to develop regulations on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law in April 2015, which codifies the new system physicians will be paid under Medicare.

MACRA sunsets the penalties associated with the current quality reporting programs at the end of 2018, and requires CMS to streamline and incorporate them into the MIPS program, which will affect physician payments beginning in 2019. CMS is proposing the first performance year to begin January 1, 2017, which will impact payments in 2019.

This guide summarizes the proposed Resource Use, or Cost category, modeled on the current Value-Based Payment Modifier (VBPM), of MIPS.

ASCRS also has developed guides on all of the categories of MIPS. However, it is important to remember these guides explain the proposed rule, and may not reflect the provisions of the final rule. ASCRS has 60 days to provide feedback to CMS based on these proposals. A final rule is expected in fall 2016.

### Resource Use Category Weight

For 2017, the first performance year of MIPS, CMS proposes to weight a provider’s Resource Use score at 10% of the overall MIPS composite score. The MACRA statute limits the weight of the Resource Use category in the first year to 10%, but requires the weighting to increase in subsequent years. In the second year of MIPS, CMS proposes to increase the weight to 15%, and then further increase it to 30% of the overall score for the third year of the program.

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 proposes to 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 (MSBP) 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. MSBP includes costs three 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 also proposes to measure cost through several episode-based measures, including cataract surgery, using Method B. CMS did not provide details in the proposed rule of how it intends to score these measures, and has not finalized separate proposals related to episode groups. Therefore, ASCRS is recommending in our comments that the episode groups not be used to measure resource use in the first year.
Patient Attribution

CMS proposes to 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 proposes to lower the attribution threshold to 20 from the current 125 beneficiaries for scoring on the total per capita and 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. For outpatient procedural episodes, the trigger event depends on which of CMS’ proposed Methods (A or B) are used.

- For Method A, the trigger event is the day of the triggering claim, plus the day before and two days after the trigger date.
- For Method B, the trigger event is only the day of the triggering claim. The proposed rule includes the Cataract Episode from Method B.

If more than one eligible professional bills a triggering claim during the triggering event, the episode is attributed to both providers.

CMS proposes a threshold of 20 attributed episodes for a physician to be scored on an episode-based measure.

Resource Use Score

To determine a provider’s Resource Use category score, CMS proposes to 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.

A provider’s Resource Use category score will be the average score on each of the measures attributed to the provider. The Resource Use category score will then be weighted to count for 10% 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.

ASCRS Recommended Changes

ASCRS will be submitting comments to CMS on the proposed rule. The comments state our position on various provisions of the proposed rule, and recommended changes. For the Resource Use category, ASCRS:

- Continues to oppose the flawed primary care-based attribution model, which potentially holds physicians responsible for the cost of care they did not provide. ASCRS recommends CMS should adopt the same attribution methodology it currently uses for ACOs, which excludes ophthalmologists.
- Opposes lowering the beneficiary threshold of the MSPB measure, as it will likely attribute more patients to ophthalmologists.
- Opposes the proposal to include episode groups. The current episode proposals do not accurately measure cost or adjust for risk, and CMS has not provided enough information regarding how it will score these measures in MIPS.

Additional Resources

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