The MIPS Cost Category: New for 2018

By Elizabeth Woodcock, MBA, FACMPE, CPC

In 2018, the federal government began to assess the cost of caring for Medicare beneficiaries under the Merit-based Incentive Payment System (MIPS). One of four components of the MIPS composite performance score – the cost category – counts as 10% of the overall score in 2018. While it may have a limited influence on performance this year, this component will rise to 30% of the score in 2019. Therefore, it is crucial to understand how the government is measuring costs under this program.

First, it's important to recognize that participating physicians and advanced practice providers will not report any data for the cost measure. Rather, the Centers for Medicare & Medicaid Services (CMS) will analyze costs based on claims submitted to Medicare.

There are two elements being captured for the cost category: (1) Total Per Capita Costs for All Attributed Beneficiaries (TPCC); and (2) Medicare Spending Per Beneficiary (MSPB). The first element, according to CMS, is a "payment standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians." The second "assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's [acute inpatient] hospital stay." MSPB is also standardized and risk-adjusted, although there is no specialty factor.

While there are details related to each of the elements, perhaps the most crucial is to whom – and how – the costs are attributed. Let's break down the attribution for each element:

Total Per Capita Costs for All Attributed Beneficiaries (TPCC). The TPCC examines costs at a global level; namely, the government's cost of providing care to the patient during the entire reporting period, which is defined as the calendar year. The means for attributing the patient to a physician is somewhat complicated, however. CMS looks initially to whether the patient received a primary care service from a physician care practitioner (PCP). PCPs are defined by their taxonomy code: General Practice (01); Family Practice (08); Internal Medicine (11); Geriatric Medicine (38); Clinical Nurse Specialist (89); Nurse Practitioner (50); and Physician Assistant (97). If the patient received the service from one of these practitioners, the entire cost of caring for that beneficiary for the year is attributed to that practitioner.

If the patient did not receive the service from a PCP during the reporting year, however, the costs are attributed to the non-PCP who performed the plurality of primary care services. Primary care services include evaluation and management services provided in office and other non-inpatient and non-room settings, as well as initial Medicare visits and annual wellness visits.

For the TPCC element, it is crucial for PCPs to be aware of how, when and where their patients access care. For specialists, it's absolutely critical to ask every Medicare patient if and when they have seen their PCP. This must go beyond "do you have a PCP?" as simply having one won't help with the program; the patient must have seen the PCP in the office, nursing facility or home as Medicare will not be aware unless there was a claim generated. Furthermore, specialists who use advanced practice providers (APP s) to bill independently must be aware that patients may be attributed to them as the government is not crosschecking the name of the practice in which the APP works to determine whether or not it's a primary care practice. For example, if an Endocrinology practice designates a nurse practitioner to see established patients and bills for him or her as an independent practitioner, it's highly likely that the patients' costs will be attributed to the APP or practice (depending on whether individual or group reporting is chosen).

Finally, physicians who may not consider themselves as "PCPs," but who are registered with CMS under one of the aforementioned seven taxonomy codes, will be considered PCPs under the initial attribution step. This may impact Urgent Care physicians, for example, as well as those specialty physicians who may have been registered under "Internal Medicine," perhaps even unknowingly. As noted, CMS is not considering the practice's name or how it identifies itself; if the practitioner is credentialed as one of those seven taxonomy codes, he or she is considered a PCP under this program and will have patients' cost attributed to him or her.

Medicare Spending Per Beneficiary (MSPB). The MSPB episode includes all Medicare Part A and Part B claims falling in the episode "window," specifically claims with a start date between three days prior to a hospital admission through 30 days after hospital discharge. However, the costs for the episode are attributed to the physician who has the plurality of Part B services *during* the index admission. The index admission is the period between admission date and discharge date of the hospital stay, inclusive. Given the calculation, it's likely that the surgeons and proceduralists will get hit with these episodes, if applicable; if not, it will most commonly be the physician who is managing the patient's care.

For both measures, plurality is defined by payments standardized to the Medicare allowable. Part D-covered prescription drug costs are not counted for either measure; and the program only incorporates traditional Medicare patients. Those patients enrolled in Medicare Part C (Medicare Advantage plans) are not included. Furthermore, if a patient dies during the reporting episode, he or she is excluded from the data.

Finally, the case minimum for reporting is 20 episodes, regardless of reporting level. This means that if four physicians report as a group, the minimum is 20 episodes among all four; if that same group reported separately, *each* of the four physicians would need the

minimum 20 episodes to trigger reporting.

The cost category mirrors the assessment made under the Value-based Payment Modifier Program. Although the program ended on December 31, 2016, it issued insightful reports called “QRURs” - Quality and Resource Use Reports, most recently in September 2017. Understanding how you’ll be assessed, as well as obtaining and reviewing your QRUR, is vital to preparing for success under the new category of MIPS in 2018.

For additional resources, please see the article “2018 Penalties: PQRS and VBPM Informal Review Available through December 1”, originally published in the October 2017 edition of The Sentinel.

For more information, see 2018 Cost Measures
