HIMSS MACRA Final Rule Fact Sheet

Merit-Based Incentive Payment System (MIPS):
Cost Performance Category and Resource Use

November 15, 2016

HIMSS North America

Topic

Cost Performance Category and Resource Use of the Merit-Based Incentive Payment System (MIPS) component of CMS *Final Rule*: RIN 0938-AS69 | Published November 4, 2016.

Regulatory Approach

CMS proposed that this category of MIPS replaces the cost component of the Value Modifier Program (VM) aka *Resource Use*.

CMS is finalizing, without exception, the following approaches described in the proposed rule:

- CMS starts with existing condition and episode-based measures, and total per capita costs for attributed beneficiaries.
- Measures will be adjusted for geographic payment rates and beneficiary risk factors.
- An adjustment for specialties will be applied to the total per capita cost measure.
- All measures will be equally weighted within the category, with no minimum number of measures to receive a score.
- CMS plans on drawing from standards for measure reliability, patient attribution, risk adjustment, and payment standardization from the VM as well as the Physician Feedback Program.
- All measures used are derived from Medicare administrative claims data, thus with no data submission required from participants.
- New care episode groups, patient condition groups, and patient relationship categories (and related codes) will be developed; new measures will be incorporated when available.

Cost Performance Weighting in the Final Score. Under the proposed rule, the cost performance category accounted for 10 percent of the total performance score in payment year 1 (CY 2019), 15 percent in payment year 2 (CY 2020), and 30 percent in payment year 3 and beyond (CY 2021+) In the final rule, CMS believes that a transition period would be appropriate and is lowering the weight of the cost performance category for the first and second MIPS payment years to 0 percent for the transition year and 10 percent for the second MIPS payment year. As required by statute, the cost performance category will 30 percent in payment year 3 and beyond (CY 2021+).

It is important to note that CMS is not reducing the weight of the cost category due to concerns with attribution, risk adjustment, or the measure specifications challenges, but instead because of the changes in scoring and attribution. This change allows clinicians to have more time to become familiar with these measures in the context of MIPS.

Cost Criteria. This category would be assessed using measures based on administrative Medicare claims data, with no additional data submissions by participants required. As such, MIPS eligible clinicians and groups will be assessed based on cost for Medicare patients only, and only for patients that are attributed to them. MIPS eligible clinicians or groups that do not have enough attributed cases to meet or exceed the case minimums will not be measured on cost.

Value Modifier Cost and Episode-Based Measures. For purposes of assessing performance of MIPS eligible clinicians on the cost performance category, CMS is specifying cost measures for a performance period. For the CY 2017 MIPS performance period, CMS will utilize the total per capita cost measure, the Medicare spending per beneficiary (MSPB) measure, and several episode-based measures for the cost performance category.

CMS is finalizing the inclusion of the total per capita cost measure because it is a global measure of all Medicare Part A and Part B resource use during the MIPS performance period and it is inclusive of the four condition-specific total per capita cost measures under the VM (chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and diabetes mellitus) for which performance tends to be correlated. CMS states that these measures have the advantage of having been used within the VM and covering a broad population of patients.

CMS is also calculating several episode-based measures for inclusion in the cost performance category, though episode-based measures for specific disease focus areas will not be used until future years.

The proposed rule included in the cost performance category several clinical condition and treatment episode-based measures that have been reported in the supplemental Quality and Resource Use Reports (sQRUR) or were included in the list of the episode groups. The proposed rule listed the 41 clinical condition and treatment episode-based measures.

The final rule includes only 10 measures, and only finalizes episode-based measures for CY 2017 performance period that have been previously reported in the 2014 sQRUR and which meet reliability thresholds. They are as follows:

Breast
• Mastectomy for Breast Cancer

Cardiovascular
• Aortic/Mitral Valve Surgery
• Coronary Artery Bypass Graft (CABG)

Musculoskeletal
• Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based
• Hip Replacement or Repair
• Knee Arthroplasty (Replacement)

Gastrointestinal
• Cholecystectomy and Common Duct Exploration
• Colonoscopy and Biopsy
• Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia

Ophthalmology
• Lens and Cataract Procedures

Of note, CMS intends to provide performance feedback to clinicians on additional episode-based measures that are not finalized for inclusion in the MIPS cost performance category for the CY 2017 performance period, but which they may want to consider proposing for inclusion in the MIPS cost performance category in the future.

Attribution for Individual and Groups. In the proposed rule, CMS proposed the attribution logic used in the 2014 sQRUR with modifications for individual or group assessment. For individuals, CMS will use Tax Identification Number/National Provider Identifier (TIN/NPI). For groups, CMS will use the TIN under which the group reports.

To reduce complexity in the MIPS program, CMS is finalizing the alternative proposal to attribute cost measures for *all clinicians* at the TIN/NPI level. For those groups that participate in group reporting in other MIPS performance categories, their cost performance category scores will be determined by aggregating the scores of the individual clinicians within the TIN. For example, if a TIN had one surgeon that billed for 11 codes and another surgeon in that TIN billed for 12 codes that would trigger the knee arthroplasty episode-based measure, neither surgeon would have enough cases to be measured individually. However, if the TIN elects group reporting, the TIN would be assessed on the 23 combined cases. This alternative applies one consistent methodology to both groups and individuals, compared to having a methodology that assigns cases using TIN/NPI for assessment at the individual level and another that assigns cases using only TIN for assessment at the group level.

Implications for Health IT

A concern was raised by commenters to the proposed rule that cost measures would discourage the development of new therapies. One commenter suggested that CMS not include the costs of new technology within cost measures.

CMS responded that cost measurement does not hinder the appropriate uptake of new technologies. They acknowledged that one challenge of new technologies is that the costs are not represented in the historical benchmarks. However, a policy to create benchmarks for the cost measures based on the performance period is included, so the benchmarks will build in the costs associated with adoption of new technologies in that period.

CMS also anticipates that new technologies may reduce the need for other services, which could further reduce the cost of care. Even though CMS believes excluding new technology from the cost measures is not appropriate when the technology is being paid for by the Medicare program and its beneficiaries, they will continue to monitor this issue to determine whether adjustments should be made in the future.

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