2018 Medicare Quality Payment Program FAQs: Cost Category

This document is a supplement to the AMA's MIPS Action Plan and provides additional information about the Cost category of the 2018 Merit-Based Incentive Payment System (MIPS) under the Quality Payment Program (QPP).

Relationship between the Cost Category and other MIPS Components

The Cost category differs from the other components (Quality, Improvement Activities, Advancing Care Information) upon which a MIPS-eligible clinician's overall MIPS score is based because it is calculated by CMS using only administrative claims data, rather than performance data reported by you. It is therefore important to understand how CMS will be using claims data to calculate your performance in this category.

Q1. What is the Cost category?
A. The Cost category will compare the cost of services for patients attributed to a MIPS-eligible clinician to a national benchmark. Cost is one of four categories that CMS will use for the 2018 MIPS performance period (January 1, 2018-December 31, 2018), along with 1) Quality; 2) Advancing Care Information (ACI); and 3) Improvement Activities (IA), to calculate a MIPS-eligible clinician's overall MIPS score.

The term "MIPS-eligible clinician" is defined as an individual clinician or a group, depending on how the individual or group chooses to participate in MIPS.

Q2. How much does the Cost category factor in to my overall MIPS score?
A. For those with enough applicable cases to calculate a cost score, this category will account for 10 percent of a MIPS-eligible clinician's overall MIPS score in 2018. The other components make up the remainder of the MIPS score as follows: Quality – 50 percent; ACI – 25 percent; and IA – 15 percent.

Q3. What are the components of the Cost category?
A. In 2018, the Cost category is comprised of two measures:

1. *Medicare Spending Per Beneficiary (MSPB)*. This measure includes Medicare Part A and Part B claims submitted for services from three days prior to 30 days after an inpatient hospitalization and attributes all of these costs to the physician with the most (plurality of) Part B charges during the period from the patient's inpatient admission to discharge date.
2. *Total Per Capita Cost (TPCC)*. The TPCC measure is a measure of all Medicare Part A and Part B costs for patients attributed to the individual clinician with the most allowed charges for E&M services other than inpatient hospital, emergency department, and skilled nursing visits during the 2018 performance period.

Q4. How are these measures converted to a score?
A. Each measure is worth 10 points but a measure is only used in the score if the physician or group met the measure's minimum case threshold. Performance on each attributable measure is compared to a benchmark that is determined annually. A score for the category (expressed as a percentage) is then calculated by dividing the total points that were achieved to the total points available for the attributed measures.

Q5. What is the improvement score?
A. The law that created the QPP required CMS to begin rewarding physicians for cost improvements starting in the second year of the program. However, the Bipartisan Budget Act of 2018 delays implementation of the improvement score until the 2022 performance year. Thus, CMS will not calculate improvement scores for the 2018 performance year.

Q6. What happens if neither of the cost measures is available to me?
A. You will not be scored in the Cost category and the 10 percent weight of this category will be transferred to the Quality category. In such cases, the Quality category will make up 60 percent of your score rather than 50 percent.

Q7. Is the Cost category new to MIPS in 2018?
A. No. In the 2017 MIPS performance period (2019 Medicare Part B reimbursement year), CMS collected data for the Cost category, but weighted the category at 0 percent when calculating a MIPS score. 2018 is the first year in which the Cost category can impact a physician's future Medicare Part B reimbursement.

Q8. Is the Cost category the same thing as the Value-Based Payment Modifier (VBM)?
A. No. The Cost category replaces the VBM, which sunsets this year. 2016 was the last performance period for the VBM and 2018 will be the final payment adjustment period under the VBM. The method for comparing performance and calculating a cost score is different under MIPS than it was under the VBM, which incorporated both quality and cost calculations. However, the two measures that will be used in the Cost category in 2018 were carried over from the VBM.

Q9. How Do MIPS Eligible Clinicians Report Under the Cost category?
A. Clinicians and groups do not need to submit information for the Cost category as each MIPS eligible clinician's performance will be calculated using Medicare administrative claims data that has already been submitted for billing purposes.

Q10. What data does CMS use to determine performance in the Cost category?
A. For both the MSPB and TPCC measures, the data source is all Medicare Parts A and B final action claims during the 2018 performance period. These include inpatient hospital, outpatient, skilled nursing facility, home health, hospice, durable medical equipment, prosthetics, orthotics, and supplies, and Medicare Part B (non-institutional Physician/Supplier) claims.

Under the Bipartisan Budget Act of 2018, CMS will only consider the Medicare Part B costs of "covered professional services." Therefore, reimbursement for Medicare-covered "items" such as durable medical equipment, prosthetics, orthotics, and supplies may not be included. CMS may issue additional rules or guidance in the future to help providers understand whether or not specific codes billable under Medicare Part B will be included in the Cost calculation.

Q11. What are the minimum thresholds required to receive a score under the Cost category?
A. A score in the Cost category will be calculated only if you (or your group, depending on how you are reporting in MIPS) meet the case minimum for at least one of the measures. The case minimum for the MSPB cost measure is least 35 episodes. For the TPCC measure, the case minimum is 20 episodes. If you do not meet the case minimum threshold for at least one of the cost measures, you will not be scored on costs and the 10 percent Cost category weight will be transferred to the Quality category, raising the percentage of your score that is tied to quality from 50 percent to 60 percent.

Medicare Spending Per Beneficiary Measure

Q12. What is the Medicare Spending Per Beneficiary (MSPB) measure?
A. The MSPB measure includes the cost of all Part A and Part B services for covered professional services, performed immediately prior to, during, and following a patient's inpatient hospital stay.

Q13. When does a MSPB episode begin and end?
A. A MSPB episode begins 3 days prior to the index hospital admission and ends 30 days after hospital discharge, and is not adjusted for specialty.

Q14. Which costs and patients are included in the MSPB measure calculations?
A. Generally, the costs for all patients that are Medicare beneficiaries are included in the MSPB measure calculation, unless:

1. The patient was not continuously enrolled in both Medicare Parts A and B from 93 days prior to the index admission through 30 days after discharge;
2. The patient dies during the MSPB episode;
3. The patient is enrolled in a Medicare Advantage plan or Medicare is the secondary payer at any time during the MSPB episode or 90-day look back period;
4. The index admission did not occur in a hospital paid under the Inpatient Prospective Payment System

(IPPS) or an acute hospital in the state of Maryland;

5. The discharge from the index admission occurred in the last 30 days of the 2018 performance period;
6. The index admission ends in a hospital transfer or begins because of a hospital transfer;
7. The index admission occurs within 30 days of another MSPB episode; or
8. The index admission inpatient claim results in a Medicare actual or standardized payment of $0.

Q15. How is the MSPB measure calculated?
A. The MSPB measure compares observed and expected episode costs. Specifically, CMS performs the calculation by taking the following five steps:

1. Identify patient population of index admissions.
2. Calculate the standardized cost of each MSPB episode by summing all standardized Medicare claims payments made during the MSPB episode. (Payment-standardization adjusts for payments unrelated to provision of care, such as add-on payments for medical education and geographic variation in Medicare reimbursement rates. It does not include an adjustment for site of service—e.g., hospital outpatient versus physician office.)
3. Calculate expected episode costs using a model based on the CMS Hierarchical Condition Category (CMS-HCC), in which CMS risk adjusts for patient age and comorbidities.
4. Exclude statistical outliers to mitigate the effect of high- and low-cost episodes on the MIPS eligible clinician's score on the measure.
5. Attribute the MSPB episode to the Medicare Taxpayer Identification Number/National Provider Identifier (TIN-NPI) responsible for the plurality of Part B Physician/Supplier standardized costs during the index admission.

Q16. How does CMS determine attribution for purposes of the MSPB measure?
A. The MSPB measure is attributed to individual clinicians, as identified by their TIN-NPI. CMS attributes those Medicare Part B services billed by MIPS-eligible clinicians that occurred:

1. Three days prior to the admission date in an inpatient, outpatient, or emergency room setting;
2. During the index hospital stay, regardless of place of service; and
3. On the discharge date with place of service restricted to inpatient hospital.

Q17. How does CMS determine attribution in cases where there is more than one TIN-NPI?
A. If more than one TIN-NPI has the plurality of Part B standardized payments, the episode will be attributed to the TIN-NPI with the plurality of Part B services billing lines. If more than one TIN-NPI also has the same count of services during a given episode's index hospitalization, the MSPB episode is randomly attributed to one TIN-NPI.

Q18. How does CMS calculate the MSPB measure for each TIN-NPI or TIN?
A. CMS calculates the MSPB measure for the TIN-NPI or TIN by calculating the ratio of standardized observed costs over the entire episode including the 3 days prior to the admission and 30 days following it to expected episode costs, and multiplying that ratio by the national average cost of all MSPB episodes. This means that the MSPB measure is an average of cost ratios for all MSPB episodes for each TIN-NPI or TIN (depending on whether the MIPS eligible clinician is reporting as an individual or group).

Q19. How is the MSPB measure converted to a part of the MIPS score?
A. Once CMS calculates the MSPB score for a MIPS-eligible clinician, it compares the MSPB score against a measure benchmark, which is calculated retroactively. Based on the benchmark comparison, the MIPS eligible clinician is assigned a certain number of measure points, which are then combined with any other applicable cost measures to determine a score for the cost category. In 2018, the only other cost measure which might be applicable (depending on whether the minimum case threshold was met) is the TPCC measure. Additional cost measures may be added in future years. For additional details on scoring, see additional discussion below and the AMA's Strategic Scoring resource.

Total Per Capita Cost Measure

Q20. What is the Total Per Capita Cost (TPCC) measure?
A. The TPCC measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of Parts A and B care provided to patients attributed to clinicians, as identified by a TIN-NPI.

Q21. How is TPCC measure calculated?
A. As with the MSPB measure, the TPCC measure calculates risk adjusted per capita costs for patients at the individual physician level (TIN-NPI), using Medicare Part A and Part B claims, with certain exclusions. The results are

then applied at the TIN-NPI or TIN level, depending on the QPP reporting option (TIN-NPI or TIN level) chosen by the physician.

Q22. Which patient costs are included in the TPCC measure calculations?

A. The TPCC measure assesses the total cost of care for services to attributed patients by any provider, including services that occurred before and after the patient was treated by the physician to whom the TPCC episode may be attributed. Generally, the costs for all Medicare beneficiaries are included in the TPCC measure calculation, unless the patient meets one of the following conditions:

1. The patient was not enrolled in both Medicare Part A and Part B for every month during the performance period, unless part year enrollment was the result of new enrollment or death;
2. The patient was enrolled in a private Medicare health plan (for example, a Medicare Advantage HMO/PPO or a Medicare private FFS plan) for any month during the performance period; or
3. The patient resided outside the United States, its territories, and its possessions during any month of the performance period.

Q23. How does CMS determine attribution for the TPCC measure?

A. CMS attributes patients to a single TIN-NPI by looking at allowed charges for specific primary care services under Part A and covered professional services under Part B, as well as the specialties of clinicians who performed these services.

Only patients who received a primary care service during the MIPS performance period are attributed for purposes of the TPCC measure. Primary care services include outpatient evaluation and management services, as well as initial Medicare visits, annual wellness visits, and transitional care, chronic care and complex chronic care management. Evaluation and management care associated with skilled nursing facility patients is not included, but visits to patients receiving lower level nursing facility care are included.

If a patient received a primary care service during the MIPS performance period, the total Parts A and B costs will be attributed to the primary care provider (primary care physician, nurse practitioner, physician assistant, or clinical nurse specialist) from whom the patient received the largest share of primary care services (as measured by Medicare allowed charges during the performance period). If none of the designated services to that patient were delivered by a primary care provider, then the patient would be attributed to the non-primary care clinician with the most allowed charges for the designated services.

If two TIN-NPIs tie for the largest share of a patient's primary care services, the patient will be attributed to the TIN-NPI that provided primary care services most recently.

Q24. Does CMS standardize payments when calculating the TPCC measure?

A. Yes. CMS calculates payment-standardized per capita costs to adjust for payments unrelated to provision of care, such as add-on payments for medical education and geographic variation in Medicare reimbursement rates. There is no adjustment for payment differences associated with whether a patient was treated in a physician's office or a hospital outpatient department.

CMS also annualizes costs to account for Medicare patients who were enrolled in Medicare Parts A and B for only part of the year, as these patients may be attributed to a TIN-NPI if the reason for their partial year enrollment was either that they were new enrollees in Medicare at some time other than the start of the calendar year, or they died during the calendar year.

Q25. Does CMS adjust the TPCC measure for patient mix or specialty care?

A. Yes. CMS will risk-adjust costs to account for certain beneficiary-level risk factors that can affect medical costs, regardless of the care provided. To estimate the expected per capita cost for each beneficiary, the TPCC methodology risk adjusts for two measures of beneficiary risk: (1) the beneficiary's CMS-HCC risk score; and (2) End Stage Renal Disease (ESRD) status. Note that the CMS-HCC risk score captures dual eligible status.

Unlike the MSPB, the TPCC will also be adjusted to compare the TIN's or TIN-NPI's costs to an expected cost that is reflective of the specialty or specialties of physicians in the practice. CMS makes this adjustment by calculating a national average per capita cost for each billing specialty, which is the weighted average of each TIN's or TIN-NPI's risk-adjusted costs. For a MIPS-eligible clinician reporting as a multi-specialty group, the group's expected specialty-adjusted costs will be weighted based on the Medicare Part B payment share of each TIN-NPI specialty within the group.

CMS will calculate the TPCC measure for the TIN-NPI or TIN by summing the risk-adjusted, specialty-adjusted total per capita cost across all attributed patients for a TIN or TIN-NPI (depending on the level of reporting), divided by the number of attributed patients for the TIN or TIN-NPI.

Q26. How are the MSPB and TPCC benchmarks established?

A. CMS establishes a single price-standardized national benchmark for each of the TPCC and MSPB measures each year, based on the current performance period. This means that the measure benchmarks reflect the same payment rate for a particular service regardless of the region in which it is provided. Because the benchmarks are tied to the current year, rather than a past year, CMS does not publish the actual numerical benchmarks for the MSPB and TPCC cost measures in advance of the performance period.

The CMS-generated table below illustrates how the agency will compare a MIPS-eligible clinician's score on the Cost category measures against a benchmark in order to calculate a measure score.

Example: CMS TABLE – USING BENCHMARKS FOR ONE SAMPLE MEASURE TO ASSIGN POINTS

Decile	Average Cost	Possible Points
Benchmark Decile 1	$100,000 or more	1.0–1.9
Benchmark Decile 2	$75,893–$99,999	2.0–2.9
Benchmark Decile 3	$69,003–$75,892	3.0–3.9
Benchmark Decile 4	$56,009–$69,002	4.0–4.9
Benchmark Decile 5	$50,300–$56,008	5.0–5.9
Benchmark Decile 6	$34,544–$50,299	6.0–6.9
Benchmark Decile 7	$27,900–$34,543	7.0–7.9
Benchmark Decile 8	$21,656–$27,899	8.0–8.9
Benchmark Decile 9	$15,001–$21,655	9.0–9.9
Benchmark Decile 10	$1,000–$15,000	10

Note: The numbers provided in this table are for illustrative purposes only.

Overall Cost Category Scoring

Q27. How is the overall Cost category scored?

A. A MIPS-eligible clinician receives one to 10 points for each measure, based on performance compared to the measure benchmark. Applicable measures are weighted equally in determining a Cost category score, meaning that if a physician meets the minimum threshold for both the MSPB and TPCC measures, each will account for 50 percent of the Cost category score and the total available points for the cost category will be 20. If a MIPS-eligible clinician has the case minimum for only one measure, then the cost score will be based only on the 10 points available from that measure. If the MIPS-eligible clinician does not have the case minimum for either measure no score is assigned for the Cost category, and the Cost category will be re-weighted at 0 percent and the Quality category will be re-weighted at 60 percent.

Example: MEASURES INCLUDED IN COST CATEGORY AND PERCENTAGE OF CATEGORY SCORE

Measure	Total possible measure achievement points, assuming case minimums met for both measures	Percentage of Cost category score, assuming case minimums met for both measures
MSPB Measure	$75,893–$99,999	2.0–2.9
TPCC Measure	$69,003–$75,892	3.0–3.9
Total	$56,009–$69,002	4.0–4.9

The score for the Cost category is then calculated in three steps:

1. The measure achievement points earned for each measure is determined by comparing the cost of services to the measure benchmark, and the measure achievement points for applicable measures are added to get a measure achievement point total.
2. The measure achievement point total is divided by the total possible measure achievement points available from the applicable measures to calculate a percentage score on the Cost category.
3. The Cost category score is calculated by multiplying the percentage score (i.e. percent of possible points that was actually achieved) by the weight of the Cost category (10 percent) to determine the number of Cost category points in the final MIPS score.

The table below provides an example in which a MIPS-eligible clinician earned 6.4 measure points in the MSPB measure and 8.2 points in the TPCC measure.

Example: COST CATEGORY SCORE CALCULATION

Measure	Measure achievement points earned	Total possible measure achievement points
MSPB Measure	6.4	10
TPCC Measure	8.2	10
Total	14.6	20

To calculate the number of Cost category points for this MIPS eligible clinician, apply the following four steps:

1. Add measure points together:
   6.4 + 8.2 = 14.6
2. Divide measure achievement point total by the total possible measure achievement points:
   14.6 / 20 = 73.0%
3. Calculate the total Cost category points by multiplying percent score by the Cost category weight for 2018 (i.e., 10%):
   73.0 x 10% = 7.30 points

Result = This MIPS eligible clinician would receive 7.30 points in the Cost category, which would be added to the scores in the three other categories to tally the total MIPS score.

Note: In the Quality Payment Program Final Rule covering 2018, CMS created a policy to provide a scoring bonus reflecting improvement in the Cost category. Under the Bipartisan Budget Act of 2018, CMS cannot take Cost improvement into account until the 2022 performance year.

Q28. How is the Cost category calculated for Non-Patient Facing Clinicians?

A. For the 2018 MIPS performance period, CMS did not include alternative cost measures for non-patient facing MIPS-eligible clinicians or groups. This means that non-patient facing MIPS-eligible clinicians or groups are unlikely to meet the volume threshold for either cost measure. As such, CMS anticipates that many non-patient facing MIPS-eligible clinicians will not be scored on the Cost category under MIPS. In this scenario, the Cost category will be re-weighted at 0 percent and the Quality category will be re-weighted at 60 percent.

Q29. Will the Cost category count in future years?

A. Yes. The Medicare Access & CHIP Reauthorization Act (MACRA) required CMS to weigh the Cost category at 3 0 percent of the MIPS score starting in 2019. However, the Bipartisan Budget Act of 2018 modified this requirement so that for the next three years, CMS is required only to set the cost score at no less than 10 percent. Clinicians should anticipate that the cost of services furnished to Medicare beneficiaries will continue to play a role in the calculation of MIPS payment adjustments going forward.

Q30. Where can I find more information about the Cost category?

A. The CMS QPP Resource Library offers additional information for both the MSPB and TPCC measures.