Podcast series: Value-Based Care

Episode 14: The MIPS Cost Category

Welcome to APTA’s podcast series on value-based care, which explains how value is measured in the provision of health care, and describes different aspects of the Quality Payment Program, including the Merit-based Incentive Program, or MIPS, and Advanced Alternative Payment Models, or Advanced APMs. Episode 14 is The MIPS Cost Category. To get the most from this episode, you may want to check out earlier episodes first.

I’m Heather Smith, APTA’s director of quality.

The Merit-based Incentive Payment System, or MIPS, is part of the Quality Payment Program, or QPP, which began on January 1, 2017. MIPS replaces several quality-reporting programs such as the former Physician Quality Reporting System. Physical therapists are not yet required to report under MIPS, but they are likely to be added in 2019.

MIPS requires reporting performance across 4 categories: quality, cost, improvement activities, and advancing care information. In this episode we’ll dive into the cost category.

It’s no surprise the Centers for Medicare & Medicaid Services (CMS) wants to see how providers are doing on spending. For 2018, CMS will not include cost in providers’ overall MIPS scores, but the agency will provide feedback on providers’ performance.

When cost does become part of the MIPS calculation, this category will consider 3 elements:

- Medicare spending per beneficiary, or MSPB
- Total costs per capita or per beneficiary
- Condition and treatment episode-based measures

Currently, both the MSPB and the total cost per capita measures are attributed to providers through a methodology that uses E&M, examination and management CPT codes that are used primarily by physicians, to determine the primary provider for the calendar year. Because PTs do not use E&M codes for billing, they would not be subject to these measures.

The condition and treatment episode-based measures are currently under development, and CMS has begun initial testing of them. Although these episode-based measures also use E&M codes in their attribution methodology, there is a desire to apply these measures more broadly to all providers involved in the episode. APTA anticipates that CMS will begin to experiment with other attribution methodologies in the near future so that the measures can be more inclusive.

CMS determines cost using claims data if there are enough attributed patients for a particular cost measure, and if a benchmark has been established for that measure. Since CMS will use
your claims data from previous years, there’s no need to submit any additional information on
cost. Just strive to focus on value and take steps to avoid waste and unnecessary expenditures.

Your performance in the cost category will be compared with the performance of other providers
during the same performance period. The final score in the category will be an average of the
measures that can be scored—which, again, are those that have an established benchmark and a
sufficient number of attributed patients.

If a provider cannot be scored on costs, the weight of the cost category will be moved into the
quality category, which will allow the provider to make up those lost points with quality
performance measures.

As with the other MIPS reporting categories, PTs can position themselves for optimal MIPS
performance in future years by becoming familiar now with the available cost measures and
calculations so their scores won’t come up as a surprise. The most up-to-date measures and
information can be found at the QPP website at qpp.cms.gov.

This has been Episode 14 of the podcast series on value-based care. To find all episodes of this
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