MIPS

Cost Guide

The Cost performance category is intended to assess MIPS eligible clinicians on their ability to manage their patients' use of healthcare resources under the Medicare program. For 2021 performance, which affects payments for 2023, the Cost category weight has increased to 20 percent, up from 15 percent for 2020 performance. **As has been the case in previous years, no additional reporting is necessary for the Cost component of MIPS.** Further, it is unlikely that physiatrists will be attributed to a sufficient number of patients to be measured under any of the Cost measures.

MIPS COST MEASURES

For 2021, performance in the Cost category may be assessed on up to 20 measures, consistent with the available measures for 2020:

The first two measures have been included in MIPS since the first performance year:

- Medicare Spending Per Beneficiary (MSPB) – Evaluates Medicare Part A and B costs in the period immediately prior to, during, and following a patient's inpatient hospital stay. This episode is defined as 3 days prior to an inpatient hospitalization, the hospitalization itself, and 30 days after an inpatient hospitalization. For medical episodes (as opposed to surgical episodes), beneficiaries are attributed to any TIN that provides at least 30 percent of the evaluation and management (E/M) visits during the inpatient stay, and then to any clinician within the TIN who provides one of those E/M visits.
- Total Per Capita Cost (TPCC) – Evaluates all Medicare Part A and B costs associated with any beneficiary over a year. This measure relies on a 2-step attribution process that assigns a beneficiary to a single clinician based on the amount of primary care services received and the clinician specialties that perform these services. However, certain specialists, including physical medicine and rehabilitation, are excluded from attribution starting with the 2020 performance year.

The other 18 measures are episode-based cost measures, which are focused on either procedures or acute inpatient medical conditions:

- Elective outpatient percutaneous coronary intervention (PCI; procedural)
- Knee arthroplasty (procedural)
- Revascularization for lower extremity chronic critical limb ischemia (procedural)
- Routine cataract removal of intraocular lens (IOL) implantation (procedural)
- Screening/surveillance colonoscopy (procedural)
- Intracranial hemorrhage or cerebral infarction (acute inpatient medical)
- Simple pneumonia with hospitalization (acute inaptient medical)
- ST-elevation myocardial infarction (STEMI) with percutaneous coronary intervention (PCI; acute inpatient medical)
- Non-emergent coronary artery bypass graft (CABG; procedural)
- Femoral or inguinal hernia repair (procedural)
- Elective primary hip arthroplasty (procedural)
- Lumpectomy, partial mastectomy, simple mastectomy (procedural)

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healthpolicy@aapmr.org

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- Lumbar spine fusion for degenerative disease, 1-3 levels (procedural)
- Hemodialysis access creation (procedural)
- Renal or ureteral stone surgical treatment (procedural)
- Acute kidney injury requiring new inpatient dialysis (procedural)
- Lower gastrointestinal hemorrhage or cerebral infarction (acute inpatient medical)
- Inpatient COPD exacerbation (acute inpatient medical)

For procedural episodes, CMS will attribute episodes to each MIPS eligible clinician who renders a trigger service (identified by HCPCS/CPT procedure codes specific to each episode). For acute inpatient medical condition episodes, CMS will attribute episodes to each MIPS eligible clinician who bills inpatient evaluation and management (E&M) claim lines during a trigger inpatient hospitalization under a group practice (i.e., Tax ID Number or TIN) that renders at least 30% of the inpatient E&M claim lines in that hospitalization.

It is unlikely that physiatrists will be attributed a sufficient number of patients to be measured under any of these episode-based measures. However, CMS is continuing to develop new episode-based cost measures that could impact PM&R physicians in the future.

COST MEASURE ELIGIBILITY

Clinicians and groups will only be scored on the aforementioned cost measures if they are attributed a sufficient number of patients[1]:

- For the MSPB, a minimum of 35 patients must be attributed to the clinician or group
- For the TPCC measure, 20 patients must be attributed to the clinician or group.
- For procedural episode-based cost measures, 10 episodes must be attributed to the clinician or group.
- For acute inpatient medical condition episode-based cost measures, 20 epsiodes must be attributed to the clinician or group.

Depending on practice patterns, a clinician could be held accountable for multiple cost measures.

HOW IS COST SCORED IN 2021?

CMS will assign 1 to 10 achievement points to each scored measure based on the individual's or group's performance compared to a national benchmark based on 2021 performance (not an historic benchmark). If a clinician or group is scored on multiple measures, each measure will contribute equally to the clinician's or group's total MIPS Cost category score. If only one measure can be scored, that measure's score will serve as the Cost category score. If the clinician or group does not meet the minimum number of attributable patients for any of these measures, the clinician or group will not be held accountable for cost performance, and the entire weight of the Cost category (20 percent for 2021) will be redistributed to another category – most likely the quality performance category.

HOW TO REPORT COST IN 2020

No additional reporting is necessary for the Cost component of MIPS. The cost measures are **automatically** calculated by CMS by evaluating claims data across the full calendar year 2021.

ADDITIONAL INFORMATION

For more detailed information about the calculation of cost measures under MIPS, please visit the Quality Payment Program Resource Library.

[1] *The level of analysis (indiviudal vs. group) will depend on the level at which the clinician opts to participate in MIPS.*