MIPS – COST Component

The Cost component of MIPS reflects the resources clinicians use to care for a Medicare beneficiary during an episode of care.

The goal for developing cost measures is to provide actionable information that is useful to clinicians to drive lowered costs and improve patient outcomes.

Physicians are not required to submit any data on specific cost measures for this category. CMS will use administrative claims data to assess performance on the following 2 cost measures: Medicare Spending per Beneficiary (MSPB) and Total Per Capita Cost (TPCC).

- Medicare total spending per beneficiary (MSPB)

  MSPB assesses the cost to Medicare for services performed by TINS during an MSPB episode, which includes the care provided 3 days prior to, during and 30 following a patient's hospital stay.

  - Medical episodes are attributed to a clinician group that rendered at least 30 percent of E&M services during the period between the index admission date and the discharge date for a hospitalization with a medical MS-DRG, and to any clinician that billed at least one E&M service under a clinician group that meets the 30 percent threshold.
  - Surgical episodes are attributed to the clinician and clinician group that rendered the main procedure of the stay as identified by the CPT/HCPCS code found on the PB claim concurrent to the surgical MS-DRG
  - Certain services identified as unlikely to be influenced by the clinician's care decisions are excluded
  - The case minimum for the MSPB cost measure is least 35 episodes

  Prior to its current use in MIPS, CMS used a version of the MSPB measure in the Value Modifier Program and reported it in annual QRURs until MACRA ended the Value Modifier program

- Total per capita costs (TPCC)

  Standardized, annualized, risk-adjusted and specialty adjusted evaluation of the overall total efficiency of care attributed to clinicians and groups as identified by their Taxpayer Identification Number (TIN)

  - For the TPCC measure, the case minimum is 20 episodes.

NEW

In 2019 CMS incorporated 8 condition and treatment episode-based measures, with risk adjustments for factors such as age and severity of illness as well as geographic variations.

- Episode-based cost measures represent the cost to Medicare for the items and services furnished to a patient during an episode of care. Episode-based cost measures inform clinicians about the cost of the care they are responsible for providing to a beneficiary during the episode's timeframe.
- Episode-based cost measures are calculated with Medicare Parts A and B fee-for-service claims data and are based on episode groups. Episode groups:

  • Represent a clinically cohesive set of medical services rendered to treat a given medical condition.

  • Aggregate all items and services provided for a defined patient cohort to assess the total cost of care.

  • Are defined around treatment for a condition (i.e., acute inpatient or chronic) or performance of a procedure.

2019 Episode-based measures topic	Measure type
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb	Procedural
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural
Screening/Surveillance Colonoscopy	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Procedural
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute Inpatient medical condition
Simple Pneumonia with Hospitalization	Acute Inpatient medical condition

CMS will also identify clinicians eligible for Facility based Measure Scoring.

Facility-based measurement scoring will be used for Quality and Cost performance category scores when:

- The clinician is identified as facility-based; and
- is attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score for the 2019 performance period; and
- The Hospital VBP score results in a higher score than the MIPS Quality measure data submitted, and MIPS Cost measure data CMS calculated for the clinician

To the extent possible, in future years CMS will also align episodes with indicates of quality, such as outcomes.

Patient Relationship Codes

Patient relationship codes/modifiers are under development by CMS, as part of the assessment of the cost of care, to better identify patient relationship categories and to improve the attribution of patients and care episodes to physicians who serve in different roles. These new modifiers define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service.

Modifier	Description	Details	Examples
X1	Continuous/broad	This category could include clinicians who provide the principal care for a patient, where there is no planned endpoint of the relationship. Care in this category is comprehensive, dealing with the entire scope of patient problems, either directly or in a care coordination role	Primary care, specialists providing comprehensive care to patients in addition to specialty care, etc.
X2	Continuous/focused	This category could include a specialist whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time	A rheumatologist taking care of a patient's rheumatoid arthritis longitudinally but not providing general primary care services.
X3	Episodic/broad:	This category could include clinicians that have broad responsibility for the comprehensive needs of the patients, but only during a defined period and circumstance, such as a hospitalization.	A hospitalist providing comprehensive and general care to a patient while admitted to the hospital.
X4	Episodic/focused:	This category could include a specialist focused on particular types of time-limited treatment. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.	A plastic surgeon performing a breast reconstruction and seeing the patient through the postoperative period.
X5	Only as ordered by another clinician	This category could include a clinician who furnishes care to the patient only as ordered by another clinician.	A radiologist interpreting an imaging study ordered by another clinician.

Under MACRA law, and subject to the rulemaking process, physicians have had the option of using these new modifiers on Medicare claims since Jan. 1, 2018. During the voluntary reporting period, CMS will collect data on the validity and reliability of the use of the modifiers.

Cost Requirements

2017 Performance year	0% of final MIPS score	Cost did not count toward a final score, but clinicians were evaluated on the measures to help them understand their performance.
2018 Performance year	10% of final MIPS score *In the event that there are not enough attributed beneficiaries for the Medicare Spending Per Beneficiary (MSPB) and Total per Capita Cost (TPC) measures, the Cost performance category weight will be added to the Quality performance category.*	All participants were evaluated on the same two cost measures, though some clinicians and groups did not have enough attributed patients to be evaluated on both (or either) measures.
2019 Performance year	15% of final MIPS score *This percentage can change if the measures' minimum case volumes are not met. If there are not enough attributed beneficiaries for any of the 10 measures to be scored, the Cost performance category percentage will be added to the Quality performance category.*	For 2019, MIPS will use cost measures that assess the beneficiary's total cost of care during the year, or during a hospital stay, and/or during 8 unique episodes of care. CMS will also begin identifying clinicians and groups eligible for facility-based scoring.
2020 Performance year		Pending Final Rule publication
2021 Performance year		Pending Final Rule publication

FAQs

How Are Measures Scored?

Measure achievement points are determined by comparing performance on a measure to a benchmark. Cost measure benchmarks are created using performance data from the performance period.

If a measure can be reliably scored against a benchmark, it means:

- A benchmark is available; and
- The clinician has sufficient case volume for the measure

How are the MSPB and TPCC benchmarks established?

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.

How is the overall Cost category scored?

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.

What happens if neither of the cost measures is available to a clinician?

The clinician will not be scored in the Cost category and the weight of this category will be transferred to the Quality category. In such cases, the Quality category will make up a higher percent of a total MIPS score.

Where can I find more information about the Cost category?

The CMS QPP Resource Library offers additional information for the MIPS Cost measures.