

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 2023 performance, which affects payments for 2025, the Cost category weight is 30%. As has been the case in previous years, no additional reporting is necessary to comply with the Cost component of MIPS.

MIPS COST MEASURES

For 2023, performance in the Cost category may be assessed on up to 25 measures.

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% 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 two-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. However, keep in mind that if you participate in MIPS at the group level and your group includes specialties other than physical medicine and rehabilitation, you may still receive the group's score on this measure.

The other 23 measures are episode-based cost measures, which are focused on either procedures, acute inpatient medical conditions, or chronic 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 inpatient 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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- 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)
- Melanoma resection (procedural)
- Colon and rectal resection (procedural)
- Sepsis (acute inpatient medical)
- Asthma/chronic obstructive pulmonary disease (COPD; chronic condition)
- Diabetes (chronic condition)

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 at least one inpatient evaluation and management (E&M) service under a group practice (i.e., Tax ID Number or TIN) that renders at least 30% of the inpatient E&M claim lines during the inpatient stay.

For chronic conditions, CMS will attribute episodes to the group that renders services that make up a “trigger event” (i.e., two claims – either two E&M claims or an E&M claim followed by a condition-related HCPCS/CPT code – billed in close proximity by the same group with a diagnosis code for the chronic disease captured by the measure). CMS will then attribute episodes to each MIPS eligible clinician within an attributed group that renders at least 30% of qualifying services during the episode.

It is unlikely that physiatrists will be attributed a sufficient number of patients to be held accountable, at the individual-level, under any of these episode-based measures. However, physiatrists in multi-specialty group practices could potentially receive a score on these measures if participating in MIPS at the group level. Although none of the existing episode-based cost measures are directly relevant to PM&R physicians, CMS is continuing to develop new episode-based cost measures that could impact the specialty more directly 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 patients¹:

- 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 episodes must be attributed to the clinician or group.
- For chronic condition episodes, 20 episodes must be attributed to the clinician or group.

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

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

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HOW IS COST SCORED FOR 2023?

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 2023 performance year data (i.e., unlike quality measures, which are generally scored based on historical benchmarks). If a clinician or group is scored on multiple cost 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 (30% for 2023) will be redistributed to another category – most likely the Quality performance category.

Because CMS calculates your Cost score based on performance year benchmarks, it is difficult to predict your Cost score ahead of the performance period. However, you can refer to past MIPS performance feedback reports to gain a better understanding of how you might score in the current year. You might also want to review the cost measure benchmark files available through the [QPP Resource Library](#). At the time of publication of this guidance, the most current benchmarks available were from the 2019 performance year, but it is expected that CMS will post 2020 benchmarks in the near future.

HOW TO REPORT COST IN 2022

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 2023 calendar year.



ADDITIONAL INFORMATION

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