MIPS Program: 2020 Cost Category

The 2020 Medicare Physician Fee Schedule final rule includes provisions for the 2020 Quality Payment Program (QPP), which impacts 2022 payment. The QPP includes both the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

CMS set the 2020 MIPS final score threshold at 45 points, up from 30 points in 2019. **To avoid the 9% penalty in 2022, physicians must earn at least 45 MIPS points through 2020 performance. CMS is continuing to use the transition flexibility included in the 2018 MACRA technical corrections to set the MIPS threshold at a level other than the mean or median of the previous year's scores.**

Because the total possible penalty is increasing, and the MIPS requirements have become more difficult in 2020, including an increase of the exceptional performance threshold to 85 points, CMS expects potential bonuses to be higher in 2022. CMS estimates that participants scoring 100 points in 2020 are estimated to earn an approximate 5% bonus in 2022, which is inclusive of the exceptional performance bonus.

This guide summarizes the final Cost performance category of MIPS, which is based on the previous Value-Based Payment Modifier (VBPM) program. In addition, ASCRS ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

Cost Category Weight – 15% for 2020 Performance Year

Following advocacy from ASCRS and the medical community, CMS is maintaining the Cost category weight at 15% of the final MIPS score in 2020—the same level as the 2019 performance period.

In 2018, Congress enacted ASCRS-supported technical corrections to MACRA that allow CMS to extend the flexibility included in the first three years of MACRA and weight this category at less than 30% of the final MIPS score for three additional years. The Cost category must account for 30% of the final MIPS score beginning in the 2022 performance year.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference. If a physician or group does not have any cost measures attributed, the 15% weight in 2020 will be reassigned to the Quality category.

Cost Reporting Requirements

Physicians do not need to submit separate data for the Cost category. CMS will determine cost scores through administrative claims.

Cost Measures

For 2020, this category maintains several episode-based cost measures, including one for cataract surgery. In addition, CMS has retained population-health total per capita cost measure (TPCC) and the Medicare spending per beneficiary (MSPB) measure but has updated the attribution methodology. Following years of advocacy from ASCRS and the medical community, dating back to the Value-Based Payment Modifier when these measures were first used, CMS will now exclude ophthalmologists, optometrists, and other specialists who do not provide primary care from attribution to the TPCC measure.

The MSPB measure was also updated but remains an inpatient-focused measure that is not likely to include ophthalmology. For 2020, ASCRS expects that ophthalmologists will only have the cataract surgery episode-based cost measure attributed in this category.

The episode-based measures, including cataract surgery, seek to measure the cost of care related to a specific procedure or condition and include the total costs of pre-operative testing, the surgery itself, facility fee, some drugs separately payable under Part B (including one administered during surgery), anesthesia costs, and additional post-operative care billed separately from the surgery, such as additional procedures as a result of a complication. The measure includes costs 60 days prior to the surgery and 90 days following it. Each year, the episode measures will be updated to include new Part B drugs on a case-by-case basis.

CMS has not yet released the specifications for the cataract measure in 2020. We will notify members at that time. However, in 2019, the following Part B drugs are included in the cataract surgery episode measure in conjunction with certain diagnoses:

HCPCS Code	Description	Included Diagnoses
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	Included regardless of diagnosis
J0278	Injection, amikacin sulfate, 100 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J0713	Injection, ceftazidime, per 500 mg	H44.021, H44.022, unspecified purulent endophthalmitis
J3370	Injection, vancomycin hcl, 500 mg	H25.11, H25.12, age-related nuclear cataract; H25.811, H25.812, combined forms of age-related cataract; H26.8, other specified cataract; H26.9, unspecified cataract; H44.021, H44.022, unspecified purulent endophthalmitis
J3465	Injection, voriconazole, 10 mg	H44.021, H44.022, unspecified purulent endophthalmitis; H44.011, H44.012, panophthalmitis (acute)

The cataract surgery episode measure is sub-grouped to compare the costs of cataract surgeries performed under similar conditions. Specifically, the measure divides cataract surgery between ASC and HOPDs and unilateral surgery versus bilateral surgery when the second eye is operated on within the first eye's global period. To calculate the measure, CMS will compare the costs of each sub-group of surgeries with the cost of other surgeries nationwide. For example, if a surgeon performs some surgeries in an ASC and others in an HOPD, the cost of the surgeries in the ASC will be compared to a national average of cataract surgeries in ASCs, and the surgeries performed in the HOPD will be compared to the national average cost of cataract surgeries in HOPDs.

To calculate the total measure score, CMS will evaluate each surgery, or episode, and compare it to the national average expected cost for its sub-group. This comparison is done by dividing the observed cost of the episode by its expected cost, which expresses the observed cost's deviation from the expected cost as a ratio. CMS will then add all the episodes' ratios together, across all sub-groups, and then divide that sum by the total number of episodes to determine the total average of the surgeon's episodes' deviations from the expected costs. That figure is then multiplied by a national average total cost to represent the surgeon's average deviation from expected costs as a dollar figure.

In addition, the measure is risk-adjusted to remove all patients with ocular co-morbidities. The list of excluded co-morbidities is identical to the list of exclusions for the MIPS quality measure 191, 20/40 or Better Visual Acuity 90 Days following Cataract Surgery.

The complete measure specifications for the cataract episode measure are available on the ASCRS website.

CMS and its contractor Acumen developed the episode-based cost measures with physician input, including that of ASCRS. An ASCRS physician continues to serve on a technical expert panel advising CMS and Acumen on the development of the cataract and other episode measures.

Patient Attribution

For the cataract episode measure, an ophthalmologist will be attributed a patient that meets the following characteristics:

- **Medicare Part B patient;**
- **Performed uncomplicated cataract surgery and billed only 66984; and**
- **Did not have one of the exclusionary ocular co-morbidities.**

The attribution threshold is 10 patients for the cataract surgery episode measure. If physicians or groups bill at least 10 surgeries that meet the above specifications, they will be attributed this measure.

As mentioned above, the TPCC measure now excludes ophthalmologists and optometrists from attribution, and the MSPB measure is based on inpatient care and unlikely to be attributed to ophthalmologists or optometrists. However, if an ophthalmologist or optometrist practices in a large, multispecialty group, such as an academic practice, that reports MIPS as a group, these measures may be included in the final group score if other clinicians in the group, such as primary care or hospital-based specialists, are attributed.

Cost Category Score

To determine a provider's Cost category score, CMS will assign 1 to 10 points to each measure attributed to the physician or, if reporting as a group, the entire group based on performance relative to the established benchmark. The benchmark for each measure will be determined based on **cost data from the performance period.** CMS would award points for each measure depending on how a provider scored in relation to overall performance.

The total category points possible for a performance year depend on how many measures the physician or, if reporting as a group, the group is attributed. Each attributed measure has the same weight toward the category score. The Cost category score is determined by adding the points scored on each measure and dividing by the total possible points available. **However, since it is likely that most ophthalmologists will only have the cataract episode measure attributed, the entire category score will be based on the performance on this measure.**

If a provider does not have any attributed measures, the Cost category will not be scored, and the Quality category will be re-weighted to 60%.

The MACRA statute originally required CMS to incorporate improvement into a physician's or group's Cost score beginning in 2018. However, following enactment of the MACRA technical corrections, CMS is not required to score improvement for three additional years.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.