MIPS Program: 2022 Cost Category

Cost Category Weight – 30% for 2022 Performance Year

CMS is increasing the Cost category weight to 30% of the final MIPS score in 2022—up from 20% in 2021.

CMS is statutorily required to weigh the Cost and Quality performance categories equally beginning with Performance Year 2022, and as such, the Cost category will be weighted at 30% for 2022.
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 30% weight in 2022 will be reassigned to the Quality category.

For performance year 2022, CMS will use cost measures that assess:

- The overall cost of care provided to Medicare patients, with a focus on the primary care they received.
- The cost of services related to a hospital stay provided to Medicare patients.
- Costs for items and services provided during 23 procedural and condition-based episodes of care for Medicare patients. There are 25 cost measures available for performance year 2022.

There are 5 new measures for performance year 2022:

- 2 procedural measures: Melanoma Resection; Colon and Rectal Resection
- 1 acute inpatient measure: Sepsis.
- 2 chronic condition measures: Diabetes; Asthma/Chronic Obstructive Pulmonary Disease.

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 2022, 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, as of 2020, CMS excludes ophthalmologists, optometrists, and other specialists who do not provide primary care from attribution to the TPCC measure.

For 2022, ophthalmologists will continue to only have the cataract surgery episode-based cost measure attributed in this category (Routine Cataract Removal with Intraocular Lens (IOL) Implantation).

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.

For 2022, 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
J0197	Phenylephrine 10.16 Mg/Ml And Ketorolac 2.88 Mg/Ml Ophthalmic	Included regardless of diagnosis
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.

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%.

Additional Resources

For additional information, ASCRS ASOA members may contact Jennifer Gallihugh, ASOA Sr. Manager of Strategic Initiatives, at jgallihugh@asoa.org