Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Participating in the Cost Performance Category in the 2020 Performance Year

Updated: 3/9/21

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

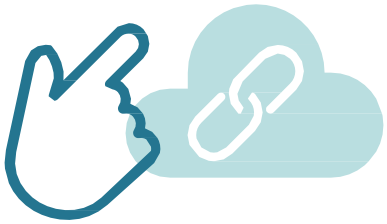
Contents

Already know what MIPS is?
Skip ahead by clicking the links in the Table of Contents

Purpose: *This detailed resource focuses on performance year (PY) 2020 MIPS Cost performance category requirements. This resource does not review requirements for MIPS Alternative Payment Model (APM) participants scored under the APM Scoring Standard.*

How to Use This Guide

How to Use This Guide



Please Note: This guide was prepared as a general summary for informational purposes only, not intended to grant rights, impose obligations, or take the place of the written law. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

The table of contents is interactive. Click on a chapter in the table of contents to read that section.

You can also click on the icon on the bottom left to go back to the table of contents.

Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout this guide to direct the reader to more information and resources.

Overview

COVID-19 and 2020 Participation

CMS continues to offer flexibilities to provide relief to clinicians responding to the 2019 Coronavirus (COVID-19) pandemic. We are applying the MIPS automatic extreme and uncontrollable circumstances policy to all individual MIPS eligible clinicians for the 2020 performance period. We are also reopening the MIPS EUC application for groups, virtual groups, and Alternative Payment Model (APM) Entities through March 31, 2021 at 8 p.m. ET.

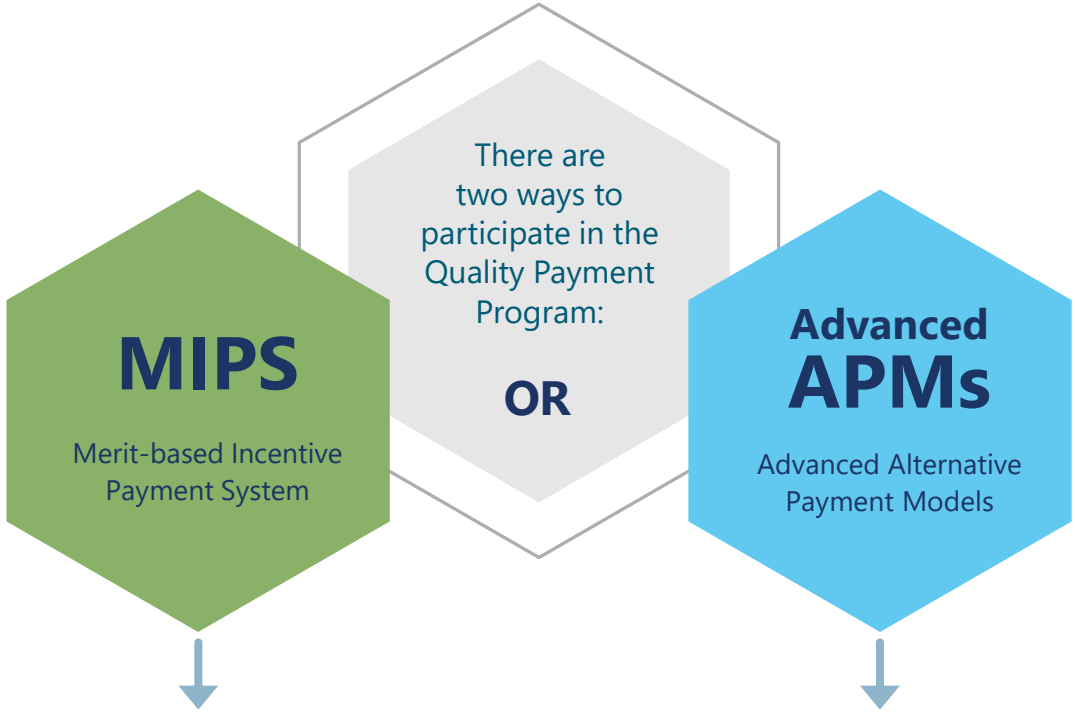
Please note that applications received by March 31, 2021 won't override previously submitted data for individuals, groups and virtual groups. However, data submission for an APM Entity won't override performance category reweighting from an approved application.

For more information about the impact of COVID-19 on Quality Payment Program participation, see the Quality Payment Program COVID-19 Response webpage or our Quality Payment Program COVID-19 Response Fact Sheet.

Overview

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which rewards value in 1 of 2 ways:



If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

MIPS Overview

MIPS is one way to participate in QPP. The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, we evaluate your performance across four performance categories that lead to improved quality and value in our healthcare system.

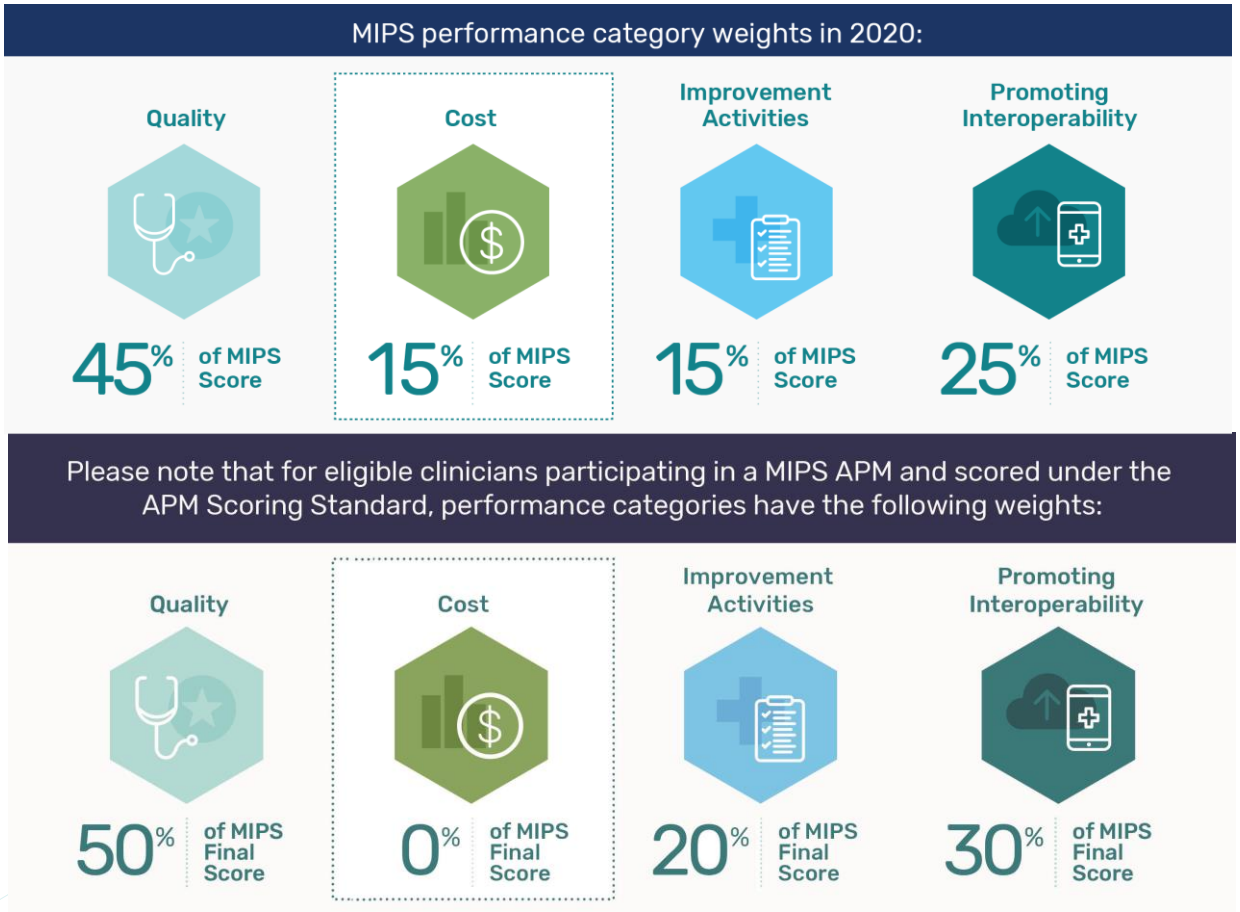
If you're eligible for MIPS in 2020:

- You generally have to submit data for the Quality, Improvement Activities, and Promoting Interoperability performance categories. (We collect and calculate data for the Cost performance category for you.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points. The MIPS performance category weights in the performance year (PY) are the same as in PY 2019.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based off your performance during the 2020 performance year and applied to payments for covered professional services beginning on January 1, 2022.

Overview

MIPS Overview *(continued)*

This guide focuses on the MIPS Cost performance category in the 2020 performance year of the Quality Payment Program.



To learn more about how to participate in MIPS:

- *Visit the How MIPS Eligibility is Determined and Individual or Group Participation webpages on the Quality Payment Program website.*
- *View the 2020 MIPS Eligibility and Participation Quick Start Guide.*
- *Check your current MIPS participation status using the QPP Participation Status Tool.*

Cost Performance Category Basics

Cost Performance Category Basics

Overview

CMS uses Medicare claims data to calculate cost measure performance, which means clinicians do not have to submit any data for this performance category.

A total of 20 cost measures are used to evaluate Cost performance category performance in the 2020 MIPS performance year (PY):

18 Episode-based Measures

8 of these 18 measures were used in the 2019 PY. CMS has changed the way these episodes are attributed to clinicians.

Total Per Capita Cost (TPCC) Measure

A revised version that's not identical to the version used in prior PYs

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Measure

A revised version that's not identical to the version used in prior PYs

Each measure is payment-standardized and risk-adjusted. The risk adjustment methodology varies by measure, and the only measure that is specialty-adjusted is the TPCC measure.

The policy of attributing cost measures at the Taxpayer Identification Number (TIN)-National Provider Identifier (NPI) level, regardless of whether a clinician's performance is assessed as an individual or group, applies only to the 2017, 2018 and 2019 performance years. Beginning in PY 2020, each cost measure will be attributed to providers according to the measure's unique specifications.

Cost Performance Category Basics

Overview *(continued)*

Two important documents are now available for each cost measure for the 2020 PY:

- A Measure Information Form (MIF) in a PDF file
- A measure codes list Excel file

The MIF describes the methodology used to construct each measure. Measure codes list files contain service codes and clinical logic used in the methodology, including episode triggers, exclusion categories, episode subgroups, assigned items and services, and risk adjustors.

Please note: the 2019 versions of the TPCC and MSPB measures did not include codes list files. These measures were significantly revised for PY 2020 as explained in the table on the next page.

Cost Performance Category Basics

Understand the Cost Performance Category Measures

The following table summarizes the 20 cost measures used in the 2020 performance year:

Measure Name	Description	Case Minimum	Data Source	Summary of Modifications from Prior Performance Years
Total Per Capita Cost (TPCC)	Measures the overall cost of care delivered to a patient with a focus on primary care received.	20 Medicare patients	• Medicare Parts A and B claims data from the Common Working File (CWF)[1] • Enrollment Data Base (EDB) • Common Medicare Environment (CME) • Long Term Care Minimum Data Set (LTC MDS) • Provider Enrollment, Chain, and Ownership System (PECOS)	• Change in attribution methodology to more accurately identify a patient's primary care relationships through establishing risk windows • Use of service category and specialty exclusions • Patients' risk scores will be determined for each beneficiary-month using diagnostic data for the year prior to that month • Patient costs evaluated on a monthly basis, rather than on an annual basis
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	Assesses the cost to Medicare for services provided to a patient immediately prior to, during, and following a hospital stay.	35 episodes	• Medicare Parts A and B claims data from the CWF • EDB • LTC MDS • PECOS	• Revised attribution methodology allowing the measure to be attributed to multiple clinicians to account for the team-based nature of care provided during an inpatient hospital stay • Use of separate attribution methods for medical episodes and surgical episodes • Service exclusions remove costs that are unlikely to be influenced by a clinician's care decisions • Modification to risk adjustment allowing for more accurate comparisons of predicted episode spending between clinicians treating patients with similar characteristics
13 Procedural episode-based measures and 5 acute inpatient medical condition episode-based measures (*see Table on Page 33)	Assess the cost of care that is clinically related to initial treatment of a patient and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode-based measures, 10 episodes for procedural episode-based measures	• Medicare Parts A and B claims data from the CWF • EDB • LTC MDS	• See specific measure MIFs and codes list files.

[1] The Common Working File is an electronic system of records that serves as a single data source of individual patient information for Medicare entities to verify Medicare eligibility, prepayment reviews, and claims approval.

Cost Performance Category Basics

Understand the Cost Performance Category Measures *(continued)*

Certain features apply to the TPCC, MSPB Clinician, and procedural and acute inpatient condition episode-based measures. These include:

- **Payment Standardization** – Payment standardization is the process of adjusting the allowed charge for a Medicare service to facilitate comparisons of resource use across geographic areas. This allowed charge for a single service, referred to as the Medicare allowed amount,[2] differs to accommodate varying input costs, such as local wages, and to address policy goals, such as add-on payments in under-served geographic areas. Payment standardization assigns a comparable allowed amount for the same service provided by different providers and/or in different settings to reveal differences in spending that result only from care decisions and resource use. Payments included in MIPS cost measures are payment-standardized (sometimes referred to as "price standardized"). More details about payment standardization are available on QualityNet's CMS Price (Payment) Standardization Overview Page.

The allowed charge for a single Medicare service can vary across geographic areas due to several factors, such as:

- Regional differences in labor costs and practice expenses
- Differences in relative price of inputs in local markets where a service is provided
- Extra payments from Medicare in medically underserved regions
- Policy-driven payment adjustments such as those for teaching hospitals

[2] Medicare fee-for-service allowed amounts include the amount of the Medicare Trust Fund payment plus any applicable beneficiary deductible and coinsurance amounts. In some cases, beneficiary deductibles and coinsurance amounts may be covered by third-party payers other than Medicare.

Cost Performance Category Basics

Understand the Cost Performance Category Measures *(continued)*

- **Benchmarks** – CMS will establish a single, national benchmark for each cost measure. These benchmarks are based on the performance year, not a historical baseline period. Therefore, CMS can't publish the actual numerical benchmarks for the cost measures before the start of each performance year. All MIPS eligible clinicians that meet or exceed the case minimum for a measure are included in the same benchmark.

  For Example: The MSPB Clinician benchmark used to determine MIPS eligible clinicians' 2020 Cost performance category score will be based on 2020 claims data.

- **Attribution** – calculation of claims-based measures requires the attribution (or assignment) of treatment costs to clinicians so that those costs can be evaluated though a specific measure. Each measure employs its own attribution method, described in detail in the measure MIFs.

- **Risk Adjustment** accounts for differences in patient characteristics (such as clinical risk factors) that are not directly related to patient care but may influence the cost of care provided. All measures included in the Cost performance category are adjusted for clinical risk. However, the specific methodology used to risk adjust each measure varies. Methodological detail can be found in each measure's specification documents. Risk adjustment should not be confused with the complex patient bonus, which is applied at the final score level and adjusts again for patient clinical complexity as well as some elements of social complexity.

Cost Measures

Cost Measures

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Overview

This section describes the major components of the MSPB Clinician measure and reviews changes in the methodology compared to the version used in prior PYs. For additional detail, please refer to the 2020 PY MSPB Clinician MIF and the associated measure codes list file.

The MSPB Clinician attribution method now distinguishes between surgical episodes and medical episodes. MSPB Clinician episodes are identified as surgical or medical by the Medicare Severity Diagnosis Related Group (MS-DRG) of the inpatient hospital admission (referred to as the "index admission").

MSPB Clinician attribution begins by identifying the "episode," triggered by an inpatient hospital admission.

TIP: Refer to the "Attribution_Rule" tab of the MSPB Clinician codes list file to determine the MS-DRG type of different medical conditions and procedures.

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Overview *(continued)*

- **Medical** MSPB Clinician episodes are attributed to clinicians in 2 steps:
  1. The episode is first attributed to the TIN that billed at least 30% of the inpatient evaluation & management (E&M) services listed on Part B physician/supplier claims during the inpatient stay, which includes the time period beginning on the day of admission through the day of discharge. The time period used for this step of episode attribution doesn't include the 3 days prior to the index admission, the 90-day lookback period, nor 30 days after discharge. This step is referred to in the codes list file documentation as the "E&M Attribution Rule."

> **TIP:** To see which Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes qualify as E&M services used for this purpose, refer to the "Med_Attribution_E&M" tab in the 2020 PY MSPB Clinician codes list Excel file.

  2. The episode is then attributed to any clinician in the TIN who billed at least one inpatient E&M service that was used to attribute the episode to the TIN.

- **Surgical** MSPB Clinician episodes are attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay and to the TIN under which the clinician(s) billed for the procedure.

> **TIP:** Index admissions in specific DRGs are attributed to any clinician or clinician group who bill certain CPT/HCPCS codes during the index admission. See the "Surg_Attribution_CPT_HCPCS" tab of MSPB Clinician codes list file.

Cost Measures

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Overview *(continued)*

Costs that are unlikely to be influenced by clinicians' care decisions are now removed from the MSPB Clinician measure through the use of service exclusions. The specific services excluded from measurement depend on the Major Diagnostic Category (MDC) of the episode's index admission. The MDC of the index admission is determined by the MS-DRG of the index admission.

TIP: See the "SE_General_Rules" tab of the MSPB Clinician codes list file to find the general service exclusion rules that apply to all episodes.

Services excluded from the MSPB Clinician measure are classified into the following service categories (contained on separate tabs) in the MSPB Clinician codes list file:

- *inpatient surgical services*
- *inpatient medical services*
- *outpatient facility and clinician services*
- *durable medical equipment, prosthetics, orthotics and supplies*

The MSPB Clinician measure assesses Medicare Parts A and Part B costs incurred by a single patient during an episode window: the period of time beginning **3 days before an index admission through 30 days** after hospital discharge.

Cost Measures

MSPB Clinician Beneficiary Exclusion Criteria

A patient is excluded from the population measured if he/she:

- Was not enrolled in Medicare Parts A and B during the 93-day period prior to the index admission through 30 days after discharge
  - *This time frame includes an additional 90-day period (referred to as the "90-day look-back period") because this period is used to identify a patient's comorbidities for use in risk-adjustment*
- Was enrolled in a private Medicare health plan (such as a Medicare Advantage or a Medicare private fee-for-service (FFS) plan) at any time during the episode window or the 90-day look-back period
- Resided outside the United States (including territories) during any month of the performance year

Episodes are also excluded if the index admission:

- Did not occur in a "subsection (d) hospital"[3] paid under the Inpatient Prospective Payment System (IPPS) or an acute care hospital in Maryland
- Was involved in an acute-to-acute hospital transfer[4]

[3] Subsection (d) hospitals do not include: psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals, and hospitals involved extensively in the treatment for or research on cancer.
[4] If an acute-to-acute hospital transfer and/or hospitalization in an IPPS-exempt hospital occurs during the 30 days following discharge from an index admission, then these post-discharge costs are included in the MSPB episode.

Cost Measures

MSPB Clinician Case Minimum

The minimum case volume for the MSPB Clinician measure is 35, meaning 35 total MSPB Clinician episodes (surgical and/or medical) must be attributed to a MIPS eligible clinician or group for the measure to be scored. For groups, a total of 35 MSPB Clinician episodes must be attributed across all MIPS eligible clinicians who have re-assigned their billing rights to the group's TIN.

A clinician who is participating in MIPS as an individual will not receive an MSPB Clinician measure score if the clinician does not bill Medicare for Part B physician/supplier services furnished to patients during hospital stays and therefore doesn't meet the case minimum.

Minimum case volume for the MSBP Clinician measure:

MSPB Clinician Risk Adjustment

The MSPB Clinician measure is risk-adjusted to account for patient age, comorbidities, disability, and illness severity.

A separate risk adjustment model is estimated for episodes within each MDC (determined by the MS-DRG of the index admission). This allows for more accurate comparisons of predicted episode spending between clinicians treating patients with similar characteristics.

A patient's illness severity is determined by the following indicators:

- 79 Hierarchical Condition Category (HCC) indicators[5] from a patient's claims during the 90-day period before the start of the episode
- Recent long-term care status
- End stage renal disease (ESRD) status
- Prior acute hospital admission
- Comorbidities (the presence of more than one simultaneous clinical condition) by including interactions between HCC variables and enrollment status variables
- The reason a patient qualified for Medicare—referred to as "entitlement category"
- Disease interactions that are included in the Medicare Advantage risk adjustment model

TIP: Refer to the "RA_Vars" tab of the MSPB Clinician codes list file for the variables used in the risk adjustment model for this measure.

Note: The MSPB Clinician measure is not adjusted to account for patient sex, race, nor provider specialty.

[5] The 79 HCC indicators are in Version 22 of the CMS-HCC model.

Cost Measures

MSPB Clinician Calculation

The MSPB Clinician measure is calculated through the following steps:

Step 1
Define the population of index admissions.

Step 2
Attribute the episode to a clinician group/clinician.

Step 3
Exclude clinically unrelated services and calculate the episode observed costs

Step 4
Exclude episodes

Step 5
Calculate expected episode costs through risk adjustment

Step 6
Calculate the measure score

Individuals

$$\frac{\text{Sum of Ratios*} \times \text{National Average}}{\text{Total \# MSPB Clinician Episodes**}}$$

*Sum of the ratios of payment-standardized observed to expected MSPB Clinician episode costs for all MSPB Clinician episodes attributed to an individual clinician's TIN-NPI

**Total number of MSPB Clinician episodes attributed to an individual MIPS eligible clinician's TIN-NPI

Groups

$$\frac{\text{Sum of Ratios*} \times \text{National Average}}{\text{Total \# MSPB Clinician Episodes**}}$$

*Sum of the ratios of payment-standardized observed to expected MSPB Clinician episode costs for all MSPB Clinician episodes attributed to all individual eligible clinicians' TIN-NPIs under the group's TIN

**Total number of MSPB Clinician episodes attributed to all individual eligible clinicians' TIN-NPIs under the group's TIN

TIP: For more detailed information, see the 2020 MIPS MSPB Clinician Measure Information Form.

Cost Measures

Total Per Capita Cost (TPCC) Overview

This section describes the major components of the TPCC measure and reviews changes in the methodology compared to the version used in prior PYs. For additional detail, please refer to the 2020 PY TPCC MIF and the associated measure codes list file.

The TPCC measure is intended to assess the impact of primary care management on healthcare costs.

The revised TPCC measure includes the following 4 major modifications:

MODIFICATION #1: A new attribution method more accurately identifies a patient's primary care relationships through establishing "risk windows."

- ***What is a risk window?*** A risk window is a year-long period of time during which a clinician or group could reasonably be held responsible for a patient's treatment costs. A risk window begins at the onset of a candidate event.
- ***What is a candidate event*?** A candidate event identifies the start of a primary care relationship and is defined by the occurrence of an eligible E&M service paired with additional services that are indicative of general primary care.

Did you know?

A candidate event is composed of 2 parts:

1) An initial qualifying E&M primary care service (there are 46 of them) billed on a Part B physician/supplier (aka "carrier") claim AND
2) EITHER another primary care service (which doesn't have to be from the qualifying E&M primary care service list) from any TIN occurring within 3 days prior or 3 days after the initial qualifying E&M primary care service OR a second E&M primary care service or another qualifying primary care service from the same TIN within 90 days after the initial qualifying E&M primary care service.

Cost Measures

Total Per Capita Cost (TPCC) Overview *(continued)*

MODIFICATION #1 *(continued)*:

- ***How does a candidate event, a risk window, and the QPP performance year interact?*** A candidate event initiates a yearlong risk window from the eligible E&M primary care service. Only the portion of the risk window that overlaps with the QPP performance year is attributable to a clinician for a given performance year.
- ***What are beneficiary-months, and what role do they play in TPCC attribution?*** For purposes of calculating the TPCC measure, the performance year is divided into 13, 4-week blocks called beneficiary-months. Dividing the performance year into beneficiary-months allows costs to be assigned to clinicians and groups during the parts of the year that they are primarily responsible for a patient's care management.

The tab labelled "E&M_Prim-Care" in the TPCC measure codes list file contains the CPT/HCPCS codes for eligible E&M services that, paired with another service listed on the "Prim_care_Servics" tab, create a candidate event and initiate a risk window.

What other rules are used to attribute patient costs to clinicians and groups for the TPCC measure?

- If 2 different clinician groups each initiate risk windows for the same patient, the 2 risk windows will occur concurrently and will be attributed to their respective TINs. Within an attributed TIN, the beneficiary-months will be attributed to the TIN-NPI combination that performed the highest number of candidate events for the patient.
- Multiple TINs may be attributed beneficiary-months for the same patient during a performance year.
- Clinicians billing under different TINs may be attributed beneficiary-months during the same performance year for the same patient.
- The same clinician can be attributed beneficiary-months for the same patient, spanning multiple performance years, if multiple candidate events open multiple risk windows.

Cost Measures

Total Per Capita Cost (TPCC) Overview *(continued)*

MODIFICATION #2: **Adoption and use of service category exclusions and specialty exclusions.** Candidate events are excluded from measurement if performed by clinicians who frequently perform non-primary care services and if performed by clinicians in specialties unlikely to be responsible for providing primary care.

- No candidate events will be attributed to a TIN-NPI and their corresponding TIN if the TIN-NPI is classified as 1 of 56 Medicare specialty designations. Physicians self-designate their Medicare specialty on their Medicare Enrollment Application (CMS-8551) or in PECOS.
- No candidate events will be attributed to a TIN-NPI and their corresponding TIN if the clinician frequently performs non-primary care services. To be excluded based on services rendered during the performance year, a clinician must reach one or more of the following thresholds:
  - At least 15% of the clinician's candidate events are comprised of 10-day or 90-day global surgery services
  - At least 5% of a TIN-NPI's candidate events are comprised of anesthesia services
  - At least 5% of a TIN-NPI's candidate events are comprised of therapeutic radiation services
  - At least 10% of the clinician's candidate events are comprised of chemotherapy services

All candidate events that overlap with the 12-month measurement period are assessed for this purpose.

The "Eligible_Clinicians" tab of the TPCC measure codes list file indicates whether certain specialties are excluded from the measure. For example, the following specialties are excluded from measurement: neurology, neurosurgery, sports medicine, dentists, sleep medicine, and dermatology. This is not an exhaustive list of excluded specialties.

To view the CPT/HCPCS codes used to identify therapeutic radiation services, see the "HCPCS_Ther_Rad" tab of the TPCC measure codes list file. For the CPT/HCPCS codes used to identify 10-day or 90-day global surgery codes, refer to the "HCPCS_Surgery" tab of the codes list file.

MODIFICATION #3: Change in TPCC measure risk adjustment methodology: A patient's risk score is determined for each beneficiary-month using diagnostic data for the year prior to that month, rather than calculating one risk score for the entire performance year using diagnostic data from the previous year.

MODIFICATION #4: Patient costs are evaluated on a monthly basis rather than an annual basis; this avoids measuring annualized costs for patients who died during the performance year.

Cost Measures

TPCC Beneficiary Exclusion Criteria

A patient is excluded from the population measured if he/she:

- Was not enrolled in both Medicare Parts A and B for every month of the performance year
  - *If a patient was enrolled in Medicare Parts A and B for a partial year because he/she newly-enrolled in Medicare or he/she died during the performance year, then the patient is included in the measure.*
- Was enrolled in a private Medicare health plan (such as a Medicare Advantage or a Medicare private FFS plan) during any month of the performance year
- Resided outside the United States (including territories) during any month of the performance year
- Is covered by the Railroad Retirement Board

TPCC Case Minimum

Clinicians will only be scored on the measure if they are attributed beneficiary-months across at least 20 patients.

Minimum case volume for the TPCC measure:

20

Cost Measures

TPCC Risk Adjustment

In order to account for patient risk factors that can affect medical costs, patients' monthly costs are risk-adjusted via the following steps:

1. A risk score is generated for each beneficiary-month using diagnostic data from the 12 months immediately preceding each beneficiary-month. For example, to determine the risk score for a beneficiary-month of August 2020, diagnostic data from August 2019 to July 2020 will be used. A patient's risk score summarizes their expected cost of care relative to other patients.
2. Risk scores are normalized by dividing by the average risk score among all beneficiary-months from all patients included in the measure.
3. Observed costs for each beneficiary-month are divided by the normalized risk scores to obtain risk-adjusted monthly costs.
4. Risk-adjusted monthly costs are adjusted by assigning the 99th percentile of monthly costs to all attributed beneficiary-months with costs above the 99th percentile.
5. Monthly costs are normalized to account for differences in expected costs based on the number of clinician groups to which a patient is attributed in a given month.

The "HCC_Risk_Adjust" tab in the TPCC codes list file contains the variables included in the CMS Hierarchical Condition Category Version 22 (CMS-HCC V22) 2016 Risk Adjustment model and in the CMS-ESRD Version 21 (CMS-ESRD V21) 2016 Risk Adjustment model that are used for new enrollees, continuously enrolled beneficiaries, beneficiaries in a long-term institutional setting, as well as enrollees with ESRD, respectively. Risk adjustors for dual-eligibility and sex are included in the revised TPCC measure.

TPCC Specialty Adjustment

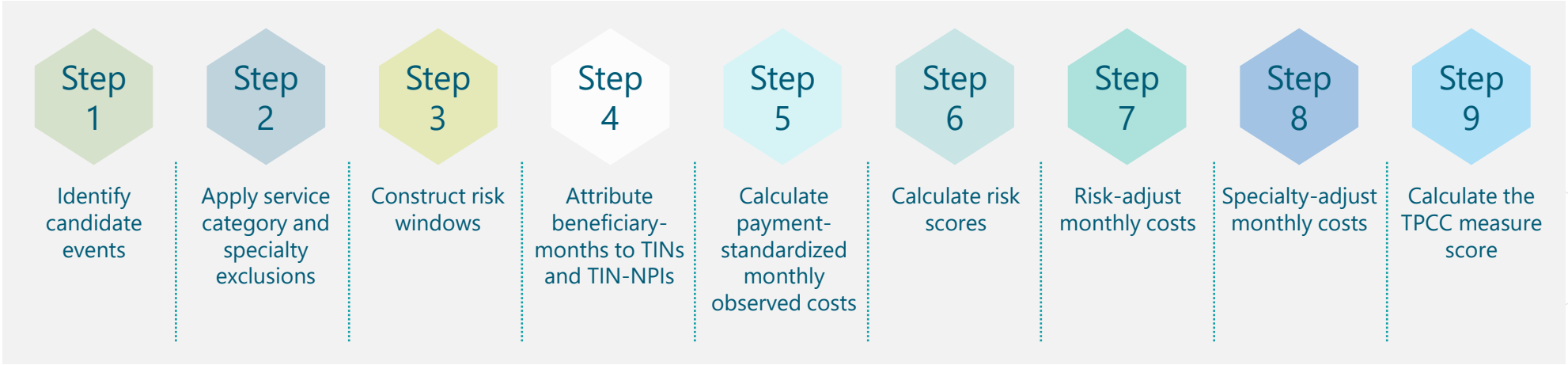
Specialty adjustment is applied to the TPCC measure to account for the fact that costs vary across specialties and across TINs with differing specialty compositions. As noted earlier, specialty adjustment differs from risk adjustment because it is performed at the provider level rather than the patient level.

See Appendix F of the 2020 TPCC MIF for an example of how specialty adjustment is applied to the TPCC measure.

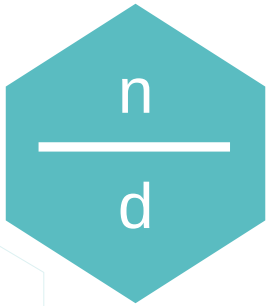
Cost Measures

TPCC Measure Calculation

The TPCC measure is calculated through the following steps:



The TPCC measure assesses total Medicare Parts A & B costs for a patient during the performance year by calculating the risk-adjusted, per capita costs for patients attributed to an individual clinician or group of clinicians. The measure is calculated and expressed by CMS at the TIN or TIN-NPI level.



Numerator = Sum of the risk-adjusted, payment-standardized and specialty-adjusted Medicare Parts A & B costs across all beneficiary-months attributed to a TIN or TIN-NPI during the measurement period.

Denominator = Number of beneficiary-months attributed to a TIN or TIN-NPI during the measurement period.

Cost Measures

Episode-based Cost Measure Basics

This section reviews the fundamental components of procedural and acute inpatient condition episode-based measures and reviews changes in overall methodology compared to prior PYs. For additional detail, please refer to the 2020 PY episode-based measure MIFs and the associated measure codes list files.

Episode-based measures are intended to assess and compare clinicians on the costs of care clinically related to their initial treatment of a patient and care provided during a specific time frame.

Did you know? Cost is defined as the allowed amounts on Medicare claims, which include both Medicare payments and patient deductible and coinsurance amounts.

CMS has posted detailed methodology documents for each of the 18 episode-based measures finalized for 2020.

Each episode-based measure has a corresponding measure codes list file that contains service codes and clinical logic used in the methodology including episode triggers, exclusions, subgroups, assigned items and services, and risk adjustors.

Episode-based measures are generally calculated via the following 6 steps:

1. Trigger and define an episode

Procedural episodes are defined by specific CPT/HCPCS codes on Part B physician/supplier (A.K.A. "carrier") claims that open, or trigger, an episode.

AND

Acute inpatient medical condition episodes are defined by Medicare Severity Diagnosis-Related Group (MS-DRG) codes that open, or trigger, an episode.

TIP: Refer to the "Triggers" and "Triggers_Detail" tab(s), if applicable, in a measure's codes list file.

2. Attribute episodes to a clinician

Cost Measures

Episode-based Cost Measure Basics *(continued)*

3. Assign costs to an episode and calculate total observed episode costs. Costs of services that are clinically related to the attributed clinician's role in managing the patient's care are assigned to the episode.

TIPS:

- See the "Service_Assignment" tab in a measure's codes list file. Each row in the service assignment tab is a possible instance of when a service could be assigned. Each row should be read from left to right to determine the rules for assignment for that particular service.
- To illustrate how to use a codes list file to interpret service assignment rules, look at Row 319/Initial Sort Order 311 in the "Service_Assignment" Tab for the Elective Outpatient Percutaneous Coronary Intervention (PCI) measure:
  - A service assignment rule applies to any time during the post-trigger period (columns D/E) for Clinical Classifications Software (CCS)[6] category 178: CT Scan Chest (columns F-H). If a rule is determined at the CCS category level and applies to all CPT/HCPCS codes within that CCS, then columns K and L will be blank; if a rule only applies to certain CPT/HCPCS codes within that CCS, then columns K-L would be filled in with specific codes in each relevant row. In this example, these columns are blank, so the decision is to assign all CPT/HCPCS within 178 depending on the decision in Column I. The decision is to assign depending on diagnosis. This means that further information, in further right columns, is required to determine whether a given CPT/HCPCS within CCS 178 should be assigned.
  - Scrolling right, Columns N-P and R-T provide more information about diagnoses. Columns O-P list I21: Acute Myocardial Infarction as the parent/3-Digit diagnosis code, and Column Q indicates to assign for all services with the diagnosis. This means that no further columns to the right are needed to determine the full service assignment rule. Based on all the information to the left in this row, the full service assignment rule is: Assign all CPT/HCPCS within CCS 178 if the CPT/HCPCS occurs with 3-digit diagnosis code I21: Acute Myocardial Infarction, when you see the CPT/HCPCS code + the diagnosis code billed together any time in the post-trigger period.

[6] https://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccsfactsheet.jsp

Cost Measures

Episode-based Cost Measure Basics *(continued)*

4. Exclude episodes

TIPS:

The following rules apply to all **acute inpatient condition** episode-based measures (each measure also has measure-specific exclusions). Acute inpatient condition episodes are excluded if:

- The patient was enrolled in a private Medicare health plan (such as Medicare Advantage or a Medicare FFS plan) at any time during the episode window or 120-day lookback period prior to the trigger day.
- The patient was not enrolled in Medicare Parts A and B for the entire lookback period plus episode window.
- No TIN is attributed to the episode.
- The patient's date of birth is missing from data sources.
- The patient died before the episode ended.
- The trigger inpatient (IP) stay has the same admission date as another IP stay.
- The IP facility is not a short-term stay acute hospital as defined by subsection (d).

See the "Exclusions" and "Exclusions_Details" tab, if applicable, in a measure's codes list file and the "Exclude Episodes" section in Appendix A of the MIF.

Cost Measures

Episode-based Cost Measure Basics *(continued)*

4. Exclude episodes *(continued)*

TIPS:

The following rules apply to all **procedural** episode-based measures (each measure also has measure-specific exclusions). Procedural episodes are excluded if:

- The patient was enrolled in a private Medicare health plan (such as Medicare Advantage or a Medicare private FFS plan) at any time during the episode window or 120-day lookback period prior to the trigger day.
- The patient was not enrolled in Medicare Parts A and B during the entire lookback period plus episode window.
- No main clinician is attributed the episode.
- The patient's date of birth is missing from data sources.
- The patient died before the episode ended.
- The episode trigger claim was not performed in an ambulatory/office-based care center, IP hospital, outpatient (OP) hospital, or ambulatory surgical center (ASC) setting based on its place of service code.
- The IP facility is not a short-term stay acute hospital as defined by subsection (d) when an IP stay concurrent with the trigger is found.

5. Estimate expected costs through risk adjustment

6. Calculate measure scores

Cost Measures

Episode-based Cost Measure Basics *(continued)*

For each measure listed in the table below and on subsequent pages:

- The cost measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician.
- Each episode-based measure includes costs of services that are clinically related to the attributed clinician's role in managing care during the defined episode window.
- An episode is opened (aka "triggered") by a certain clinical event, referred to in the table and other documentation as a trigger.
- An episode window may (but not always) include a period of time before the triggering clinical event, referred to as a "pre-trigger period," plus a period of time after the triggering clinical event (referred to as a "post-trigger period").
- Some episode windows begin when the triggering event occurs and do not include a pre-trigger period (therefore, they have a pre-trigger period of 0 days). The episode window used to calculate each of the episode-based measures is listed below.

Measure Name	Measure Type	Episode Window	Is the Measure New in 2020?	This measure evaluates a clinician's risk adjusted cost to Medicare for….	Measure can be triggered based on claims data from the following settings:
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	Pre-Trigger Period= 0 days Post-Trigger Period= 30 days	No	patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance year.	Ambulatory/office-based care centers, hospital outpatient departments (HOPDs), Ambulatory surgical centers (ASCs)
Knee Arthroplasty	Procedural	Pre- Trigger Period= 30 days Post- Trigger Period=90 days	No	patients who receive an elective knee arthroplasty during the performance year.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural	Pre-Trigger Period= 30 days Post- Trigger Period=90 days	No	patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance year.	ASCs, HOPDs and acute IP hospitals
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	Pre-Trigger period=60 days Post-Trigger period=90 days	No	patients who undergo a procedure for routine cataract removal with intraocular lens implantation during the performance year.	ASCs, ambulatory/office-based care, and HOPDs

Cost Measures

Episode-based Cost Measure Basics *(continued)*

Measure Name	Measure Type	Episode Window	Is the Measure New in 2020?	This measure evaluates a clinician's risk adjusted cost to Medicare for….	Measure can be triggered based on claims data from the following settings:
Screening/Surveillance Colonoscopy	Procedural	Pre-Trigger Period= 0 days Post-Trigger Period= 14 days	No	patients who undergo a screening or surveillance colonoscopy procedure during the performance year.	ASCs, ambulatory/office-based care, HOPDs
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Pre-Trigger Period= 0 days Post-Trigger Period= 30 days	Yes	patients who receive their first inpatient dialysis service for acute kidney injury during the performance year.	Acute IP hospitals
Elective Primary Hip Arthroplasty	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Yes	patients who receive an elective primary hip arthroplasty during the performance year.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Femoral or Inguinal Hernia Repair	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Yes	patients who undergo a surgical procedure to repair a femoral or inguinal hernia during the performance year.	Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Hemodialysis Access Creation	Procedural	Pre-Trigger Period= 60 days Post-Trigger Period=90 days	Yes	patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis during the performance year.	Ambulatory/office-based care centers, OP hospitals, and ASCs
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Yes	patients who undergo surgery for lumbar spine fusion during the performance year.	ASCs, HOPDs, and acute IP hospitals
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Yes	patients who undergo partial or total mastectomy for breast cancer during the performance year.	Ambulatory/office-based care centers, outpatient hospitals, and ASCs
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	Pre-Trigger Period= 30 days Post-Trigger Period=90 days	Yes	beneficiaries who undergo a CABG procedure during the performance year.	Acute inpatient hospitals

Cost Measures

Episode-based Cost Measure Basics *(continued)*

Measure Name	Measure Type	Episode Window	Is the Measure New in	This measure evaluates a clinician's risk adjusted cost to Medicare for….	Measure can be triggered based on claims data from the following settings:
Renal or Ureteral Stone Surgical Treatment	Procedural	Pre-Trigger Period= 90 days Post-Trigger Period=30 days	Yes	patients who receive surgical treatment for renal or ureteral stones during the performance year.	Acute inpatient hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	Pre-Trigger Period= 0 days Post-Trigger Period=90 days	No	patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance year.	Acute inpatient hospitals
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	Pre-Trigger Period= 0 days Post-Trigger Period= 30 days	No	patients who receive inpatient treatment for simple pneumonia during the performance year.	Acute inpatient hospitals
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	Pre-Trigger Period=0 days Post-Trigger Period= 30 days	No	patients who present with ST-Elevation Myocardial Infarction indicating complete blockage of a coronary artery who emergently receive Percutaneous Coronary Intervention as treatment during the performance year.	Acute inpatient hospitals
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	Pre-Trigger Period= 0 days Post-Trigger Period= 60 days	Yes	patients who receive inpatient treatment for an acute exacerbation of COPD during the performance year.	Acute inpatient hospitals
Lower Gastrointestinal Hemorrhage (**applies to groups only**)	Acute inpatient medical condition	Pre-Trigger Period= 0 days Post-Tigger period=35 days	Yes	patients who receive inpatient non-surgical treatment for acute bleeding in the lower gastrointestinal tract during the performance year.	Acute inpatient hospitals

Cost Measures

Episode-based Measure Attribution

Acute Inpatient Medical Condition Episode Attribution

- Acute inpatient medical condition episodes are attributed to clinician groups (identified by TIN) that bill at least 30% of the inpatient E&M claim lines during the trigger inpatient stay, and to clinicians (identified by TIN-NPI) who bill at least one E&M claim line under a TIN that met the 30% threshold.
- All TIN-NPIs who bill at least one inpatient E&M service within a TIN that met the 30% threshold will be attributed the episode. As a result, an acute inpatient medical condition episode can be attributed to more than one individual clinician.

TIP: The same 12 inpatient E&M services, identified by CPT/HCPCS codes, are used to determine whether the 30% threshold is met and attribute acute inpatient medical condition episodes to TINs. For more details on the E&M services, see the "Attribution" tab in the measure codes list files or Appendix of this document.

Procedural Episode-Based Cost Measure Attribution

- Procedural episodes are attributed to any TIN-NPI who bills a trigger code, defined by CPT/HCPCS codes, on the date of the procedure or during a concurrent related inpatient stay.
- As a result, procedural episodes can be attributed to more than one clinician.

CMS does not exclude episodes if a patient already qualified for another episode, since allowing for overlapping episodes incentivizes communication and care coordination as a patient moves through the care continuum. For example, if a patient is re-hospitalized for pneumonia after an initial episode, this would trigger 2 separate episodes of care for pneumonia.

TIP: Episodes can be attributed to clinicians of a specialty that is eligible for MIPS. Some episode groups require additional attribution rules, such as modifier code requirements for procedural episodes or the existence of CPT/HCPCS codes in the list of E&M codes used for attribution for acute inpatient medical condition episodes. For more information, refer to the "Attribution" tab in the episode measure codes list files.

Cost Measures

Episode-based Measure Case Minimums

To be assessed on episode-based measures, you must meet the minimum case volume.

The minimum case volume for **procedural episode-based measures** is 10, meaning 10 episodes must be attributed to a MIPS eligible clinician or group for the measure to be scored. For groups, a total of 10 procedural episode-based episodes must be attributed across all clinicians (including MIPS eligible clinicians AND eligible clinicians) who have re-assigned their billing rights to the group's TIN.

The minimum case volume for **acute inpatient medical condition episode-based measures** is 20, meaning 20 episodes must be attributed to a MIPS eligible clinician or group in order for the measure to be scored. For groups, a total of 20 acute inpatient medical condition episode-based measures must be attributed across all clinicians (including MIPS eligible clinicians AND eligible clinicians) who have re-assigned their billing rights to the group's TIN.

Cost Measures

Risk Adjustment Methodology for Episode-based Measures

Risk adjustment is used to estimate expected episode costs, recognizing that patients may require different levels of care due to comorbidities, disability, age and other risk factors.

The risk adjustment methods for the episode-based measures:

Adjust for differences in clinical complexity

AND

Include variables from the CMS-HCC Version 22 Risk Adjustment Model

AND

Include standard risk adjustors and variables for clinical factors outside the influence of the attributed clinician

Risk adjustors are typically identified using patients' Medicare claims history during the period prior to the start of the episode. Claims from the triggering hospitalization or on the triggering Part B physician/supplier claim are not included. The risk adjustment method used for each episode-based measure is customized by the use of risk adjustors specifically adapted for each episode group.

TIP: See the "RA" and "RA_Details" tabs in a measure's codes list file. Measures include standard risk adjustor variables and measure-specific risk adjustor variables.

Reporting Requirements

Reporting Requirements

Overview

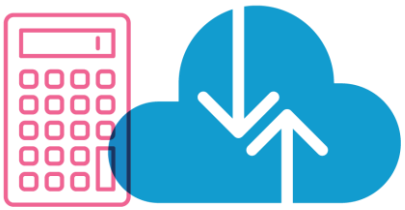
CMS will use data from Medicare Parts A and B claims—with dates of service from January 1, 2020 to December 31, 2020—to calculate your Cost performance category score.

AND

You **do not** need to submit any data or take any separate actions for this performance category.

AND

MIPS eligible clinicians should continue to see patients and submit claims data as usual.



Scoring

Scoring

Overview

For a cost measure to be scored, an individual MIPS eligible clinician or group must meet or exceed the case minimum for that cost measure.

1

If **only** one cost measure can be scored, that measure's score will serve as the Cost performance category score.

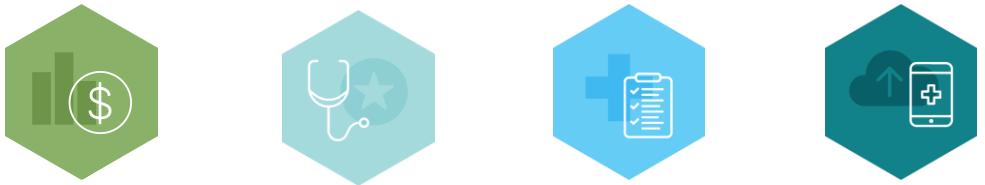
multiple

If **multiple** cost measures are scored, the Cost performance category score is the equally-weighted average of all the scored measures.

For example, if 7 out of 20 cost measures are scored, the Cost performance category is the equally weighted average of the 7 scored measures.

none

If **none** of the cost measures can be scored, the Cost performance category will count toward 0% of your MIPS final score, and we'll reweight your Quality performance category score to 60%, Improvement Activities to 15%, and Promoting Interoperability to 25%.



Cost	Quality	Improvement Activities	Promoting Interoperability
0%	60%	15%	25%

To calculate the Cost performance category score in 2020, CMS will assign **1 to 10 achievement points** to each scored measure based on the MIPS eligible clinician or group's performance on the measure compared to the PY benchmark.

As a result, the achievement points assigned for each measure depends on which decile range you or your group's performance on the measure is between.

Note: the Cost performance category percent score will not include improvement scoring until the 2022 MIPS performance year and corresponding 2024 MIPS payment year.

2020 Cost Performance Category Illustrative Scoring Example for a Group

Measure	Measure Achievement Points Earned by the Group	Total Possible Measure Achievement Points Available
TPCC Measure	8.2	10
MSPB Clinician Measure	6.4	10
Elective Outpatient PCI Measure	Not scored	N/A-not scored
Knee Arthroplasty	Not scored	N/A-not scored
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Not scored	N/A-not scored
Routine Cataract Removal with IOL Implantation	Not scored	N/A-not scored
Screening/Surveillance Colonoscopy	7	10
Intracranial Hemorrhage or Cerebral Infarction	4.8	10
Simple Pneumonia with Hospitalization	6.7	10
STEMI with PCI Measure	Not scored	N/A-not scored
Acute Kidney Injury Requiring New Inpatient Dialysis	9	10
Elective Primary Hip Arthroplasty	Not scored	N/A-not scored
Femoral or Inguinal Hernia Repair	6.6	10
Hemodialysis Access Creation	8.3	10
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Not scored	N/A-not scored

2020 Cost Performance Category Illustrative Scoring Example for a Group *(continued)*

Lumpectomy Partial Mastectomy, Simple Mastectomy	Not scored	
Non-Emergent CABG	Not scored	N/A-not scored
Renal or Ureteral Stone Surgical Treatment	Not scored	
Inpatient COPD Exacerbation	5	
Lower Gastrointestinal Hemorrhage (applies to groups only)	8.8	

In the example above:

The group's Cost performance category score is (70.8/100=0.708), which is equal to a Cost performance category percent score of 70.8%. Because the Cost performance category is worth 15 points in the MIPS final score, this group would earn 10.6 points towards their final score (70.8 x .15=10.6)

Scoring

Reweighting the Cost Performance Category

CMS will automatically reweight the Cost performance category for MIPS eligible clinicians who are located in a CMS-designated region or locale that has been affected by extreme and uncontrollable circumstances. If a MIPS eligible clinician is located in an affected area, we will:

Assume the clinician does not have sufficient cost measures applicable

AND

Assign a weight of 0 to the Cost performance category in the final score even if we receive administrative claims data that would enable us to calculate cost measures for that clinician

If other performance categories are reweighted, the Cost performance category will always be weighted at either 15% or 0%—we will not redistribute weight to the Cost performance category for the 2020 performance year, except in cases when the Cost and the Improvement Activities performance categories are the only 2 categories scored. In this case, both categories will receive a weight of 50%.

Note, the Quality, Cost, Improvement Activities and Promoting Interoperability performance categories will be reweighted to 0% for MIPS eligible clinicians who join an existing practice (i.e., an existing TIN) during the final 3 months of the PY that is not participating in MIPS as a group, or a practice that is newly formed (i.e., a new TIN) during the final 3 months of the PY regardless of whether the clinicians in the practice report for purposes of MIPS as individual clinicians or as a group.

Facility-Based Scoring

Facility-based measurement offers certain clinicians and groups that primarily work within an inpatient setting the opportunity to receive MIPS Quality and Cost performance categories scores based on their assigned facility's Hospital Value-Based Purchasing (VBP) Program score instead of receiving scores based on MIPS quality and cost measures. For more information on facility-based measurement, please review the 2020 Facility-based Quick Start Guide.

Cost Performance Category Feedback

For the 2020 MIPS PY, Cost performance category feedback and additional patient-level data will be provided in the Summer of 2021.

Help, Resources, Glossary, and Version History

Help, Resources, Glossary, and Version History

Where Can You Go for Help?

Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 a.m.-8:00 p.m. Eastern Time or by e-mail at: QPP@cms.hhs.gov.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Connect with your local technical assistance organization. We provide no-cost technical assistance to small, underserved, and rural practices to help you successfully participate in the Quality Payment Program.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out resources available in the QPP Resource Library.

Help, Resources, Glossary, and Version History

Additional Resources

The following resources are available on the QPP Resource Library and other QPP webpages:

- 2020 MIPS Quick Start Guide
- 2020 MIPS Eligibility and Participation Quick Start Guide
- 2020 MIPS Cost Measure Information Forms
- 2020 Cost Measure Codes Lists
- 2020 Cost Requirements Webpage

Help, Resources, Glossary, and Version History

Glossary

Help, Resources, Glossary, and Version History

Version History

If we need to update this document, changes will be identified here.

Date	Change Description
3/9/2021	Updated to reflect new EUC policy changes (automatic EUC policy for all individual MIPS eligible clinicians and EUC application deadline extended to 3/31 for groups, virtual groups and APM Entities).
8/17/2020	Original posting

Appendix

Appendix

Inpatient E&M Services used for Acute Inpatient Condition Episode-Based Measure Attribution

CPT/HCPCS Code	Code Label
99221	Initial Hospital Inpatient Care, Typically 30 Minutes Per Day
99222	Initial Hospital Inpatient Care, Typically 50 Minutes Per Day
99223	Initial Hospital Inpatient Care, Typically 70 Minutes Per Day
99231	Subsequent Hospital Inpatient Care, Typically 15 Minutes Per Day
99232	Subsequent Hospital Inpatient Care, Typically 25 Minutes Per Day
99233	Subsequent Hospital Inpatient Care, Typically 35 Minutes Per Day
99234	Hospital Observation Or Inpatient Care Low Severity, 40 Minutes Per Day
99235	Hospital Observation Or Inpatient Care Moderate Severity, 50 Minutes Per Day
99236	Hospital Observation Or Inpatient Care High Severity, 55 Minutes Per Day
99238	Hospital Discharge Day Management, 30 Minutes Or Less
99239	Hospital Discharge Day Management, More Than 30 Minutes
99291	Critical Care Delivery Critically Ill Or Injured Patient, First 30-74 Minutes