Merit-based Incentive Payment System (MIPS)

2023 Cost Performance Category Quick Start Guide

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Already know what MIPS is?
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Purpose: This resource focuses on the cost performance category under the traditional MIPS and MIPS Value Pathways (MVPs) reporting options, providing high level information about the cost measures, including calculation and attribution for the 2023 performance period. For comprehensive information about these measures, please refer to the Measure Information Forms (linked in the Help, Resources, and Version History section). This resource doesn't address requirements under the Alternative Payment Model (APM) Performance Pathway (APP) since cost isn't evaluated under the APP.

How to Use this Guide

How to Use This Guide

Table of Contents

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Please Note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Hyperlinks

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

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Overview

Overview

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program rewards MIPS eligible clinicians for providing high quality care to their patients by reimbursing Medicare Part B-covered professional services.

Under MIPS, we evaluate your performance across multiple categories that drive improved quality and value in our healthcare system.

If you're eligible for MIPS in 2023:

- You generally have to report measure and activity data for the quality, improvement activities, and Promoting Interoperability performance categories. (We collect and calculate data for the cost performance category for you, if applicable.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2023 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2025.

To learn more about MIPS:

- Visit the Learn about MIPS webpage
- View the 2023 MIPS Overview Quick Start Guide.
- View the 2023 MIPS Quick Start Guide for Small Practices.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- View the 2023 MIPS Eligibility and Participation Quick Start Guide.
- Check your current participation status using the QPP Participation Status Tool.

Overview

What is the Merit-based Incentive Payment System? (Continued)

There are 3 reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements:

Traditional MIPS, established in the first year of QPP, is the original reporting option for MIPS. You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS. You'll also report the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

The Alternative Payment Model (APM) Performance Pathway (APP) is a streamlined reporting option for clinicians who participate in a MIPS APM. The APP is designed to reduce reporting burden, create new scoring opportunities for participants in MIPS APMs, and encourage participation in APMs. You'll report a predetermined measure set made up of quality measures in addition to the complete Promoting Interoperability measure set (the same as reported in traditional MIPS). MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.

MIPS Value Pathways (MVPs) are the newest reporting option that offer clinicians a subset of measures and activities relevant to a specialty or medical condition. MVPs offer more meaningful groupings of measures and activities, to provide a more connected assessment of the quality of care. Beginning with the 2023 performance year, you'll select, collect, and report on a reduced number of quality measures and improvement activities (as compared to traditional MIPS). You'll also report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS). We collect and calculate data for the cost performance category and population health measures for you.

To learn more about traditional MIPS:

- Visit the Traditional MIPS Overview webpage on the Quality Payment Program website.

To learn more about the APP:

- Visit the APM Performance Pathway webpage on the Quality Payment Program website.

To learn more about MVPs:

- Visit the MIPS Value Pathways (MVPs) webpage on the Quality Payment Program website

Overview

What is the MIPS Cost Performance Category?

The cost performance category is an important part of MIPS. Although clinicians don't personally determine the price of individual services provided to Medicare patients, they can affect the amount and types of services provided. By better coordinating care and seeking to improve health outcomes by ensuring their patients receive the right services, clinicians play a meaningful role in delivering high-quality care at a reasonable cost.

Traditional MIPS Performance Category Weights in 2023:
Individual, Group, and Virtual Group Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
			
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

Traditional MIPS Performance Category Weights in 2023:
APM Entity Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
55%	0%	15%	30%

Overview

What's New with Cost in 2023?

- We're establishing a maximum cost improvement score of 1 percentage point out of 100 percentage points available for the cost performance category, starting with the 2022 performance period.
- We note that all MIPS eligible clinicians will receive a cost improvement score of zero percentage points for the 2022 performance period because we didn't calculate cost measure scores for the 2021 performance period.
- We're establishing this policy to adhere to the statutory requirement of accounting for improvement in the assessment of performance under the cost performance category.

Reminders:

- We use Medicare administrative claims data to calculate your cost measure performance, which means you don't have to submit any data for this performance category when reporting traditional MIPS or MVPs.
- Under traditional MIPS, you'll be scored on each measure for which you meet or exceed the established case minimum.
- Each MVP includes cost measures that are relevant and applicable to the MVP clinical topic or episode of care. We'll calculate performance exclusively on the cost measures that are included in the selected MVP for which you meet or exceed the established case minimum.

The APP doesn't measure cost performance.

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Get Started with the Cost Performance Category in 4 Steps

Get Started with Cost Measures in 4 Steps

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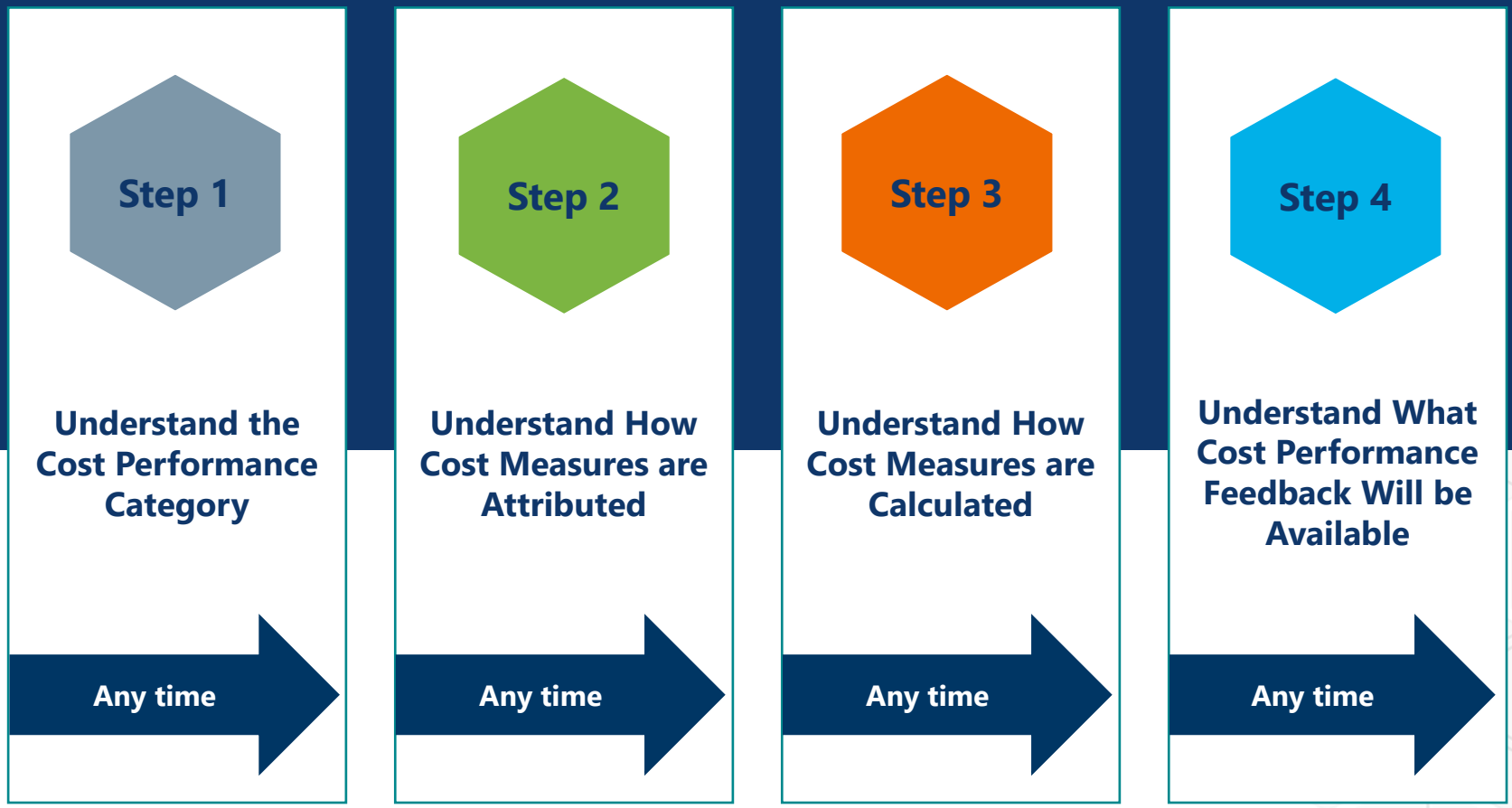

Get Started with Cost Measures in 4 Steps

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Step 1. Understand the Cost Performance Category Measures

There are 25 total cost measures for the 2023 performance period.

Measure Name/Type	Description	Case Minimum	Data Source
Total Per Capita Cost (TPCC)	This population-based measure assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.	20 Medicare patients	Medicare Parts A and B claims data
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	This measure assesses the cost of care for services related to qualifying inpatient hospital stays (immediately prior to, during, and after) for a Medicare patient.	35 episodes	Medicare Parts A and B claims data
15 procedural episode-based measures	Assess the cost of care that's clinically related to a specific procedure provided during an episode's timeframe.	10 episodes for all procedural episode-based measures **except** the Colon and Rectal Resection measure which has a case minimum of 20 episodes	Medicare Parts A and B claims data
6 acute inpatient medical condition episode-based measures	Assess the cost of care clinically related to specific acute inpatient medical conditions and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode-based measures	Medicare Parts A and B claims data (all acute inpatient condition episode-based cost measures), Medicare Part D claims (Sepsis episode-based cost measure)
2 chronic condition episode-based measures	Assess the cost of care clinically related to the care and management of patients' specific chronic conditions provided during a total attribution window divided into episodes.	20 episodes for chronic condition episode-based measures	Medicare Parts A, B and D claims data

Get Started with Cost Measures in 4 Steps

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Step 1. Understand the Cost Performance Category Measures (Continued)

There are 23 MIPS Episode-Based Cost Measures available in the 2023 performance period.

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures 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	Patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance period.	Ambulatory/office-based care centers, outpatient hospitals, Ambulatory surgical centers (ASCs)
Knee Arthroplasty	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who receive an elective knee arthroplasty during the performance period.	Acute inpatient (IP) hospitals, hospital outpatient department (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	Patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance period.	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	Patients who undergo a procedure for routine cataract removal with intraocular lens implantation during the performance period.	ASCs and HOPDs
Screening/Surveillance Colonoscopy	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 14 days	Patients who undergo a screening or surveillance colonoscopy procedure during the performance period.	ASCs, ambulatory/office-based care, HOPDs
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	• Pre-Trigger Period = 0 days • Post-Trigger Period = 30 days	Patients who receive an inpatient dialysis service for acute kidney injury during the performance period.	Acute IP hospitals

Get Started with Cost Measures in 4 Steps

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Step 1. Understand the Cost Performance Category Measures (Continued)

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Elective Primary Hip Arthroplasty	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who receive an elective primary hip arthroplasty during the performance period.	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	Patients who undergo a surgical procedure to repair a femoral or inguinal hernia during the performance period.	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	Patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis during the performance period.	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	Patients who undergo surgery for lumbar spine fusion during the performance period.	ASCs, HOPDs, and acute IP hospitals
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	• Pre-Trigger Period = 30 days • Post-Trigger Period = 90 days	Patients who undergo partial or total mastectomy for breast cancer during the performance period.	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	Patients who undergo a CABG procedure during the performance period.	Acute IP hospitals
Renal or Ureteral Stone Surgical Treatment	Procedural	• Pre-Trigger Period = 90 days • Post-Trigger Period = 30 days	Patients who receive surgical treatment for renal or ureteral stones during the performance period.	Acute IP 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	Patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance period.	Acute IP hospitals

Get Started with Cost Measures in 4 Steps

Step 1. Understand the Cost Performance Category Measures (Continued)

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	• Pre-Trigger Period = 0 days • Post-Trigger Period = 30 days	Patients who receive inpatient treatment for simple pneumonia during the performance period.	Acute IP 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	Patients who present with STEMI indicating complete blockage of a coronary artery who emergently receive PCI as treatment during the performance period.	Acute IP hospitals
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	• Pre-Trigger Period = 0 days • Post-Trigger Period = 60 days	Patients who receive inpatient treatment for an acute exacerbation of COPD during the performance period.	Acute IP hospitals
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	• Pre-Trigger Period = 0 days • Post-Tigger period = 35 days	Patients who receive inpatient non-surgical treatment for acute bleeding in the lower gastrointestinal tract during the performance period.	Acute IP hospitals
Melanoma Resection	Procedural	• Pre-Trigger Window: 30 days • Post-Trigger Window: 90 days	Patients who undergo an excision procedure to remove a cutaneous melanoma during the performance period.	ASCs, ambulatory/office-based care, and HOPDs.
Colon and Rectal Resection	Procedural	• Pre-Trigger Window: 15 days • Post-Trigger Window: 90 days	Patients who receive colon or rectal resection for either benign or malignant indications during the performance period.	ASCs, HOPDs, and acute IP hospitals.

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Step 1. Understand the Cost Performance Category Measures (Continued)

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for…	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Sepsis	Acute inpatient medical condition	• Pre-Trigger Window: 0 days • Post-Trigger Window: 45 days	Patients who receive inpatient medical treatment for sepsis during the performance period.	Acute IP hospitals.
Diabetes	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients who receive medical care to manage and treat diabetes during the performance period.	The most frequent settings in which a Diabetes episode is triggered include: Office, Skilled Nursing Facility (SNF), and OP Hospital.
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days	Patients who receive medical care to manage and treat asthma or COPD during the performance period.	The most frequent settings in which an Asthma/COPD episode is triggered include: Office, SNF, and OP Hospital.

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Step 1. Understand the Cost Performance Category Measures (Continued)

Cost Performance in the MVP Reporting Option

We'll calculate performance exclusively on the cost measures that are included in the selected MVP using administrative claims data, even if additional cost measures (outside your selected MVP) are available for scoring. You'll only be scored on measures for which you meet or exceed the established case minimum. The table below shows which cost measure(s) are evaluated in each MVP:

MVP	Cost Measure(s) Assessed
Advancing Rheumatology Patient Care MVP	• TPCC
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP	• Intracranial Hemorrhage or Cerebral Infarction
Advancing Care for Heart Disease MVP	• Elective Outpatient PCI • STEMI with PCI • TPCC
Optimizing Chronic Disease Management MVP	• TPCC
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP	• MSPB Clinician
Improving Care for Lower Extremity Joint Repair MVP	• Elective Primary Hip Arthroplasty • Knee Arthroplasty
Patient Safety and Support of Positive Experiences with Anesthesia MVP	• MSPB Clinician
Advancing Cancer Care MVP	• TPCC
Optimal Care for Kidney Health MVP	• Acute Kidney Injury Requiring New Inpatient Dialysis (AKI) • TPCC
Optimal Care for Patients with Episodic Neurological Conditions MVP	• MSPB Clinician
Supportive Care for Neurodegenerative Conditions MVP	• MSPB Clinician
Promoting Wellness MVP	• TPCC

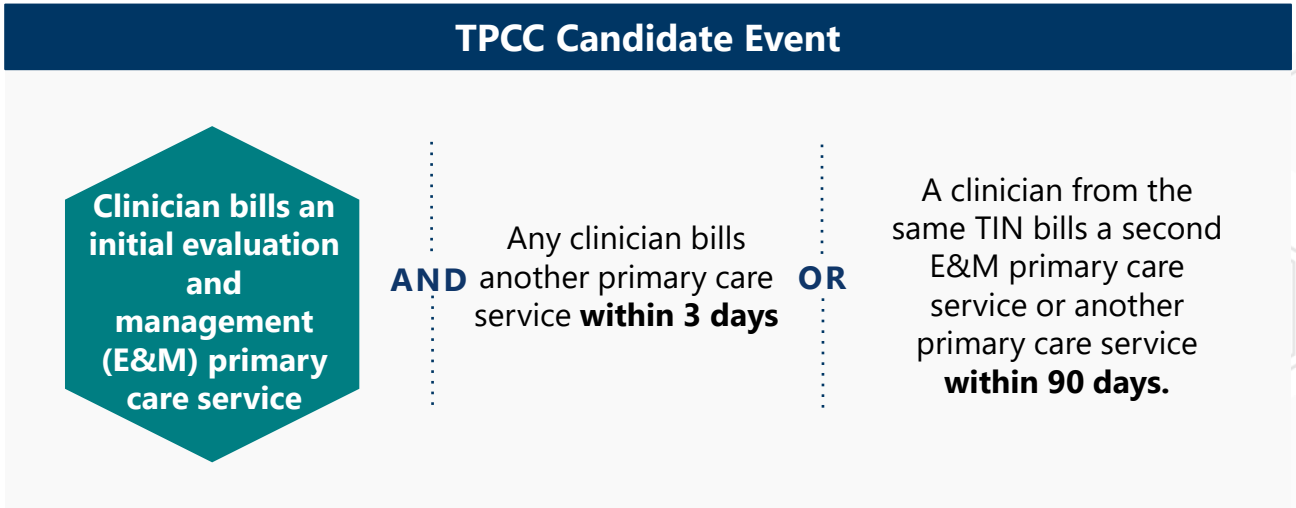
Get Started with Cost Measures in 4 Steps

Step 2. Understand How Cost Measures are Attributed

This section provides a brief overview of the steps used to attribute the TPCC and MSPB Clinician measures to individual clinicians and groups. For more information about how cost measures are attributed, please refer to the measure specifications.

TPCC Measure Attribution*

TPCC attribution begins with a "candidate event," defined as a pair of services billed by the clinician to the patient within a short period of time. A candidate event marks the start of a primary care relationship between a patient and a clinician.



*More information about attribution is available in the Total Per Capita Cost Measure Information Form (ZIP).

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Step 2. Understand How Cost Measures are Attributed (Continued)

TPCC Measure Attribution*

- A risk window is a year-long window that begins on the date of a candidate event, during which time a clinician is responsible for a patient's costs.
- The performance period is a static calendar year that is divided into 13 4-week blocks called beneficiary months. Beneficiary months that occur during a risk window and the performance period are counted towards a clinician's (or clinician group's) measure scores. These beneficiary months are attributed to the TIN billing the initial E&M "primary care" service.
- For TIN-NPI-level attribution, only the TIN-NPI responsible for the largest share of candidate events provided to the patient within the TIN is attributed the beneficiary months.

We exclude clinicians from attribution who:
Meet the criteria for one or more service exclusions in the following categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy **OR** Are designated as 1 or more of the 56 specialties unlikely to be responsible for primary care services (including but not limited to: dermatology)

*More information about attribution is available in the Total Per Capita Cost Measure Information Form (ZIP).

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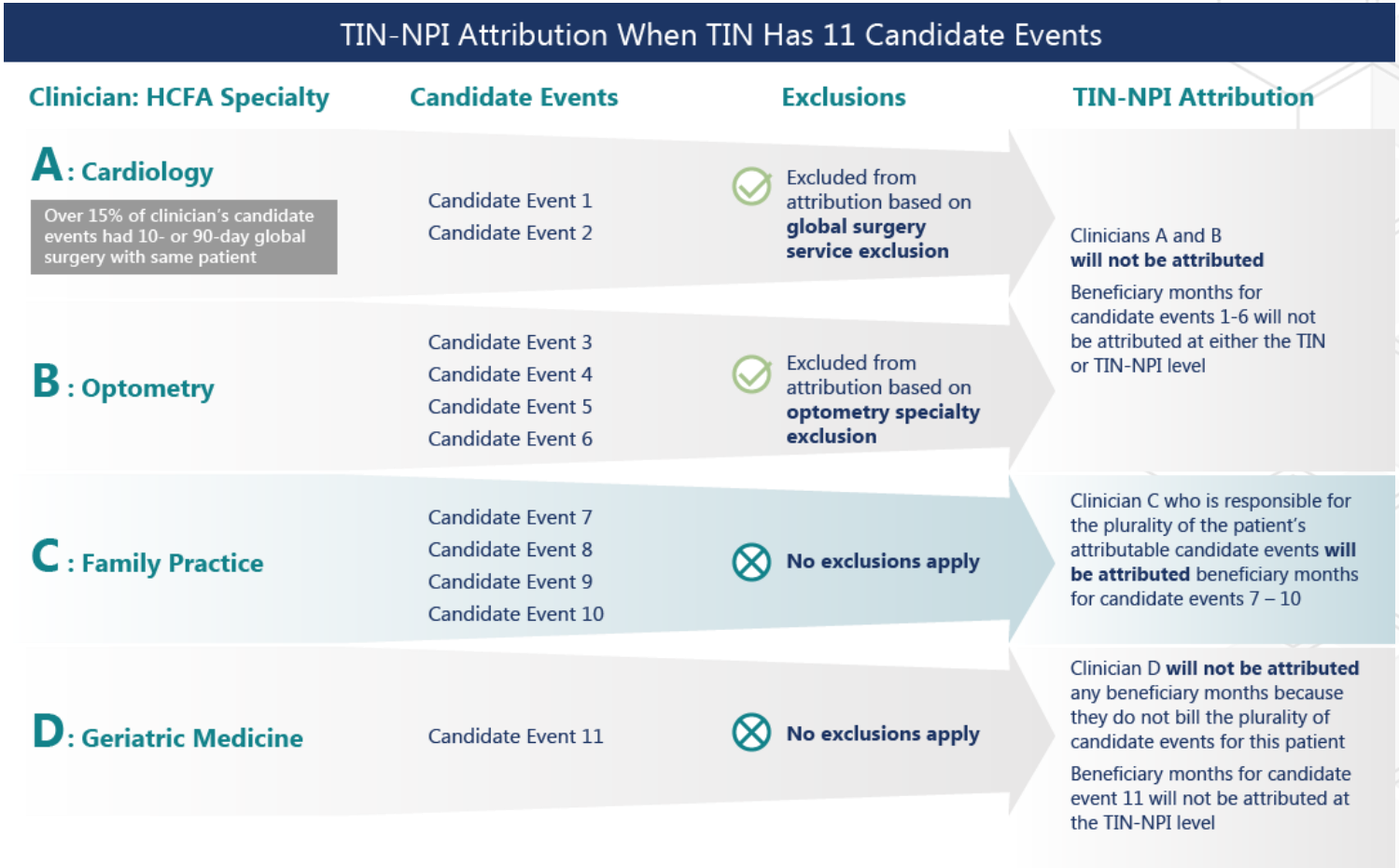
Step 2. Understand How Cost Measures are Attributed (Continued)

TPCC Measure Attribution



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Step 2. Understand How Cost Measures are Attributed (Continued)

MSPB Clinician Attribution

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

MSPB Clinician episodes are classified as either medical or surgical, based on the Medicare Severity-Diagnosis Related Group (MS-DRG) of the index admission.

- A **medical MSPB Clinician episode** is:
  - First attributed to a TIN if that TIN billed at least 30% of the E&M services on Part B physician/supplier claims during the inpatient stay.
  - Then attributed to any clinician in the TIN who billed at least one inpatient E&M service that was used to determine the episode's attribution to the TIN.
- A **surgical MSPB Clinician episode** is attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay as well as to the TIN under which the clinician(s) billed for the procedure.

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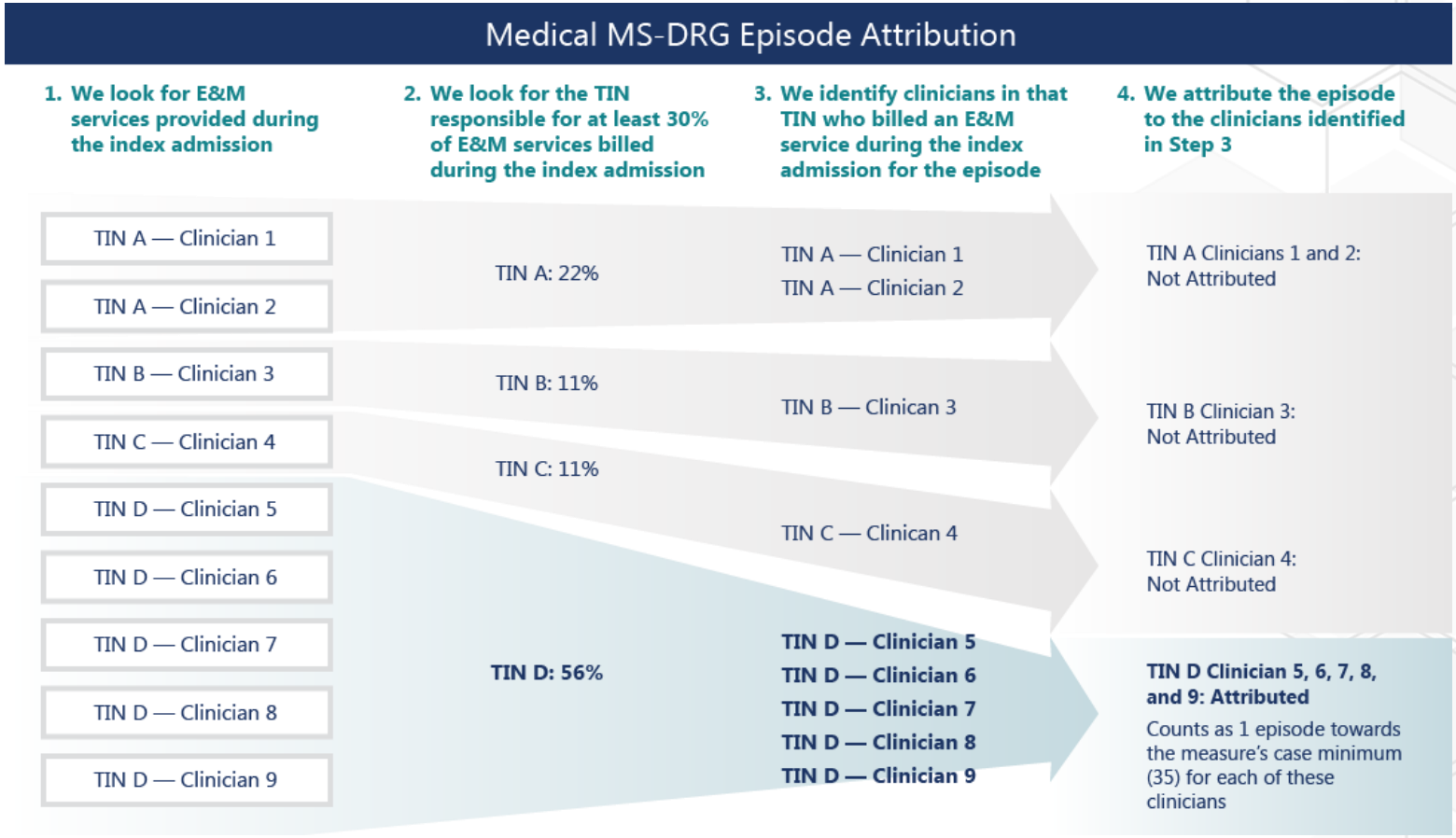
Step 2. Understand How Cost Measures are Attributed (Continued)

MSPB Clinician: Medical Episode Attribution Example



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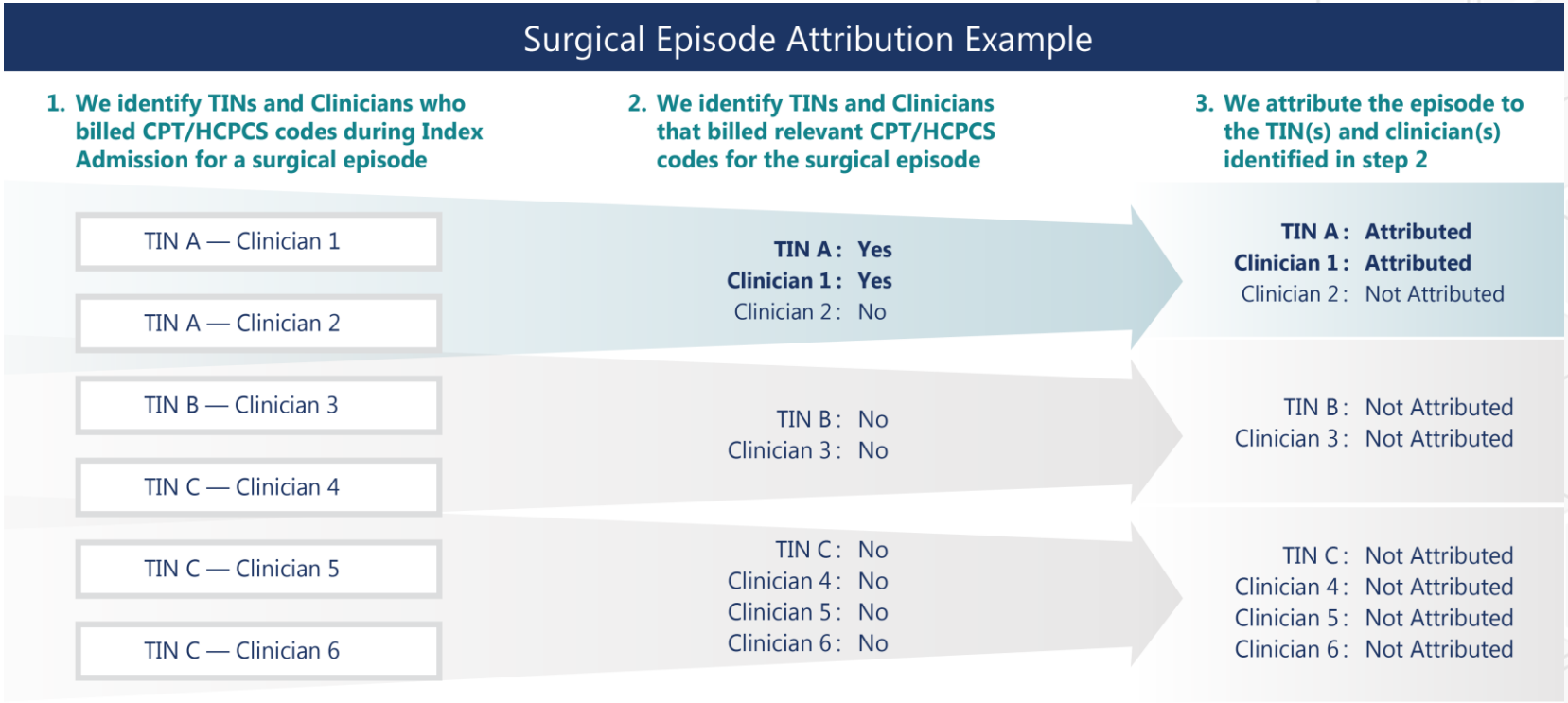
Step 2. Understand How Cost Measures are Attributed (Continued)

MSPB Clinician: Surgical Episode Attribution Example



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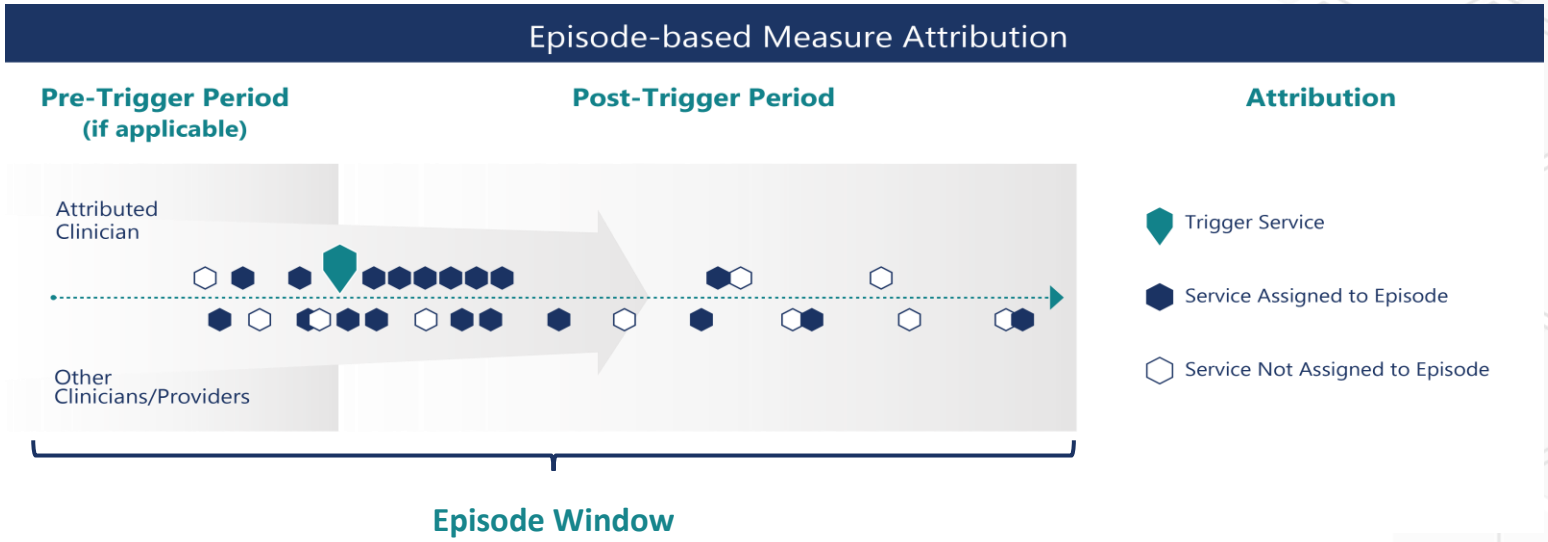
Step 2. Understand How Cost Measures are Attributed (Continued)

Episode-Based Measure Attribution

- For **acute inpatient condition episode-based measures**, an episode is:
  - First attributed to the TIN billing at least 30% of inpatient E&M services on Part B physician/supplier claims during the inpatient stay.
  - Then attributed to any clinician in that TIN who billed at least one inpatient E&M service during the inpatient stay.
- For **procedural episode-based measures**, we attribute the episode to any clinician who bills the code that triggers the episode.



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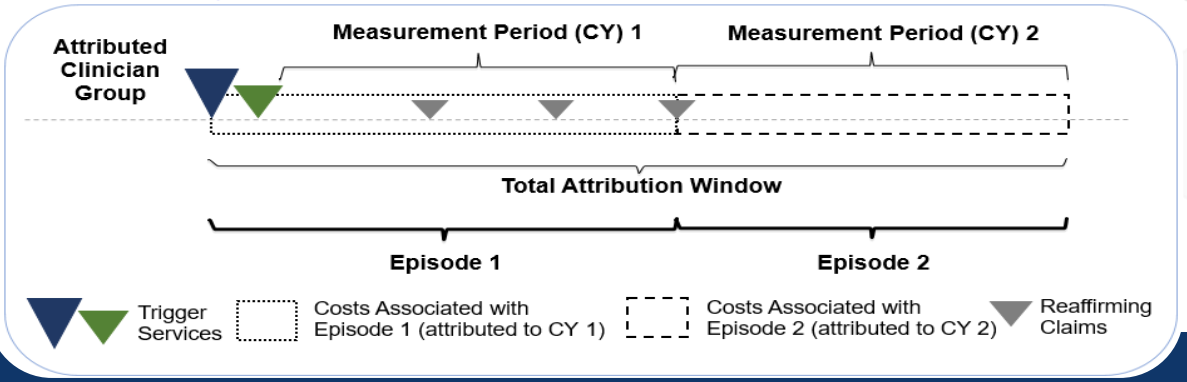
Step 2. Understand How Cost Measures are Attributed (Continued)

Episode-Based Measure Attribution (Continued)

For **chronic condition episode-based measures**:

- Episodes are attributed to the clinician group that renders services that make up a "trigger event." A trigger event for chronic condition episode-based measures is identified by the occurrence of 2 claims billed in close proximity by the same clinician group. Both claims must have a diagnosis code indicating the chronic disease captured by the measure. The first claim must have an E&M code for outpatient services (identified in the measure's codes list file (ZIP)) and the second claim must have either another E&M code for outpatient services OR a condition-related HCPCS/CPT code for procedure codes related to the treatment or management of the chronic condition.
- The trigger event opens an attribution window from the date of the initial E&M outpatient service, during which time the same clinician group could reasonably be considered responsible for managing the patient's chronic disease.
- The initial attribution window is extended each time we see additional E&M codes for outpatient services or condition-related HCPCS/CPT codes related to the treatment or management of the chronic condition, indicating an ongoing clinician-patient relationship. As a result, the total attribution window could span multiple years and vary in length for different patients.
- Because the total attribution window could span multiple performance periods, we divide the attribution window into segments of episodes which we assess in the performance period in which they conclude.



Get Started with Cost Measures in 4 Steps

Step 2. Understand How Cost Measures are Attributed (Continued)

Episode-Based Measure Attribution (Continued)

For **chronic condition episode-based measures (Continued):**

- To attribute episodes to individual clinicians, we attribute episodes to each MIPS eligible clinician within an attributed clinician group that renders at least 30% of qualifying services during the episode. Two checks are conducted to confirm an individual clinician's role in the ongoing management of a patient's chronic condition:
  - First, we check to ensure the qualifying clinician(s) have rendered at least one E&M service code for outpatient services or a condition-related HCPCS/CPT code with a relevant diagnosis in connection with the same patient triggering the episode within 1 year prior to or on the episode start date.
  - Second, we check whether the clinician(s) have written at least 2 condition-related prescriptions on different days to 2 different patients during the performance period plus a one-year lookback period.
  - MIPS eligible clinicians in an attributed clinician group that render at least 30% of qualifying services and meet the 2 additional checks are considered for attribution.
- An individual clinician's performance on a chronic condition episode-based measure is based on all episodes attributed to the individual clinician, while the clinician group's performance is based on all the episodes attributed to the clinician group.
- If a single episode is attributed to multiple clinicians in a single clinician group, the episode is counted only once toward the clinician group's performance.

Get Started with Cost Measures in 4 Steps

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Step 3. Understand How Cost Measures are Calculated

TPCC Measure Calculation

Step	Description/Additional Information
1. Identify candidate events	This is the start of a primary care relationship between a clinician and Medicare patient.
2. Apply service category and specialty exclusions	This excludes candidate events for certain clinicians. For example, clinicians whose candidate events meet thresholds for certain service categories (e.g., global surgery) or practice under certain specialties (e.g., dermatology).
3. Construct risk windows	For remaining candidate events, this opens a year-long risk window beginning with the initial E&M primary care service of the candidate event.
4. Attribute beneficiary months to TINs and TIN-NPIs	Months in the risk window that occur during the performance period are attributed to the remaining eligible TIN-NPIs within the TIN responsible for the majority share, or plurality, of candidate events for a patient.
5. Calculate payment-standardized monthly observed costs	This sums the cost of all services billed for the Medicare patient during a given month. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
6. Calculate risk-adjusted monthly costs	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
7. Apply specialty adjustment to risk-adjusted costs	This accounts for the fact that costs vary across specialties and across TINs with varying specialty compositions.
8. Calculate the measure score	This is done by dividing each TIN and TIN-NPI's risk-adjusted monthly cost by the specialty-adjustment factor and multiplying by the observed cost across the total population of beneficiary-months where the risk window overlaps with the performance year.

Get Started with Cost Measures in 4 Steps

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Step 3. Understand How Cost Measures are Calculated (Continued)

MSPB Clinician Measure Calculation

Step	Description/Additional Information
1. Define the population of index admissions	An episode is opened by an inpatient hospital admission ("index admission"). Medicare Part A and Part B claims billed 3 days prior to and during the index admission and 30 days after hospital discharge are considered for inclusion.
2. Attribute MSPB Clinician episodes	The MSPB Clinician attribution methodology distinguishes between medical episodes and surgical episodes. Episodes with medical MS-DRGs are attributed to: 1) the TIN that billed at least 30% of inpatient E&M services during the index admission, and 2) any TIN-NPI who billed at least one E&M service that was used to meet the 30% threshold for the TIN. Episodes with surgical MS-DRGs are attributed to the TIN and TIN-NPI that provided the main procedure for the index admission.
3. Exclude unrelated services and calculate episode standardized observed cost	We exclude unrelated services specific to groups of MS-DRGs aggregated by Major Diagnostic Categories (MDCs), such as orthopedic procedures. This removes services clinically unrelated to the index admission and sums the cost of the remaining services. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Risk-adjust MSPB Clinician episode costs to calculate expected cost	This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
5. Exclude outliers and winsorize costs	This mitigates the effect of outlier high- and low-cost episodes on each TIN-NPI or TIN's MSPB Clinician measure score.
6. Calculate MSPB Clinician Measure score	This is done by calculating the ratio of standardized observed episode costs to winsorized expected episode costs and multiplying the average of this cost ratio across episodes for each TIN-NPI or TIN by the national average observed episode cost.

Get Started with Cost Measures in 4 Steps

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Step 3. Understand How Cost Measures are Calculated (Continued)

Procedural and Acute Inpatient Medical Condition Episode-Based Measure Calculation

Step	Description/Additional Information
1. Trigger and define an episode	This relies on billing codes that open, or "trigger," an episode. The pre- and post-trigger period length of the episode varies by measure.
2. Attribute the episode to a clinician	For acute inpatient condition episodes, this is a clinician billing E&M services under a TIN that bills 30% of inpatient E&M services during the inpatient stay. For procedural episodes, this can be any clinician who bills the trigger procedure code.
3. Assign costs to the episode and calculate the standardized episode observed cost	The cost of the assigned services is summed to determine each episode's standardized observed cost. Costs are standardized to account for differences in Medicare payments unrelated to care provided.
4. Exclude episodes	This removes unique groups of patients in cases where it may be impractical and unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.
5. Risk-adjust cost to calculate expected episode costs	This step accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.
6. Calculate the measure score	This is done by calculating the ratio of standardized observed episode costs to expected episode costs and multiplying the average cost ratio across episodes for each TIN-NPI or TIN by the national average episode cost.

Get Started with Cost Measures in 4 Steps

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Step 3. Understand How Cost Measures are Calculated (Continued)

Chronic Condition Episode-Based Measure Calculation

Step	Description/Additional Information
1. Identify patients receiving care	A trigger event identifies the start or continuation of a clinician group's management of a patient's chronic disease. A trigger event is identified by the occurrence of 2 Part B Physician/Supplier (Carrier) claims billed by the same clinician group practice within a specified time. The pair of services must include a trigger claim and a confirming claim. The trigger claim is an initial E&M code for outpatient services along with a relevant chronic condition diagnosis. The confirming claim can be either another outpatient services E&M code with a relevant chronic condition diagnosis, or a condition-related CPT/HCPCS code with a relevant chronic condition diagnosis. Once a trigger event is identified, this opens an attribution window from the point of the trigger claim, in which the patient's chronic disease care will be monitored by a clinician group.
2. Identify the total length of care between a patient and a clinician group	Once an attribution window is opened, it continues for a determined number of days, unless there's a service that demonstrates a continuing care relationship, also known as a reaffirming claim. After a reaffirming claim is identified, the attribution window is extended by the length of the initial attribution window from the point of each reaffirming claim billed.
3. Define an episode	Episodes are segments of the total attribution window that are counted in a particular measurement period. Episodes are assigned to a clinician group (identified by TIN) or individual clinicians (identified by TIN-NPI) and can vary in length. Episodes are assessed in the measurement period in which they conclude and only attribute days not previously measured in preceding measurement periods, so there's no double counting of episode costs. After episodes are constructed, they're placed into more granular, mutually exclusive and exhaustive subgroups based on clinical criteria to enable meaningful clinical comparisons.

Get Started with Cost Measures in 4 Steps

Quality Payment PROGRAM

Step 3. Understand How Cost Measures are Calculated (Continued)

Chronic Condition Episode-Based Measure Calculation (Continued)

Step	Description/Additional Information
4. Attribute the episode to the clinician group and clinician(s)	The episode is attributed to the clinician group that bills the trigger and confirming claims for the total attribution window. To attribute the episode to an individual clinician, we identify any clinician within the attributed clinician group who plays a substantial role in the care for the patient. This is identified as a clinician billing at least 30% of outpatient services E&M codes with a relevant chronic condition diagnosis and/or condition-related CPT/HCPCS codes with a relevant chronic condition diagnosis on Part B Physician/Supplier claim lines during the episode. There are also additional checks to ensure that clinicians aren't attributed to an episode before they have their first encounter with the patient and that we capture appropriate specialties through prescription billing patterns.
5. Assign costs to the episode and calculate the episode annualized observed cost	Services that are clinically related to the care and management of a patient's chronic disease that occur during the episode are included in the measure. The standardized cost of the assigned services is summed and averaged across the number of days in an episode. This average daily cost is then multiplied by 365 to determine each episode's annualized standardized observed cost.
6. Exclude episodes	Exclusions remove unique groups of patients or episodes from cost measure calculation in cases where it may be impractical or unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.

Get Started with Cost Measures in 4 Steps

Quality Payment PROGRAM

Step 3. Understand How Cost Measures are Calculated (Continued)

Chronic Condition Episode-Based Measure Calculation (Continued)

Step	Description/Additional Information
7. Calculate the annualized expected cost for risk adjustment	Risk adjustment predicts the expected costs by adjusting for factors outside of the clinician's or clinician group's reasonable influence (e.g., patient age, comorbidities, dual Medicare and Medicaid eligibility status, and other factors). The episode group's annualized observed costs are winsorized at the 98th percentile for each model to handle extreme observations. A regression is then run using the risk adjustment variables as covariates to estimate the expected cost of each episode. Further statistical techniques are applied to reduce the effects of extreme outliers on measure scores.
8. Calculate the measure score	For each episode, the ratio of winsorized annualized standardized observed cost to annualized expected cost (both of which are from Step 7) is calculated. The measure is calculated as a weighted average of these ratios across all of a clinician's or clinician group's attributed episodes, where the weighting is each episode's number of assigned days. The weighted average episode cost ratio is then multiplied by the national average winsorized annualized observed episode cost to generate a dollar figure for the cost measure score.

Get Started with Cost Measures in 4 Steps

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Step 4. Understand What Cost Performance Feedback Will Be Available

MIPS eligible clinicians, groups, and virtual groups who meet the case minimum for any of the cost measures will receive category- and measure-level scoring information in their performance feedback. Each measure is scored out of 10 possible points, based on comparison to a performance period benchmark. (There are no historical benchmarks for cost measures.)

Please note:

- Due to COVID-19's impact on cost measures, we reweighted the cost performance category from 20% to 0% for the 2021 performance period.
- We recognized clinicians needed more insight into and familiarity with their performance in the cost performance category. To support this need, we provided 2021 patient-level reports on administrative claims-based cost and quality measures for clinicians, groups, virtual groups, and APM Entities who met the case minimum for the measures. To see what these reports contained, review the 2021 MIPS Performance Feedback Patient-Level Data Reports Supplement (PDF).

For performance year 2019, we also provided patient-level reports for viewing and downloading by clinicians and groups who were scored on a MIPS cost measure and/or the 2019 30-Day All-Cause Readmission (ACR) measure. Visit the "2019 MIPS Performance Feedback Patient-Level Data Reports FAQs" document in the 2019 MIPS Performance Feedback Resources (ZIP) for more information. (Note, this is the current resource at the time of publication.)

Final performance feedback will be available in Summer 2024 when you sign in to the QPP website.

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Help and Version History

Help and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, create a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

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

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

CMS collaborates with clinicians and other interested parties to develop cost measures for potential implementation. This webpage contains information about this process, including how to participate: QPP Cost Measure Information page.

Help and Version History

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Version History

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

Date	Description
12/27/2022	Original Posting.
04/29/2024	Updated slide 35 to include information on how to develop cost measures for potential implementation.