Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2024 Cost User Guide

Table of Contents

THE BASICS
Introduction to Cost

What Is the MIPS Cost Performance Category?

The MIPS cost performance category focuses on the **costs of services provided to Medicare patients** within a specified time frame.

- Like the quality performance category, **MIPS cost performance is tied to individual measures.**

For example.

An individual cost measure may look at:

- Management of a chronic condition
- An inpatient hospitalization
- A specific procedure
- The overall cost of care delivered to a patient
- Care provided in a certain setting

Related Measure:

- Chronic Kidney Disease (CKD) (COST_CKD_1)
- Medicare Spending Per Beneficiary (MSPB) (**MSPB_1**)
- Elective Primary Hip Arthroplasty (**COST_PHA_1**)
- Total Per Capita Cost (TPCC) (**TPCC_1**)
- Emergency Medicine (**COST_EDV_1**)

Why Is Cost Important?

Measuring cost can help us understand whether patients are getting the right care at the right time.

- Is the patient who was recently admitted to the hospital overdue for their annual wellness visit?
  - If yes, does your practice have a system in place to remind patients that it's time to schedule their annual visit?
- Is the patient diagnosed with diabetes and overdue for a follow-up appointment?
  - If yes, does your practice have a system in place to follow up with patients to ensure follow-up care occurs in the timeframe recommended by clinical guidelines?

Cost efficiency ISN'T cutting corners with the quality of care you provide your patients.

- While cost and quality aren't always linked, performing well on cost measures doesn't mean providing low quality care.
- Cost efficiency means that you're evaluating whether there's a lower-cost option that would meet your patient's care needs, or whether there are additional services you can provide to reduce costs from complications and worsening symptoms.

Why Is Cost Important? (Continued)

Measuring cost can help us understand if patients are getting the most cost-efficient option that meets their care needs.

- Would improvements in care coordination and discharge planning reduce costly re-admissions after hospitalizations?
- Would additional monitoring and patient education reduce disease progression and need for additional treatments for chronic conditions?
- Would the lower-cost version of a medication work for the patient, or is there a medical reason necessitating the higher-cost drug?

Who Is Evaluated on MIPS Cost Measures?

MIPS cost measures exclusively measure Medicare patients who meet the criteria for the measure outlined in the measure information form (MIF).

Each MIF also outlines the measure's **attribution** rules:

- These determine whether a clinician or group is **assessed on the costs** associated with a qualifying Medicare patient or episode of care.

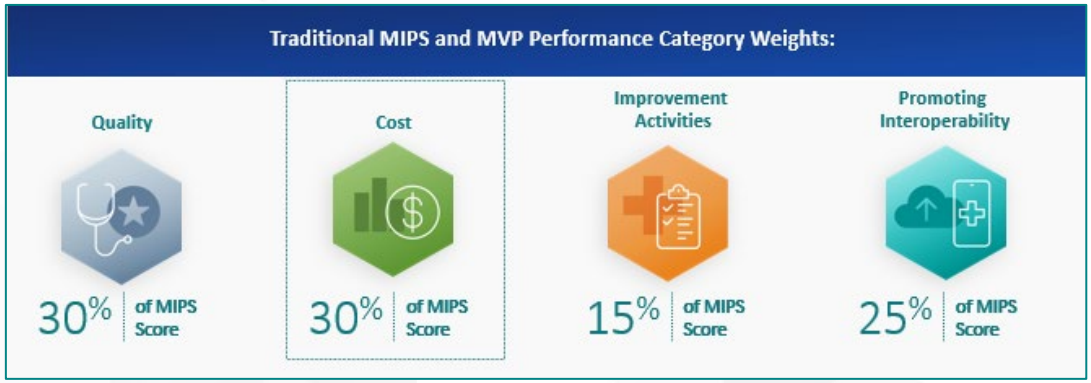
When a clinician or group is determined to provide relevant care to enough qualifying Medicare patients ("**case minimum**"), the clinician or group is scored on the measure.

More than one provider can be assessed on each patient or episode of care. See slide 36 for an example of how 5 clinicians could be attributed to one episode for the MSPB-Clinician Measure.

What Happens If We're Scored on a MIPS Cost Measure?

If you can be scored on at least 1 MIPS cost measure, the **cost** performance category will count for **30% of your MIPS final score**.

Your cost performance category score is generally the sum of the points you earned on each cost measure, divided by the total points available (10 x the number of scored measures). See the cost sections of the 2024 Traditional MIPS Scoring Guide and 2024 MVPs Implementation Guide (PDF) for more information.



How Many MIPS Cost Measures Are We Evaluated On?

It depends on your MIPS reporting option.

1. If you're reporting traditional MIPS, you'll be scored on all MIPS cost measures for which you meet or exceed the case minimum.
2. If you're registered to report a MIPS Value Pathway (MVP), you'll be scored on all cost measures available under the MVP for which you meet or exceed the case minimum.

MIPS Reporting Option: Determines which measures and activities are available for reporting.

- **Traditional MIPS:** You choose from all the quality measures and improvement activities available in MIPS.
- **MIPS Value Pathway (MVP):** You choose from the defined subset of quality measures and improvement activities, related to a particular condition or specialty

THE BASICS
What's New with Cost?

What's New with Cost in 2024?

- We finalized a **change to cost measure scoring** in the CY 2025 Physician Fee Schedule Final Rule that will result in **higher scores** for clinicians with average costs.
  - This scoring change is effective for the 2024 performance period
- We added **5 new episode-based cost measures** beginning with the 2024 performance period:
  - 3 chronic condition measures (**Depression, Heart Failure, and Low Back Pain)**
  - **1 care setting measure (Emergency Medicine)**
  - 1 acute inpatient medical condition measure (Psychoses and Related Conditions)
- We removed 1 existing episode-based cost measures beginning with the 2024 performance period:
  - **Simple Pneumonia with Hospitalization**

THE BASICS
Cost Measures

What Are the 2024 MIPS Cost Measures?

- Acute Kidney Injury Requiring New Inpatient Dialysis
- Asthma/Chronic Obstructive Pulmonary Disease (COPD)
- Colon and Rectal Resection
- Depression
- Diabetes
- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Elective Primary Hip Arthroplasty
- Emergency Medicine
- Femoral or Inguinal Hernia Repair
- Heart Failure
- Hemodialysis Access Creation
- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Intracranial Hemorrhage or Cerebral Infarction
- Knee Arthroplasty
- Low Back Pain
- Lower Gastrointestinal Hemorrhage
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy, Partial Mastectomy, Simple Mastectomy
- Medicare Spending Per Beneficiary (MSPB) Clinician
- Melanoma Resection
- Non-Emergent Coronary Artery Bypass Graft (CABG)
- Psychoses and Related Conditions
- Renal or Ureteral Stone Surgical Treatment
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with IOL Implantation
- Screening/Surveillance Colonoscopy
- Sepsis
- ST-Elevation Myocardial Infarction (STEMI) PCI)
- Total Per Capita Cost (TPCC)

Note: The Acute Kidney Injury Requiring New Inpatient Dialysis measure will not be calculated or scored for the CY 2024 performance period/2026 MIPS payment year. For more information, please see the 2024 MIPS Cost Measure Exclusion Fact Sheet.

Measure Specifications

The following slides provide information on a subset of cost measures (those most commonly scored), but the measure information form is the definitive source for measure details including attribution and applicability.

- **Measure information forms = an explanation of cost measure methodology.**
- **Measure codes lists = documents the details about codes used in measure specifications.**

You can review all of the 2024 MIPS Cost Measure Information Forms (ZIP) , 2024 MIPS Cost Measure Codes Lists, or search for individual measures on the Explore Measures & Activities tool.

Total Per Capita Costs (TPCC)

Measure Availability

- ✓ Traditional MIPS
- ✓ Advancing Cancer Care MVP
- ✓ Advancing Care for Heart Disease MVP
- ✓ Advancing Rheumatology Patient Care MVP
- ✓ Focusing on Women's Health MVP
- ✓ Gastroenterology Care MVP
- ✓ Optimal Care for Kidney Health MVP
- ✓ Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP
- ✓ Value in Primary Care MVP

Measure Type

Population-Based

Measure Summary

The TPCC measure assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received. Read the Measure Information Form.

Commonly Attributed Clinicians

- ✓ Nurse Practitioner
- ✓ Family Practice
- ✓ Internal Medicine

Clinician or group must be attributed to 20 qualifying Medicare patients.

Example Opportunities to Improve Cost Performance

- ✓ Follow preventive service recommendations
- ✓ Conduct comprehensive medical evaluations and assessment of comorbidities
- ✓ Manage or refer patients to care for chronic conditions, like diabetes, cardiovascular disease, and kidney disease
- ✓ Promote positive health behaviors, like physical activity, weight management, and smoking cessation
- ✓ Prevent or reduce the need for potentially avoidable hospitalizations, emergency department visits, etc.

Medicare Spending Per Beneficiary (MSPB) Clinician

Measure Availability

- ✓ Traditional MIPS
- ✓ Advancing Care for Heart Disease MVP
- ✓ Focusing on Women's Health MVP
- ✓ Optimal Care for Patients with Episodic Neurological Conditions
- ✓ Optimal Care for Patients with Urologic Conditions MVP
- ✓ Patient Safety and Support of Positive Experiences with Anesthesia MVP
- ✓ Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP
- ✓ Quality Care in Mental Health and Substance Use Disorder MVP
- ✓ Surgical Care MVP

Measure Type

Population-Based

Measure Summary

The MSPB Clinician measure assesses the cost to Medicare of services provided to a patient during the period immediately prior to, during, and following the patient's hospital stay. Read the Measure Information Form.

Commonly Attributed Clinicians

- ✓ Internal Medicine
- ✓ Family Practice
- ✓ Emergency Medicine

Clinician or group must be attributed to 35 qualifying episodes.

Example Opportunities to Improve Cost Performance

- ✓ Use team-based discharge planning or decision support tools to discharge patients at the appropriate time
- ✓ Communicate clearly and effectively with other clinicians after handoffs to improve post-discharge care coordination
- ✓ Reduce overuse of post-acute care by ensuring timely follow-up within 30 days post-discharge

Diabetes

Measure Availability

- ✓ Traditional MIPS
- ✓ Value in Primary Care MVP

Measure Type

Chronic Condition, Episode-Based

Measure Summary

The Diabetes measure assesses the cost of care to Medicare for patients who receive medical care to manage and treat type 1 or type 2 diabetes. Read the Measure Information Form.

Commonly Attributed Clinicians

- ✓ Internal Medicine
- ✓ Family Practice
- ✓ Nurse Practitioner

Clinician or group must be attributed to 20 qualifying episodes.

Example Opportunities to Improve Cost Performance

- ✓ Conduct comprehensive diabetes medical evaluations and assessment of comorbidities
- ✓ Manage or refer patients to care for comorbidities, like obesity, cardiovascular disease, chronic kidney disease, and retinopathy/neuropathy
- ✓ Set glycemic goals with patients, prescribe diabetes management medications, and monitor their A1C in line with clinical practice guidelines
- ✓ Promote positive health behaviors, like diabetes self-management and smoking cessation
- ✓ Prevent or reduce the severity of complications like diabetic ketoacidosis, foot ulcers, amputations, and cardiovascular events

Sepsis

Measure Availability

- ✓ Traditional MIPS

Measure Type

Acute Condition, Episode-Based

Measure Summary

The Sepsis measure assesses the cost of care to Medicare for patients who receive inpatient medical treatment for sepsis. Read the Measure Information Form.

Commonly Attributed Clinicians

- ✓ Internal Medicine
- ✓ Hospitalist
- ✓ Infectious Disease

Clinician or group must be attributed to 20 qualifying episodes.

Example Opportunities to Improve Cost Performance

- ✓ Improve early sepsis screening and recognition to prevent more severe forms of sepsis and related complications
- ✓ Follow clinical guidelines for administering antibiotics and fluid resuscitation
- ✓ Screen for common and treatable post-sepsis impairments (e.g., functional disability, swallowing impairment, mental health impairment) and treatable conditions that commonly result in readmission (e.g., infection, heart failure, renal failure) to reduce post-discharge costs
- ✓ Review and adjust long-term medication for appropriateness to post-discharge patients

Screening/Surveillance Colonoscopy

Measure Availability

- ✓ Traditional MIPS
- ✓ Gastroenterology MVP

Measure Type

Procedural, Episode-Based

Example Opportunities to Improve Cost Performance

- ✓ Educate patients on proper bowel preparation to reduce the potential for missed lesions, canceled procedures, repeat procedures, longer procedure times, and adverse events
- ✓ Follow clinical guidelines for using sedation methods to prevent interruption and premature termination of the colonoscopy
- ✓ Prevent adverse events associated with colonoscopy by following clinical guidelines to remove or biopsy polyps

Measure Summary

The Screening/Surveillance Colonoscopy measure assesses a clinician's risk-adjusted cost to Medicare for patients who undergo a screening or surveillance colonoscopy. Read the Measure Information Form.

Commonly Attributed Clinicians

- ✓ Gastroenterology
- ✓ General Surgery
- ✓ Colorectal Surgery

Clinician or group must be attributed to 10 qualifying episodes.

THE BASICS
Cost Measures in MVPs

Cost Measures in MIPS Value Pathways

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 PCI • TPCC • Heart Failure • MSPB Clinician
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP	• Emergency Medicine
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

Cost Measures in MIPS Value Pathways (Continued)

MVP	Cost Measure(s) Assessed
Value in Primary Care MVP	• Asthma/COPD • Diabetes • Depression • Heart Failure • TPCC
Focusing on Women's Health MVP	• MSPB Clinician • TPCC
Quality of Care for the Treatment of Ear, Nose and Throat Disorders MVP	• MSPB Clinician
Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP	• TPCC
Quality Care in Mental Health and Substance Use Disorders MVP	• MSPB Clinician • Depression • Psychoses and Related Conditions
Rehabilitative Support for Musculoskeletal Care MVP	• Low Back Pain

THE DETAILS
Cost Measures

Overview of Cost Measures

There are 29 total cost measures for the 2024 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)

Overview of Cost Measures (continued)

There are 29 total cost measures for the 2024 performance period.

Measure Name/Type	Description	Case Minimum	Data Source
5 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
1 measure focusing on care provided in the emergency department setting (Emergency Medicine)	Evaluates a clinician's risk-adjusted cost to Medicare for patients who have an emergency department (ED) visit during the performance period.	20 episodes	Medicare Parts A and B claims data

Episode-Based Cost Measures

There are 27 MIPS Episode-Based Cost Measures available in the 2024 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
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

Note: The Acute Kidney Injury Requiring New Inpatient Dialysis measure will not be calculated or scored for the CY 2024 performance period/2026 MIPS payment year. For more information, please see the 2024 MIPS Cost Measure Exclusion Fact Sheet.

Episode-Based Cost 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:
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
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

Episode-Based Cost 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:
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
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
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 IOL implantation during the performance period.	ASCs and HOPDs
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
Emergency Medicine	Care Setting	• Pre-Trigger Window: 0 days • Post-Trigger Window: 14 days	Patients who have emergency department (ED) visit during the performance period.	Emergency department

Episode-Based Cost 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:
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-Trigger 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
Psychoses and Related Conditions	Acute inpatient medical condition	• Pre-Trigger Window: 0 days • Post-Trigger Window: 45 days	Patients who receive inpatient treatment for psychoses or related conditions during the performance period.	Acute IP hospitals and inpatient psychiatric facilities (IPFs)
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

Episode-Based Cost Measures (Continued)

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk Adjusted and Specialty Adjusted Cost to Medicare for:	Measures Can Be Triggered Based on Claims Data from the Following Settings:
Diabetes	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days • Maximum Episode Window: 729 days	Patients who receive medical care to manage and treat diabetes during the performance period.	Offices, skilled nursing facilities (SNFs), and OP hospitals
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days • Maximum Episode Window: 729 days	Patients who receive medical care to manage and treat asthma or COPD during the performance period.	Offices, SNFs, and OP hospitals
Depression	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days • Maximum Episode Window: 729 days	Patients receiving medical care to manage and treat depression during the performance period.	Offices, nursing facilities, SNFs, and OP hospitals
Heart Failure	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 365 days • Maximum Episode Window: 729 days	Patients receiving medical care to manage and treat heart failure during the performance period.	Offices, OP hospitals, and SNFs
Low Back Pain	Chronic condition	• Pre-Trigger Window: 0 days • Minimum Episode Window: 120 days • Maximum Episode Window: 484 days	Patients receiving medical care to manage and treat low back pain during the performance period.	Offices, OP hospitals, and ASCs

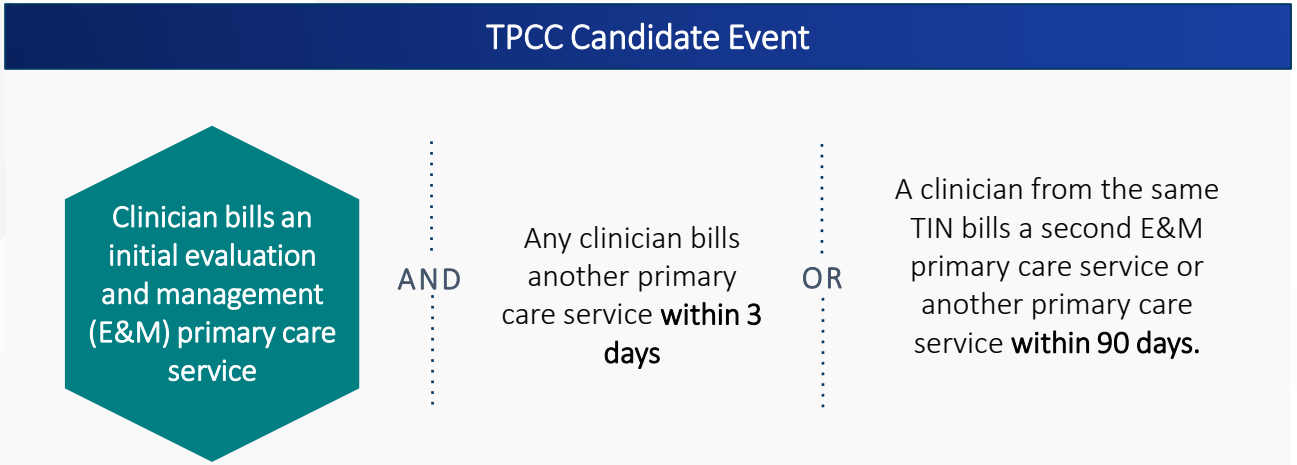
THE DETAILS
Measure Attribution

TPCC Measure Attribution

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).

TPCC Measure Attribution

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

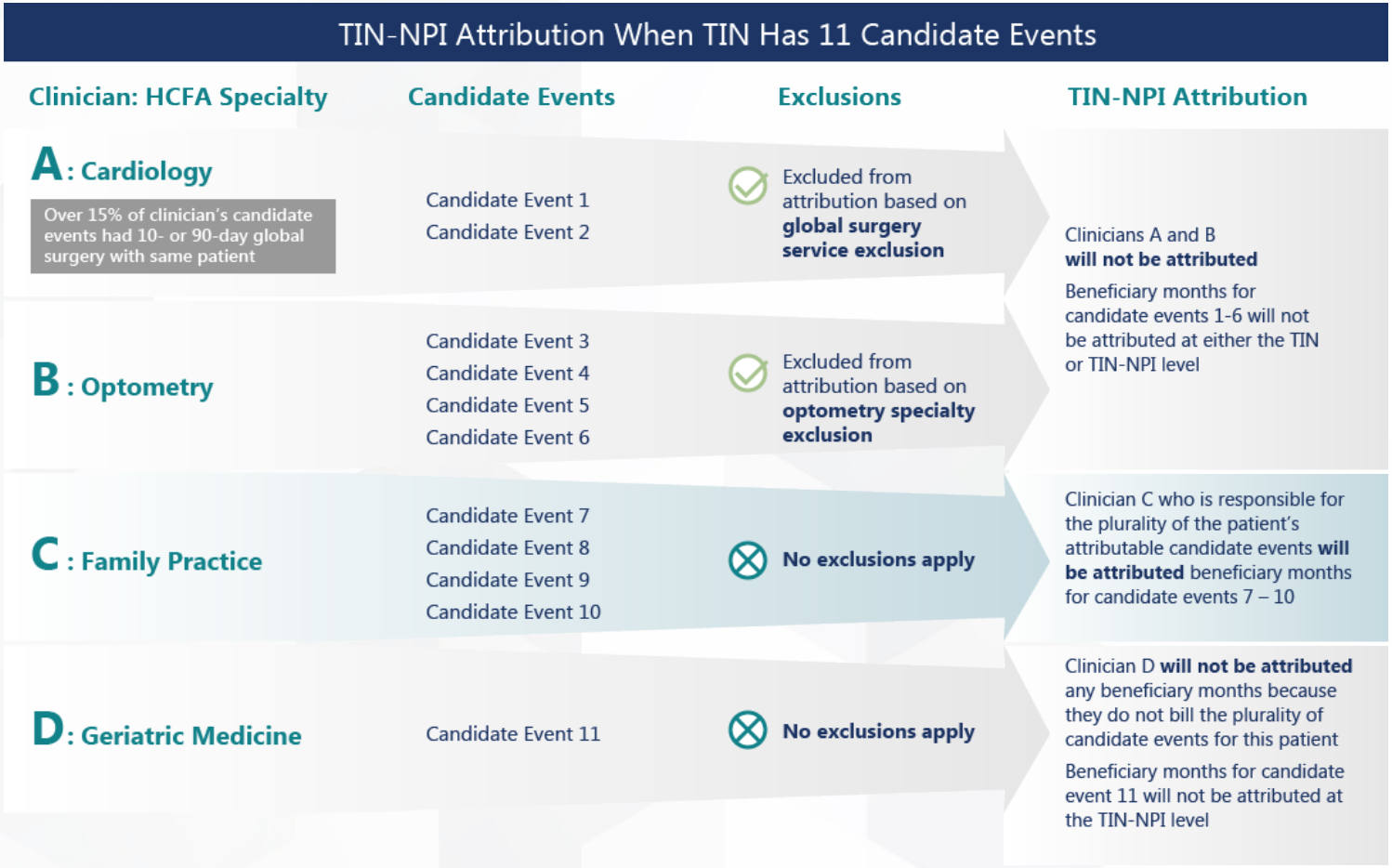
OR

Are designated as 1 or more of the 56 specialties unlikely to be responsible for primary care services (ex. dermatology)

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

TPCC Measure Attribution

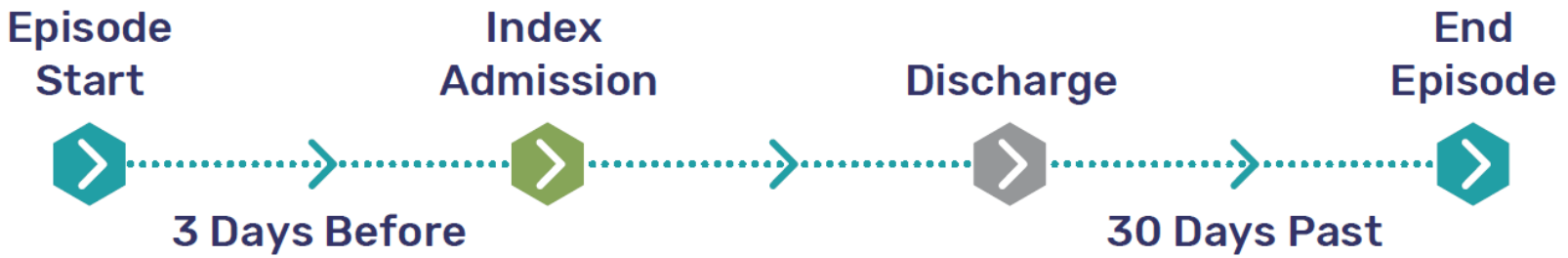
TPCC Measure Attribution



MSPB-Clinician Measure Attribution

MSPB Clinician Attribution

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

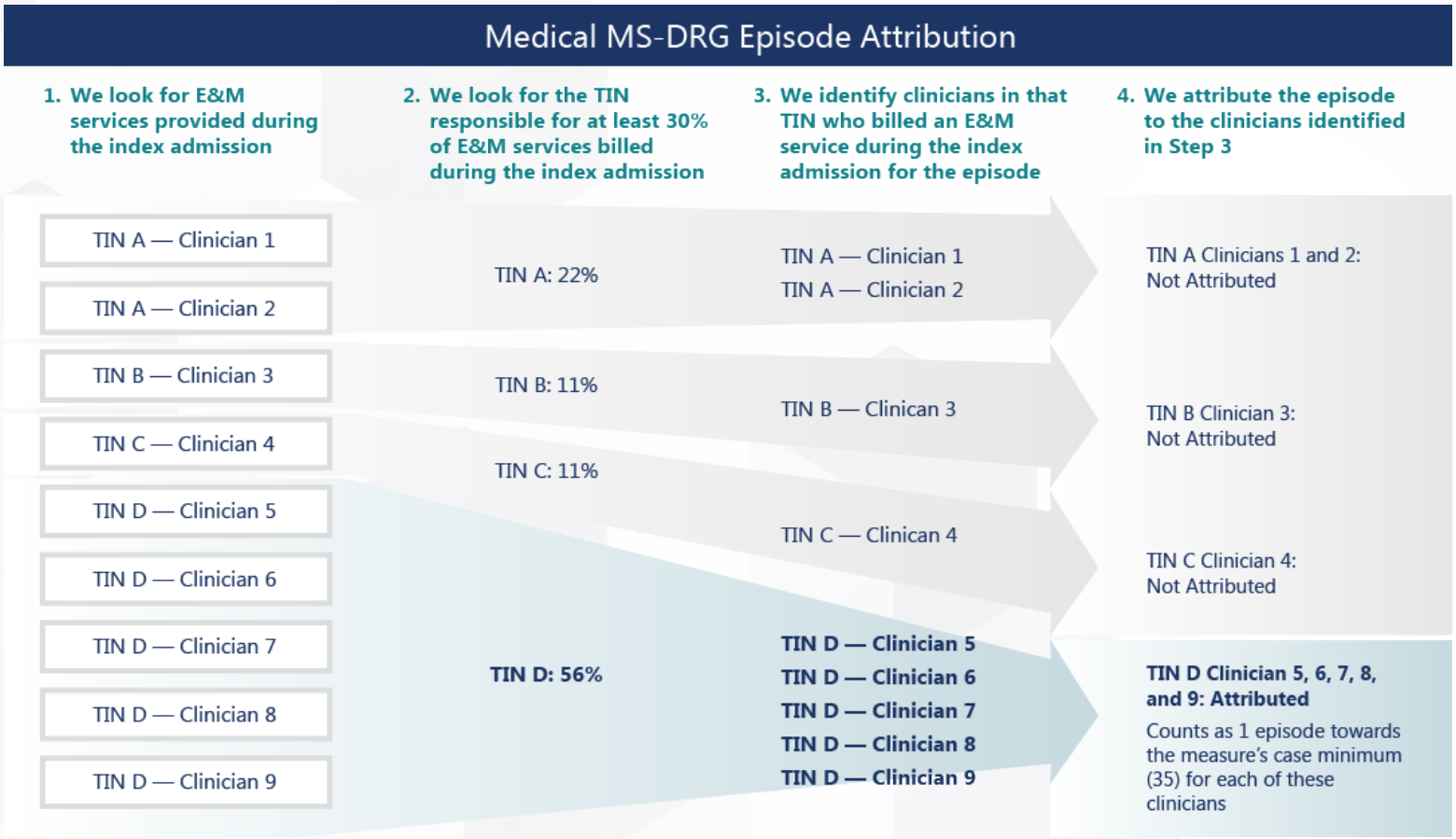


MSPB Clinician episodes are classified as either medical or surgical, based on the Medicare Severity-Diagnosis Related Group (MS-DRG) of the index admission.

- 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.

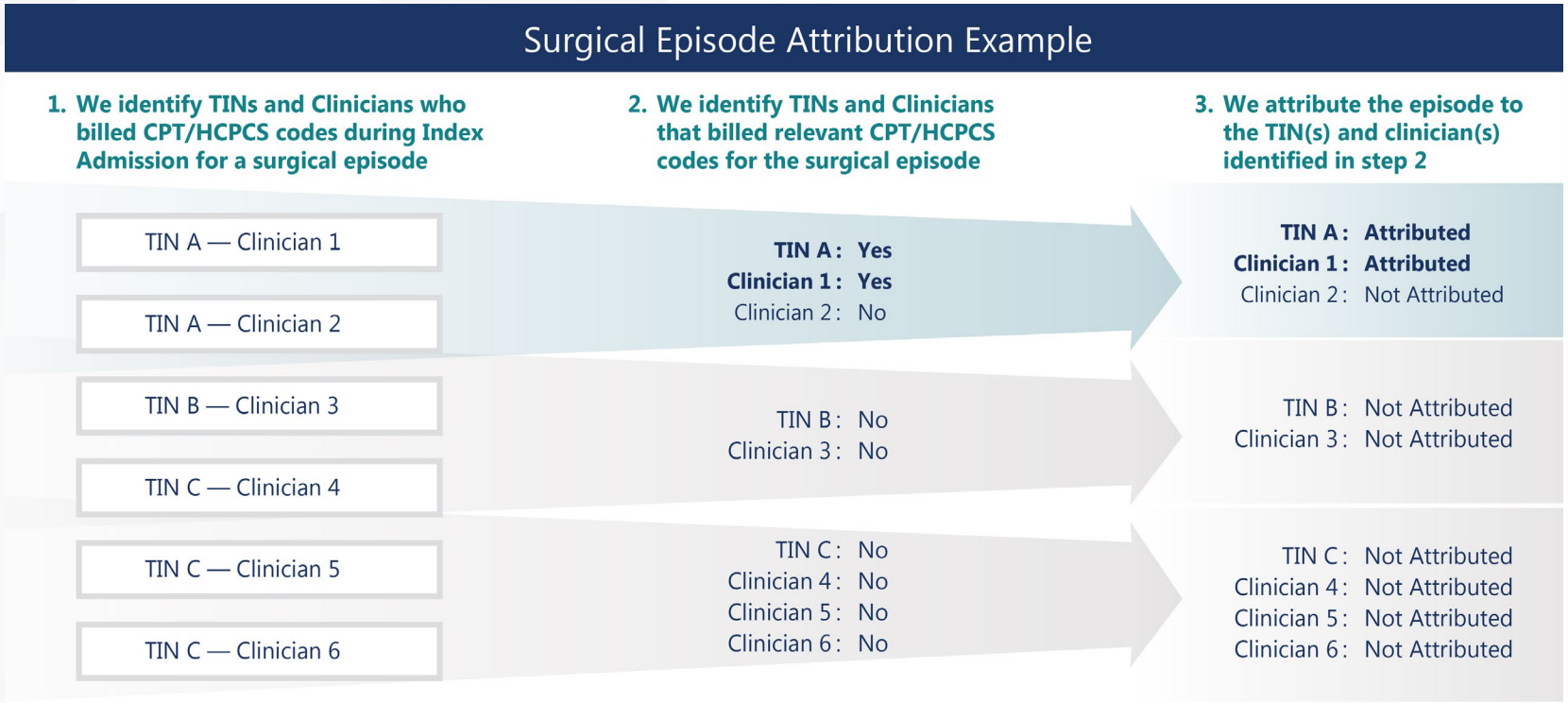
MSPB-Clinician Measure Attribution

MSPB Clinician: Medical Episode Attribution Example



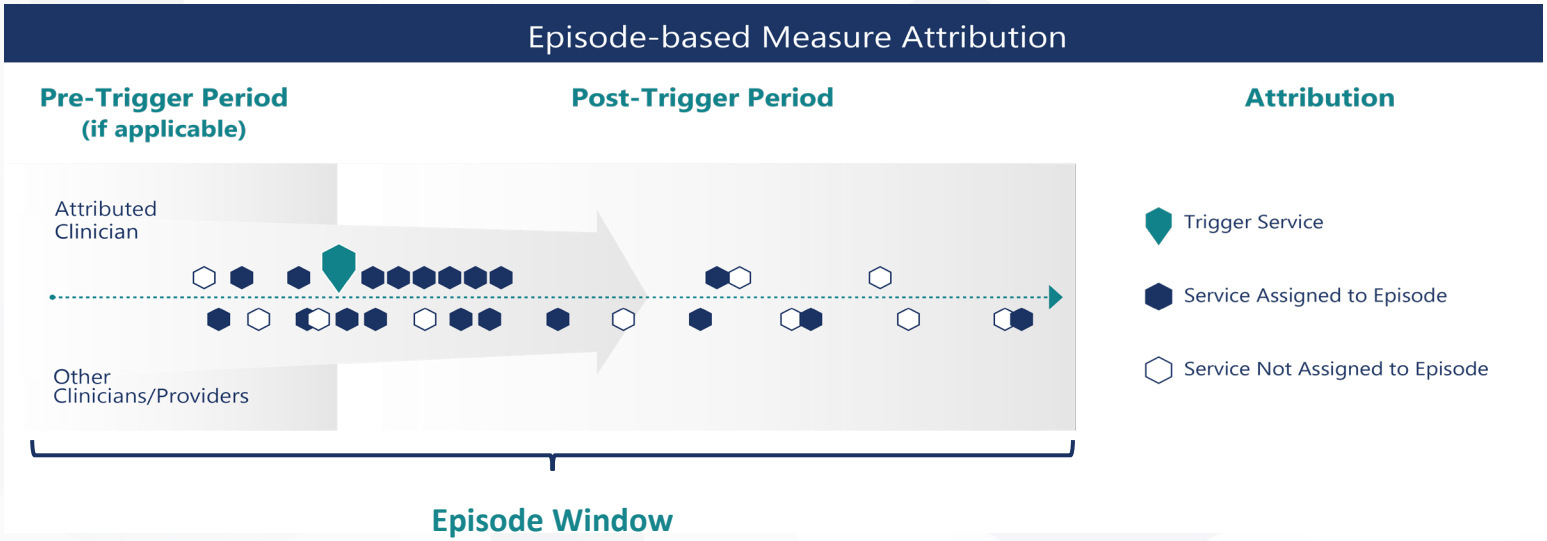
MSPB-Clinician Measure Attribution (Continued)

MSPB Clinician: Surgical Episode Attribution Example



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.



Episode-Based Measure Attribution (Continued)

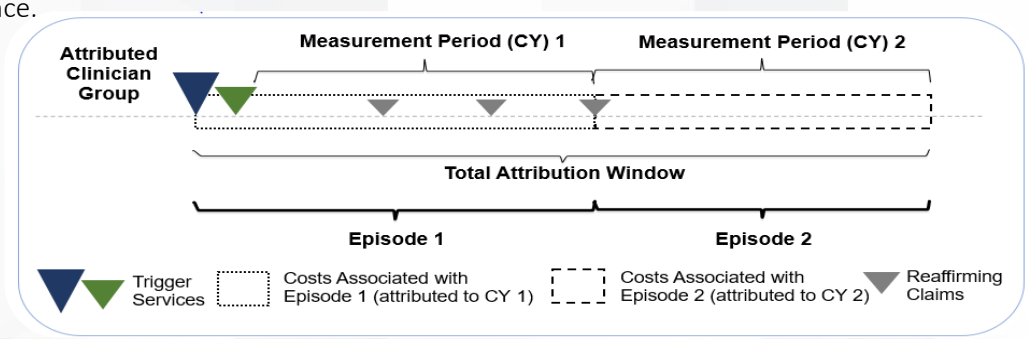
For chronic condition episode-based measures:

- 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 two 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. We apply two checks to ensure clinician groups are involved in the patient's care:
    - A clinician within the group has provided care to a patient prior to or on the episode start date.
    - At least one clinician within the group has written at least 2 condition-related prescriptions on different days to 2 different patients during the performance period plus a one-year lookback period in measures where the use of prescriptions is informative about the nature of care that the clinician provides.
- 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.

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.



Episode-Based Measure Attribution (Continued)

For the **Emergency Medicine** measure, the steps for attributing an Emergency Medicine episode are as follows:

- Identify claim lines with positive standardized payment for any trigger codes that occur on the episode trigger day.
- Attribute an episode to any Tax Identification Number (TIN)-National Provider Identifier (NPI) billing the trigger codes.
- Attribute episodes to the TIN by aggregating all episodes attributed to NPIs that bill to that TIN. If the same episode is attributed to more than one NPI within a TIN, the episode is attributed only once to that TIN.

THE DETAILS
Measure Calculation

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.

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.

Procedural and Acute Inpatient Medical Condition Episode-Based Measure Calculation

Step	Description/Additional Information
1. Trigger and define an episode (for the Emergency Medicine measure: Trigger an Episode and Define an ED Visit)	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 (for the Emergency Medicine measure: Exclude Clinically Unrelated Services to Calculate 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. Estimate Expected Costs through Risk Adjustment	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.

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.

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.

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.

Measure Scores: Assigning Points

Once a measure's score is calculated, it's assigned between 1 and 10 points based on the measure's score in comparison to the measure's benchmark. Once all cost measures have been scored, we calculate a score for the cost performance category.

For more information on MIPS cost scoring, refer to the following resources:

- Pages 39 – 50 of the 2024 Traditional MIPS Scoring Guide (PDF).
- Pages 45 – 51 of the 2024 MVPs Implementation Guide (PDF).

Help, Acronyms, and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating 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.

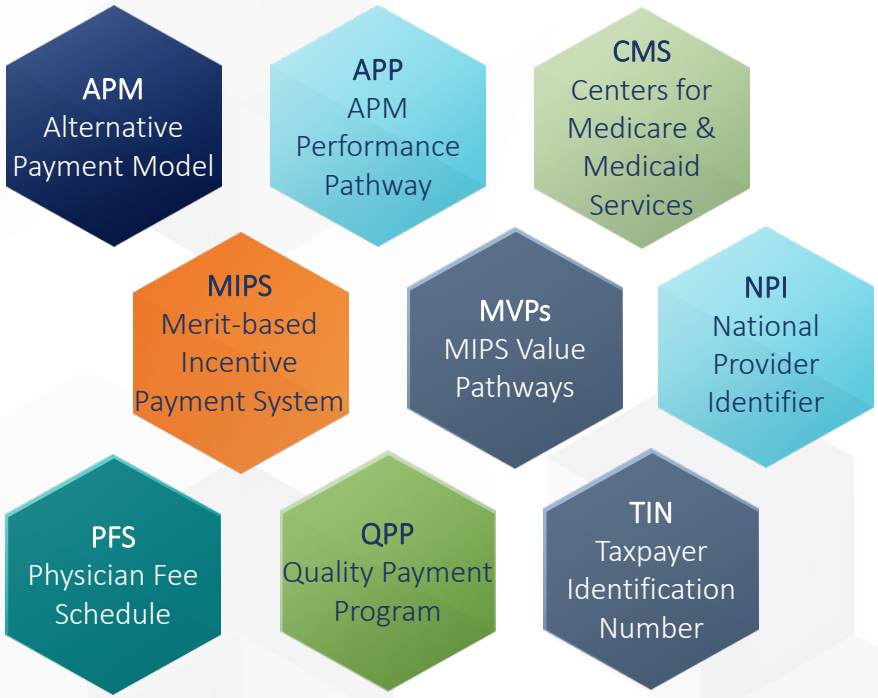
- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

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.

Visit the Small Practices page of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

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.

Acronyms


APM
Alternative Payment Model
APP
APM Performance Pathway
CMS
Centers for Medicare & Medicaid Services
MIPS
Merit-based Incentive Payment System
MVPs
MIPS Value Pathways
NPI
National Provider Identifier
PFS
Physician Fee Schedule
QPP
Quality Payment Program
TIN
Taxpayer Identification Number

Version History

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

DATE	DESCRIPTION
8/22/2025	Original Posting.