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Introduction to MIPS Cost Performance Category

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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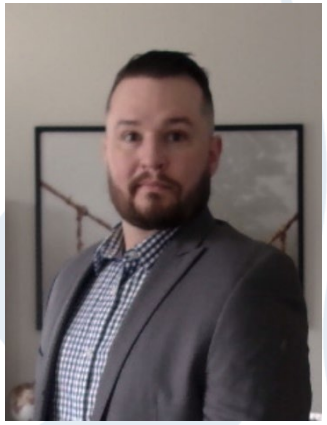

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Section 1A: Introduction to MIPS Cost Measures

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

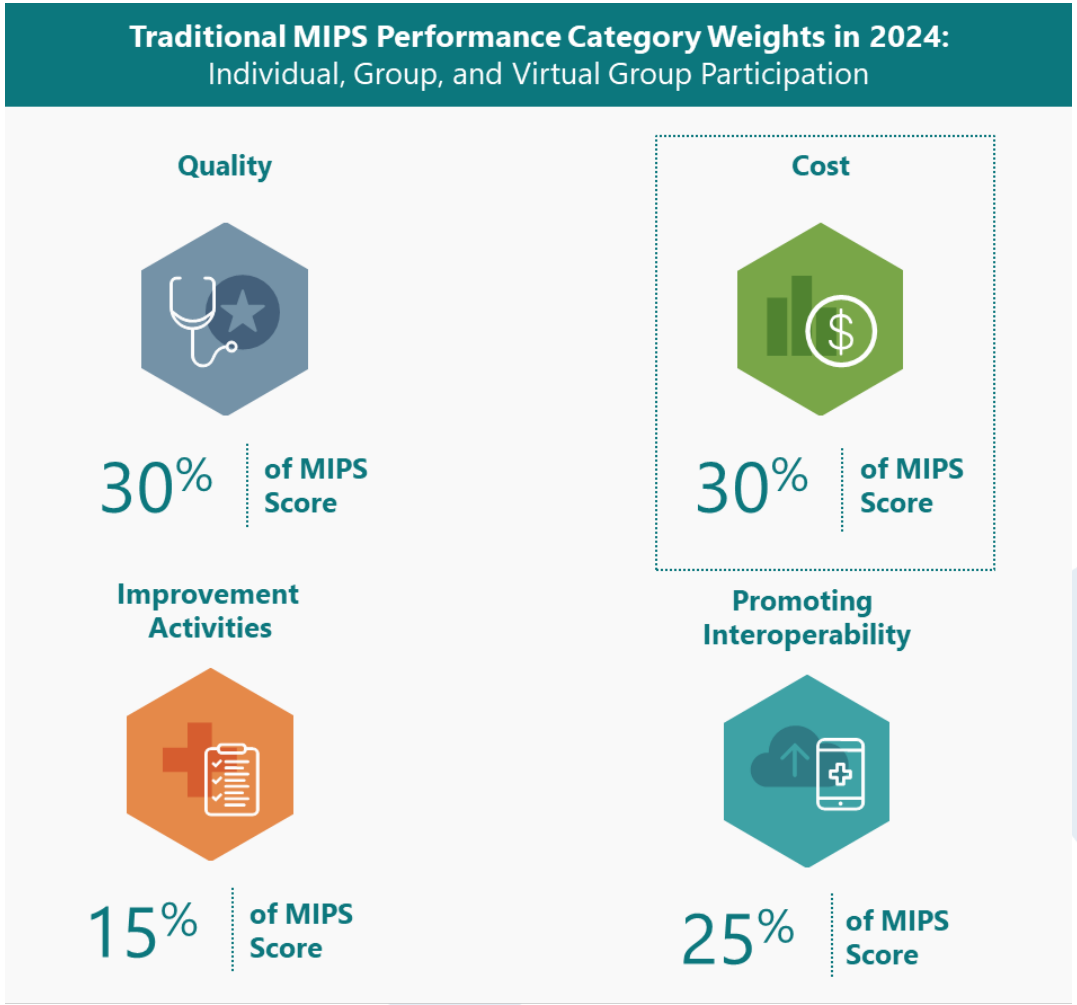
MIPS is one way to participate in the Quality Payment Program (QPP), a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The program **rewards MIPS eligible clinicians for providing high value care** to their patients by reimbursing Medicare Part B-covered professional services.

Under MIPS, CMS **evaluates performance across multiple categories** that drive improved quality and value in our healthcare system.

What is the MIPS Cost Performance Category?

- 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.
- CMS uses Medicare administrative claims data to calculate cost measure performance.



2024 Cost Quick Start Guide

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Who Provides Input on Cost Measure Development?

Technical Expert Panel (TEP)

20-member panel with diverse and balanced perspective on measure development

- Includes members affiliated with specialty societies, academia, healthcare administration, and with lived experience
- Provides overarching guidance, such as principles for measure selection, framework, and statistical methods

Clinical Expert Workgroups

Panels of ~15 experts per measure with clinical experience relevant to each measure

- Provide input to build out specifications for each episode-based cost measure
- Review empirical analyses to iteratively test measure construction

Person & Family Engagement (PFE)

Individuals with lived experience of medical conditions and procedures

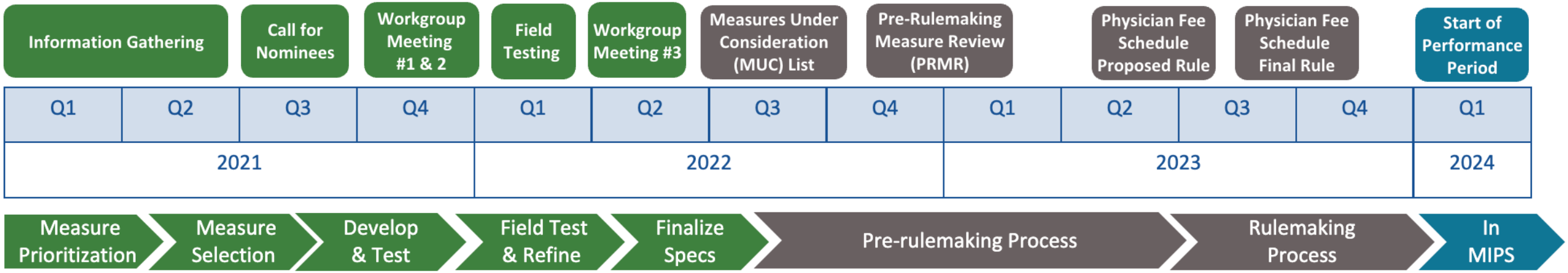
- Provides input to ensure that measures can capture care that is important to patients
- Highlights aspects of care experience that could have been improved

All Interested Parties

Members of the public, specialty societies, professional organizations

- Provides input on which measures to develop
- Participates in national field testing period by sharing feedback on draft specifications, including a public comment period
- Submit public comments via the pre-rulemaking and rulemaking processes
- Share feedback on the measures in use in MIPS

What is the Process to Develop and Add Cost Measures to MIPS?
2024 Newly Added Cost Measures Example



Episode-Based Cost Measure Development Process
2024 MIPS Annual Call for Cost Measures Fact Sheet

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What Cost Measures are Currently in Use in MIPS?

Measure Name/Type	Description
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.
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.
15 procedural episode-based measures	Assess the cost of care that's clinically related to a specific procedure provided during an episode's timeframe.
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.
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.
1 measure focusing on care provided in the emergency department setting	Evaluates a clinician's risk-adjusted cost to Medicare for patients who have an emergency department (ED) visit during the performance period.

Explore MIPS Cost Measures

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Section 1B: Understanding MIPS Cost Measures

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How Are Episode-Based Cost Measure Scores Calculated?

1. Identify patient-clinician relationship (“trigger” logic)
2. Define a period of measurement (“episode”)
3. Determine which clinicians and groups will be scored on episodes (“attribution”)
4. Calculate costs of clinically-related services (“service assignment”)
5. Exclude episode and apply risk adjustment to enable comparisons
6. Determine average cost per episode/beneficiary ($)

Step 1: Identify Patient-Clinician Relationship ("Trigger Event")

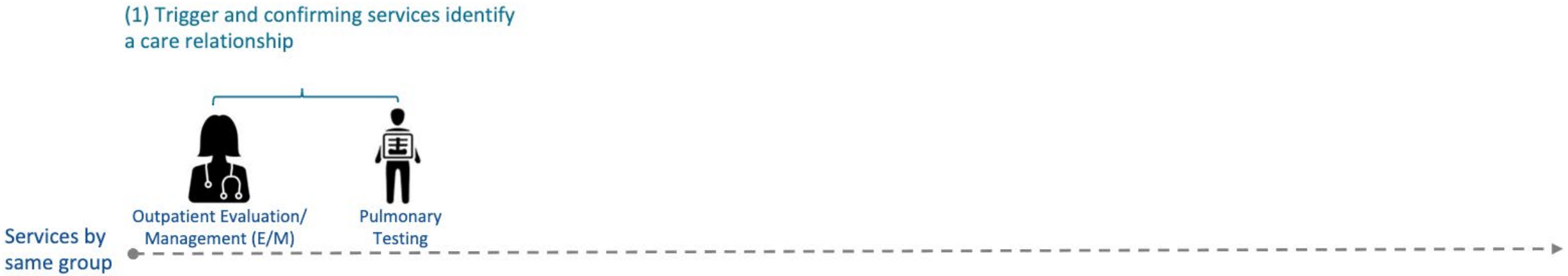
Acute and Procedural Measures

- A hospitalization or procedure

Chronic Condition Measures

- A pair of services (trigger and confirming claims) with a relevant diagnosis, billed by the same group practice within 1 and 180 days

Step 1: Identify Patient-Clinician Relationship ("Trigger Event")
Chronic Asthma/COPD Example



The Chronic Asthma/COPD episode-based cost measure assesses costs related to the management and treatment of asthma and chronic obstructive pulmonary disease (COPD). Episodes are triggered by outpatient visits, pulmonary testing, and administration of respiratory drugs with a diagnosis code for asthma or COPD.

Step 2: Define a Period of Measurement (“Episode”)

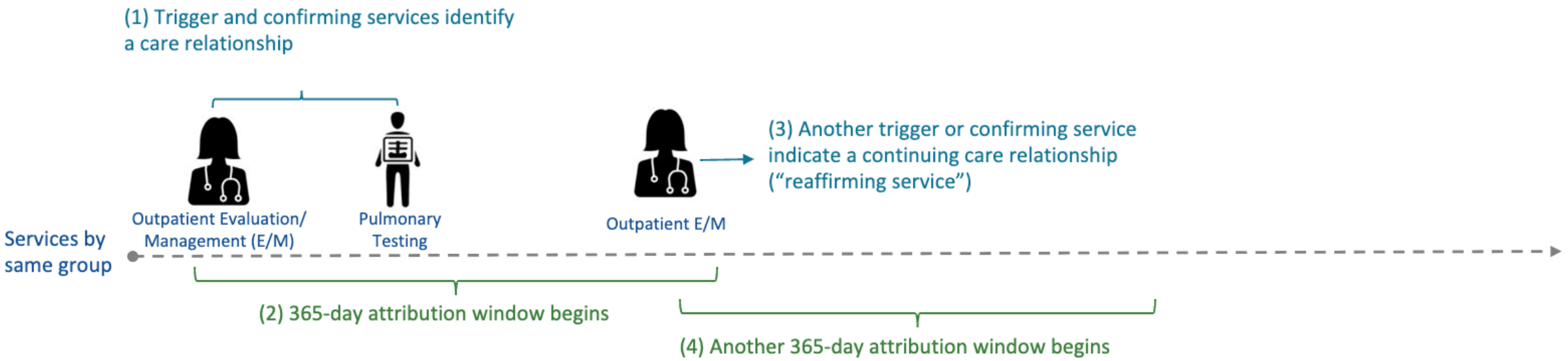
Acute and Procedural Measures

- Defined start and end point based around the date of the procedure or hospitalization

Chronic Condition Measures

- Starts with “trigger event” and may be extended if there is continued evidence of a care relationship (“reaffirming claims”)
- Divided into distinct episodes that can be measured in MIPS

Step 2: Define a Period of Measurement
Chronic Asthma/COPD Example



Asthma/COPD episodes are at least 365 days (one year), and no longer than 729 days (two years minus one day), which allows episodes to be included in the performance period in which they end.

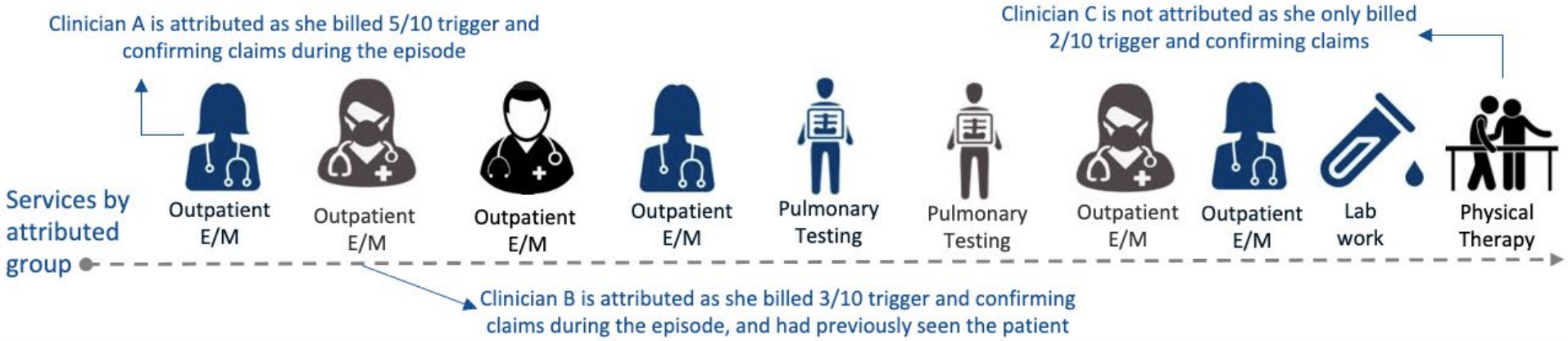
Step 3: Attribute Episodes to Clinicians and Groups

Measure Type	Clinician Group	Individual Clinician
Acute	Attribute to group(s) that provided at least 30% of E/Ms during hospitalization	Within attributed group, attribute episode to clinicians who provided at least one E/M during hospitalization
Procedural	Attribute episode to group to which attributed clinician(s) belongs	Attribute to clinician(s) performing the procedure
Chronic	Attribute episode to group that billed trigger and confirming claim	Within attributed group, attribute episode to clinician(s) who billed at least 30% of trigger/confirming claims

Specific measures may have additional attribution requirements.

Step 3: Attribute Episodes to Clinicians and Groups
Chronic Asthma/COPD Example

- Within attributed group, attribute episode to the clinician(s) who billed at least 30% of trigger/confirming claims, as long as clinician provided condition-related care to this patient prior to or on the episode start date

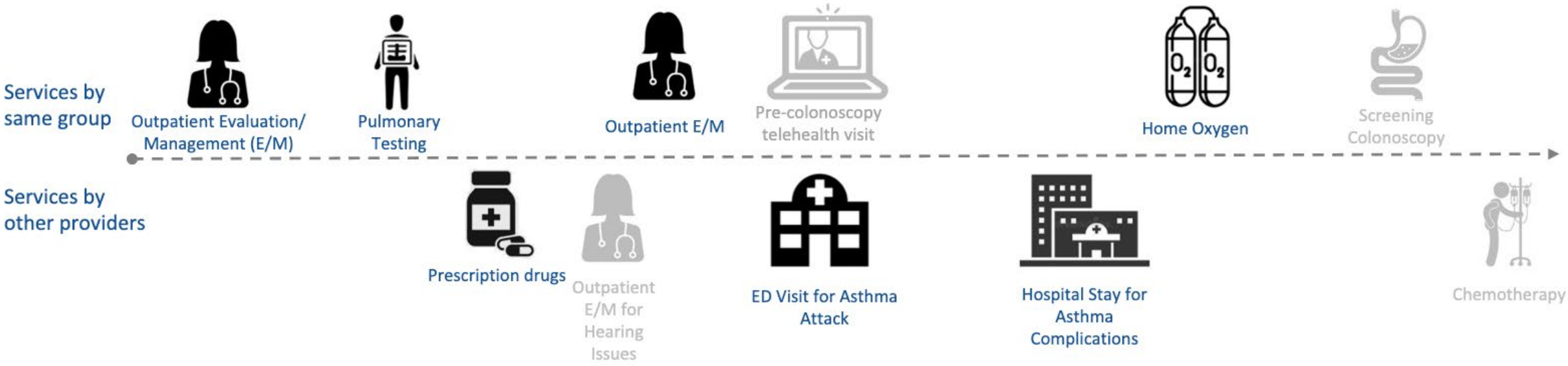


For some measures, including Chronic Asthma/COPD, clinicians must have prescribed at least 2 condition-related medications to 2 different patients during the current plus prior performance period

Step 4: Calculate the Costs of Clinically Related Services

- Clinically related services include treatment, monitoring, complications, and other services where the attributed clinician has reasonable influence on:
  - Occurrence
  - Frequency
  - Intensity
- Costs are payment standardized to remove variation due to geographic region, etc.
- Sum the cost of all assigned services and scale/annualize; this is the episode observed cost

Step 4: Calculate the Costs of Clinically Related Services
Chronic Asthma/COPD Example



This measure includes costs like asthma/COPD office visits, nebulizers and home oxygen, pulmonary imaging, home health, physical/occupational therapy, pulmonary rehabilitation and complications (e.g., ED visit for asthma attack).

Step 5: Exclude Episodes and Apply Risk Adjustment

- Apply exclusions to remove certain episodes from measure calculation
- If applicable, stratify episodes into “sub-groups”
- Estimate the episode’s (annualized) expected cost through risk adjustment
  - Risk adjustment accounts for patient and other risk factors outside of the clinician’s control
  - This includes many variables such as those from the CMS-HCC model, reason for enrollment, interaction terms, age brackets, and other factors

Step 5: Exclude Episodes and Apply Risk Adjustment
Chronic Asthma/COPD Example

Measure Specification Step	Purpose	Chronic Asthma/COPD Examples
Exclusions	Extreme variability for a small set of patients that is not susceptible to performance improvement and cannot be addressed through risk adjustment or service assignment	• Cystic fibrosis • Interstitial pulmonary fibrosis • Prior lung cancer, surgery, or transplant
Sub-groups	Characteristic has distinct effects on cost across all risk adjustors	• Asthma • COPD • Both Asthma and COPD
Risk adjustment	Patient factor affect costs and is outside the influence of the attributed providers	• CMS HCC Model • Recent Asthma/COPD hospitalization or ED visit • History of smoking

Step 6: Determine Average Cost Per Episode/Beneficiary ($)

- First, we calculate the **episode ratio (episode O/E)** as predicted through risk adjustment, for each episode attributed to a provider
  - Episode observed cost: Sum of all payment-standardized clinically related costs during the episode (O)
  - Episode expected cost: Predicted episode cost based on risk adjustment model (E)
  - The ratio of an episode's observed cost to expected cost is the episode ratio (episode O/E)
- Second, we determine the **ratio across all episodes attributed to a provider (average O/E)** and ending in the applicable performance period
- Third, we determine the **average cost per episode/beneficiary ($)**

Step 6: Determine Calculated Cost per Episode ($)
Chronic Asthma/COPD Example

Episode 1	Episode 2	Episode 3	Episode 4
Calculate winsorized scaled standardized observed cost of each episode			
$10,000	$9,000	$12,000	$15,000
Calculate scaled expected cost of each episode			
$10,000	$12,000	$8,000	$9,000
Calculate winsorized scaled observed / scaled expected cost ratio for each episode			
$\frac{\$10,000}{\$10,000} = 1$	$\frac{\$9,000}{\$12,000} = 0.75$	$\frac{\$12,000}{\$8,000} = 1.5$	$\frac{\$15,000}{\$9,000} = 1.67$
Sum the weighted cost ratios for all episodes, where the weighting factor is the number of assigned days to each episode			
1×365 +	0.75×500 +	1.5×365 +	1.67×270
= 1,738.4			
Divide by the total number of assigned days across all four episodes			
$\frac{1,738}{365 + 500 + 365+270} = \frac{1,738}{1,500} = \mathbf{1.16}$			
Multiply by the national average winsorized scaled observed cost for all episodes nationally			
$1.16 \times \$12,000 = \$13,920$			

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Section 2A: Cost Measure Scoring

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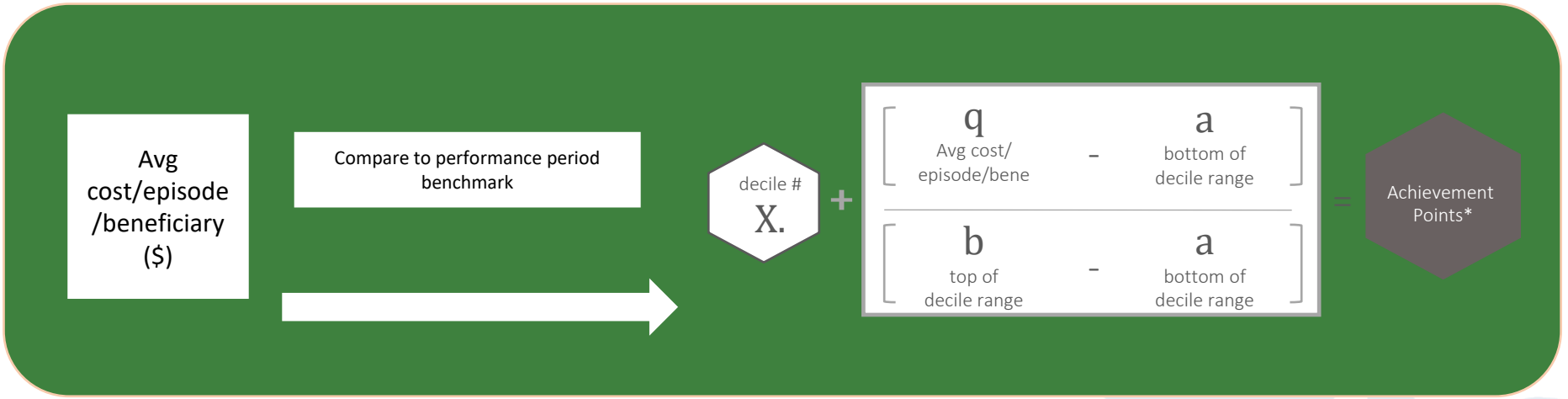
How are Traditional MIPS Cost Measures Scored?

Cost Measure Scoring



Partial achievement points are awarded to scored measures according to the following formula:

$$\frac{\text{Total achievement points earned for scored measures}}{\text{Total available measure achievement points (\# of scored measure x 10)}} = \text{Cost Performance Category Score (\%)}$$

*Achievement points is referred to as "Measure Score" in the QPP Feedback Report

Scoring Example

Dr. Cynthia Clark

- Dr. Clark was scored in traditional MIPS on 2 out of the 25 available cost measures. Each scored measure is eligible to receive a maximum of 10 points. So, 20 achievement points are available to her.
- The two cost measures she scored on are Medicare Spending Per Beneficiary (MSPB) and Acute Kidney Injury Requiring New Inpatient Dialysis.
- **Dr. Clark's average cost per episode ($) for *Acute Kidney Injury Requiring New Inpatient Dialysis* is $37,123**
- **Dr. Clark's average cost per beneficiary ($) for Medicare Spending Per Beneficiary (*MSPB*) is $22,789**

$37,123 is compared to the benchmark, and a decile # is obtained. In this case, it's decile 9

$$\text{decile \#} + \left[\frac{q - a}{b - a}\right] = \text{Achievement Points*}$$

where q = Avg cost/episode/bene, a = bottom of decile range, b = top of decile range

$$9 + \left[\frac{\$37{,}123 - \$38{,}313}{\$35{,}464 - \$38{,}313}\right] = 9.4178$$

With the same scoring calculation, Dr. Clark received 7.8556 achievement points for the MSPB measure

*Achievement points is referred to as "Measure Score" in the QPP Feedback Report

Scoring Example - Continued

Dr. Cynthia Clark

- Dr. Clark's cost performance category score is 86.367%
- The cost performance category contributes up to 30 points towards Dr. Clark's MIPS final score
- Dr. Clark earned 25.9101 points towards her MIPS final score from the cost performance category

Cost Performance Category Score

86.367 % =

$$\frac{9.4178 + 7.8556}{20}$$

Total contribution to final score

25.9101 =

86.367% X 30 points

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Section 2B: Cost Measure Feedback Report - Demonstration

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Section 3A: Q&A

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Section 3B: Additional Resources

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Where Can I Find the Cost Measure Specifications?

Measure Information Form

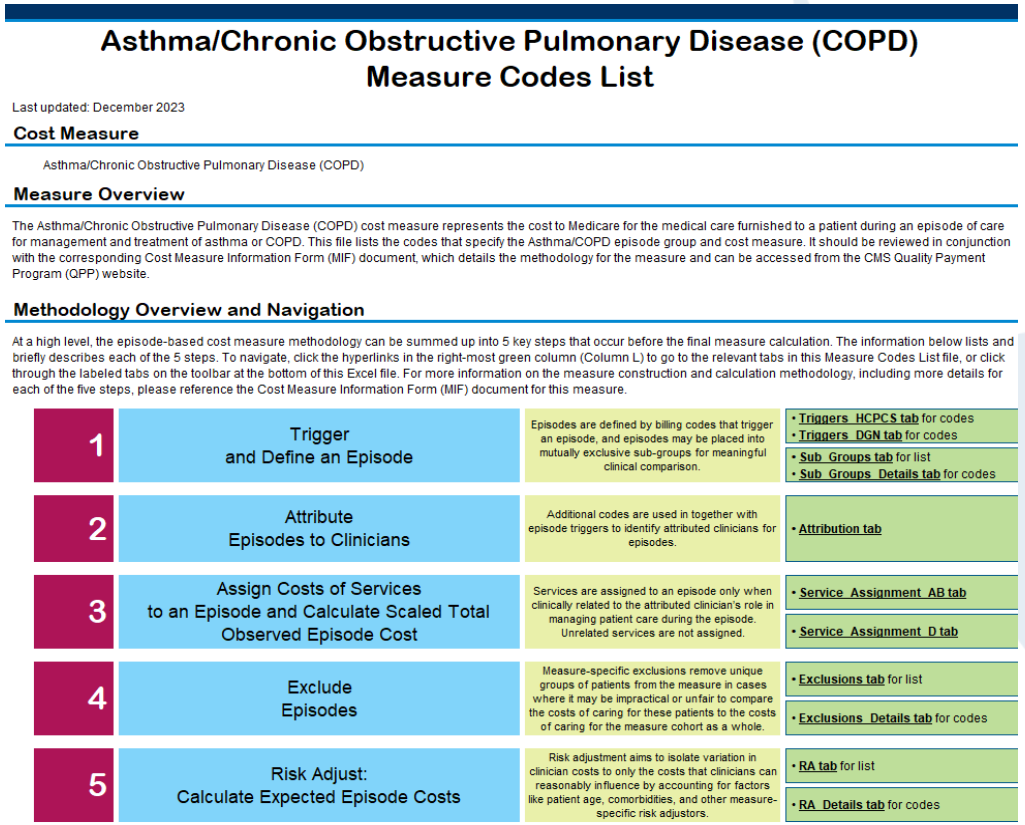
Asthma/Chronic Obstructive Pulmonary Disease (COPD) Measure

Merit-based Incentive Payment System (MIPS): Measure Information Form (MIF)

2024 Performance Period

[QPP Resource Library]

Measure Codes List



Asthma/Chronic Obstructive Pulmonary Disease (COPD) Measure Codes List

Last updated: December 2023

Cost Measure

Asthma/Chronic Obstructive Pulmonary Disease (COPD)

Measure Overview

The Asthma/Chronic Obstructive Pulmonary Disease (COPD) cost measure represents the cost to Medicare for the medical care furnished to a patient during an episode of care for management and treatment of asthma or COPD. This file lists the codes that specify the Asthma/COPD episode group and cost measure. It should be reviewed in conjunction with the corresponding Cost Measure Information Form (MIF) document, which details the methodology for the measure and can be accessed from the CMS Quality Payment Program (QPP) website.

Methodology Overview and Navigation

At a high level, the episode-based cost measure methodology can be summed up into 5 key steps that occur before the final measure calculation. The information below lists and briefly describes each of the 5 steps. To navigate, click the hyperlinks in the right-most green column (Column L) to go to the relevant tabs in this Measure Codes List file, or click through the labeled tabs on the toolbar at the bottom of this Excel file. For more information on the measure construction and calculation methodology, including more details for each of the five steps, please reference the Cost Measure Information Form (MIF) document for this measure.

1	Trigger and Define an Episode	Episodes are defined by billing codes that trigger an episode, and episodes may be placed into mutually exclusive sub-groups for meaningful clinical comparison.	• Triggers_HCPCS tab for codes • Triggers_DGN tab for codes • Sub_Groups tab for list • Sub_Groups_Details tab for codes
2	Attribute Episodes to Clinicians	Additional codes are used in together with episode triggers to identify attributed clinicians for episodes.	• Attribution tab
3	Assign Costs of Services to an Episode and Calculate Scaled Total Observed Episode Cost	Services are assigned to an episode only when clinically related to the attributed clinician's role in managing patient care during the episode. Unrelated services are not assigned.	• Service_Assignment_AB tab • Service_Assignment_D tab
4	Exclude Episodes	Measure-specific exclusions remove unique groups of patients from the measure 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 measure cohort as a whole.	• Exclusions tab for list • Exclusions_Details tab for codes
5	Risk Adjust: Calculate Expected Episode Costs	Risk adjustment aims to isolate variation in clinician costs to only the costs that clinicians can reasonably influence by accounting for factors like patient age, comorbidities, and other measure-specific risk adjustors.	• RA tab for list • RA_Details tab for codes

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Cost Measure Benchmarks for PY22

Measure Title	Measure ID	Group National Standardized Average	Individual National Standardized Average	Average Performance Rate	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Acute Kidney Injury Requiring New Inpatient Dialysis	COST_AKID_1	39491.89	46136.03	45915.03	82993.50 - 57779.01	57779.00 - 51895.11	51895.10 - 48761.71	48761.70 - 46419.61	46419.60 - 44179.41	44179.40 - 42147.81	42147.80 - 40290.31	40290.30 - 38313.41	38313.40 - 35464.11	<= 35464.10