Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Participating in the Cost Performance Category in the 2021 Performance Year: Traditional MIPS

Contents

Already know what MIPS is?
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Purpose: This detailed resource focuses on performance year (PY) 2021 MIPS cost performance category requirements. This resource doesn't address requirements under the Alternative Payment Model Performance Pathway (APP).

How to Use This Guide

How to Use This Guide

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.

Table of Contents

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Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct the reader to more information and resources.

Overview

COVID-19 and 2021 Participation

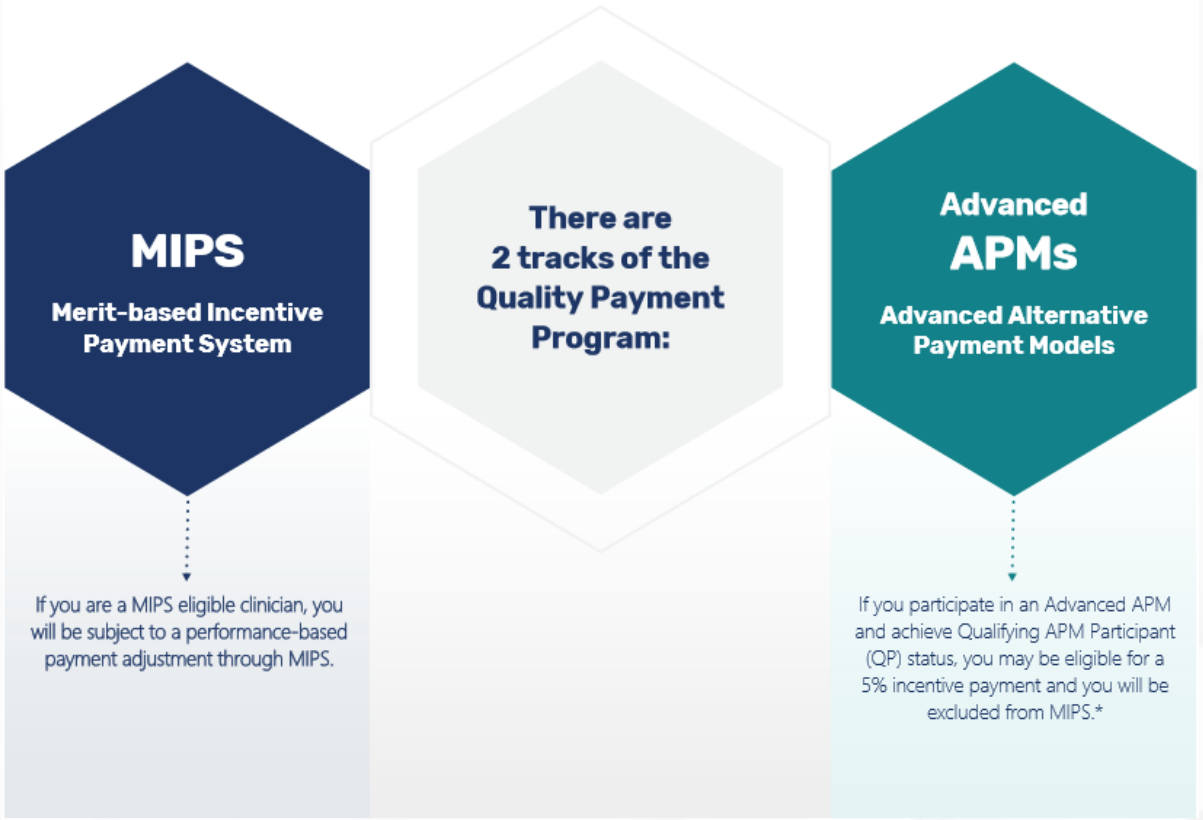
The 2019 Coronavirus (COVID-19) public health emergency continues to impact all clinicians across the United States and territories. However, we recognize that not all practices have been impacted by COVID-19 to the same extent. For the 2021 performance year, we will continue to use our Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, virtual groups, and APM Entities to submit an application requesting reweighting of one or more MIPS performance categories to 0% due to the current COVID - 19 public health emergency. The application will be available in spring 2021 along with additional resources.

Due to the anticipated need for continued COVID-19 clinical trials and data collection, MIPS eligible clinicians, groups, and virtual groups that meet the improvement activity criteria will be able to receive credit for the COVID-19 Clinical Reporting with or without Clinical Trial improvement activity for the 2021 performance year.

For more information about the impact of COVID-19 on Quality Payment Program (QPP) participation, see the QPP COVID-19 Response webpage.

What is the Quality Payment Program?

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



* Note: If you participate in an Advanced APM and don't achieve QP or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.

What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the QPP, a program authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The program changes how we reimburse MIPS eligible clinicians for Part B covered professional services and reward them for improving the quality of patient care and outcomes.

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

If you're eligible for MIPS in 2021:

- You generally have to submit data for the quality, improvement activities, and Promoting Interoperability performance categories.
- 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 2021 performance year and applied to payments for covered professional services beginning on January 1, 2023.

To learn more about how to participate in MIPS:

- Visit the How MIPS Eligibility is Determined and Participation Overview webpages on the QPP website.
- View the 2021 MIPS Eligibility and Participation Quick Start Guide (PDF).
- Check your current MIPS participation status using the QPP Participation Status Tool.

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

Traditional MIPS, established in the first year of the QPP, is the original framework for collecting and reporting data to MIPS.

Under traditional MIPS, participants select from over 200 quality measures and over 100 improvement activities, in addition to reporting the complete Promoting Interoperability measure set. We collect and calculate data for the cost performance category for you.

In addition to traditional MIPS, 2 other MIPS reporting frameworks will be available to MIPS eligible clinicians:

The **APM Performance Pathway (APP)** is a streamlined reporting framework beginning with the 2021 performance year for MIPS eligible 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.

MIPS Value Pathways (MVPs) are a reporting framework that will offer clinicians a subset of measures and activities, established through rulemaking. MVPs are tied to our goal of moving away from siloed reporting of measures and activities towards focused sets of measures and activities that are more meaningful to a clinician's practice, specialty, or public health priority. We didn't propose any MVPs for implementation in 2021 but intend to do so through future rulemaking.

To learn more about the APP:

- Visit the APM Performance Pathway (APP) webpage on the QPP website.
- View the following:
  - 2021 APM Performance Pathway (APP) for MIPS APM Participants Fact Sheet (PDF)
  - 2021 APM Performance Pathway (APP) Infographic (PDF)
  - 2021 APM Performance Pathway Reporting Scenarios (PDF)
  - 2021 APM Performance Pathway Quick Start Guide (PDF)

To learn more about MVPs:

- Visit the MIPS Value Pathways (MVPs) webpage on the QPP website.

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

This guide examines the cost performance category under traditional MIPS for the 2021 performance year of QPP.

Traditional MIPS Performance Category Weights for Individuals, Groups, and Virtual Groups in 2021:

Quality	Cost	Improvement Activities	Promoting Interoperability
			
40% of MIPS Score	20% of MIPS Score	15% of MIPS Score	25% of MIPS Score

MIPS Performance Category Weights for MIPS APM Entities Reporting Traditional MIPS in 2021:

Quality	Cost	Improvement Activities	Promoting Interoperability
50%	0%	20%	30%

By law, the quality and cost performance categories must be equally weighed at 30% beginning with the 2022 performance period.

Cost Performance Category Basics

Cost Performance Category Basics

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Overview

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

A total of 20 cost measures are available to evaluate cost category performance in the 2021 MIPS performance year

No new cost measures are being introduced in 2021.

Each measure is payment-standardized and risk-adjusted. All of the cost measures used the standard CMS-HCC risk adjustment model as a starting point, and the 18 episode-based cost measures include additional measure-specific risk adjustors informed by clinician expert workgroups that provided recommendations during the development of the measures.

Overview (Continued)

In addition, the TPCC measure is also specialty-adjusted.

Each cost measure is attributed to clinicians according to the measure's unique specifications.

Two measure specifications documents are available for each cost measure:

1. A Measure Information Form (MIF) in a PDF file, and

2. A measure codes list Excel file.

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

Cost Performance Category Basics

Quality Payment PROGRAM

Understand the Cost Performance Category Measures

The following table summarizes the 20 cost measures used in PY 2021:

Measure Name	Description	Case Minimum	Data Sources
Total Per Capita Cost (TPCC)	Measures the overall cost of care delivered to a patient with a focus on primary care received.	20 Medicare patients	• Medicare Parts A and B claims data from the Common Working File (CWF)[1] • Enrollment Data Base (EDB) • Common Medicare Environment (CME) • Long Term Care Minimum Data Set (LTC MDS) • Provider Enrollment, Chain, and Ownership System (PECOS)
Medicare Spending Per Beneficiary Clinician (MSPB Clinician)	Assesses the cost to Medicare for services provided to a patient immediately prior to, during, and following a hospital stay.	35 episodes	• Medicare Parts A and B claims data from the CWF • EDB • LTC MDS • PECOS
13 Procedural episode-based measures and 5 acute inpatient medical condition episode-based measures (*See Table on slides 33-35)	Assess the cost of care that is clinically related to initial treatment of a patient for a specific clinical event (e.g., a hospitalization or a procedure) and provided during an episode's timeframe.	20 episodes for acute inpatient condition episode-based measures 10 episodes for procedural episode-based measures	• Medicare Part A and B claims data from the CWF • EDB • LTC MDS

For PY2021, the TPCC and 18 episode-based cost measures codes list were updated for telehealth services.

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

Understand the Cost Performance Category Measures (Continued)

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

- **Payment Standardization –** Payment standardization is the process of calculating standardized claim payment amounts that allow for the measurement and analysis of provider resource use by CMS and researchers. Payments included in MIPS cost measures are payment-standardized (sometimes referred to as "price standardized"). More details about payment standardization are available on ResDAC's CMS Price (Payment) Standardization Overview Page.

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

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

The Medicare "allowed charge," which is also referred to as the "allowed amount," includes Medicare trust fund payments, payments from third-party payers, and patient deductibles and coinsurance.

Cost Performance Category Basics

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Understand the Cost Performance Category Measures (Continued)

- **Benchmarks –** CMS calculates a single, national benchmark for each cost measure. These benchmarks are based on the performance year, not a historical baseline period. All MIPS eligible clinicians that meet or exceed the case minimum for a measure are included in the same benchmark. Currently, CMS doesn't publish MIPS cost measure performance year benchmarks.

> **For example:** The MSPB Clinician benchmark used to determine MIPS eligible clinicians' 2021 cost performance category score will be based on 2021 claims data.

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

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

Cost Measures

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Overview

This document describes the major components of the MSPB Clinician measure. For additional detail, please refer to the 2021 PY MSPB Clinician MIF and the associated measure codes list file.

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

TIP: Refer to the "Attribution Rule" tab of the MSPB Clinician codes list file to view which attribution rule is used for episodes, categorized by the Base DRG of the episodes' index admission. A Base DRG combines all levels of severity for a particular condition (represented by MS-DRGs) into a single category.

- Medical MSPB Clinician Episodes are attributed to clinicians in 2 steps:

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

TIP: To see which Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes qualify as E&M services used for this purpose, refer to the "Med_Attribution_E&M" tab in the 2021 PY MSPB Clinician codes list Excel file.

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

- Surgical MSPB Clinician episodes are defined as episodes in which the index admission has a surgical MS-DRG. These episodes are attributed to any clinician(s) who performed related surgical procedures during the inpatient stay and to the TIN under which the clinician(s) billed for the procedure. This step is referred to in the codes list file documentation as the "Major CPT/HCPCS attribution rule" or the "relevant CPT/HCPCS attribution rule."

TIP: To see which CPT/HCPCS codes are used to attribute episodes with surgical MS-DRGs to a clinician or group through the relevant CPT/HCPCS attribution rule , see the "Surg_Attribution_CPT_HCPCS" tab of MSPB Clinician codes list file.

Medicare Spending Per Beneficiary Clinician (MSPB Clinician) Overview (Continued)

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

TIP: See the "SE_General_Rules" tab of the MSPB Clinician codes list file to find the general service exclusion rules that apply to all episodes. For example, all home health services provided 3 days prior to the index admission and during the index admission are excluded from medical and surgical MSPB clinician episodes. As another example, all hospice services provided 3 days prior to the index admission, during the index admission, and 30 days post-discharge are excluded.

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

TIP: Additional service exclusion rules are applied to MSPB Clinician episodes based on the MDC of the episodes' index admission. Specifically, certain services provided during the post-trigger period of the episode window are excluded. The post-trigger period includes the inpatient stay and 30 days post-discharge. These services are grouped into the following categories (each with a dedicated tab in the codes list file):

- Inpatient surgical services
- Inpatient medical services
- Outpatient facility and clinician services
- Durable medical equipment, prosthetics, orthotics and supplies

For example, the "SE_Post_IP_Surg" tab of the MSPB Clinician codes list file presents the services excluded from episodes for the IP - Surgical service category during the post-trigger period of the episode window.

MSPB Clinician Beneficiary Exclusion Criteria

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

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

Episodes are also excluded if the **index admission**:

- Didn't occur in a "subsection (d) hospital[2]" paid under the Inpatient Prospective Payment System (IPPS) or an acute care hospital in Maryland.
- Was involved in an acute-to-acute hospital transfer[3] .

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

Cost Measures

MSPB Clinician Case Minimum

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

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

MSPB Clinician Risk Adjustment

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

A separate risk adjustment model is estimated for episodes within each MDC (determined by the MS-DRG of the index admission). This allows for more accurate comparisons of predicted episode spending between clinicians treating patients with similar characteristics. Pre-existing patient characteristics are identified using Parts A and B claims that end in the 90-day lookback period from the episode start date.

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

- 79 Hierarchical Condition Category (HCC) indicators[4] from a patient's claims during the 90-day period before the start of the episode
- Recent long-term care status
- End-stage renal disease (ESRD) status
- Prior acute hospital admission
- Comorbidities (the presence of more than one simultaneous clinical condition) by including interactions between HCC variables and enrollment status variables
- The reason a patient qualified for Medicare—referred to as "entitlement category"
- Disease interactions that are included in the Medicare Advantage risk adjustment model The 79 HCC indicators are in Version 22 of the CMS-HCC model

NOTE: The MSPB measure isn't adjusted to account for sex, race, nor provider specialty.

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

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

Cost Measures

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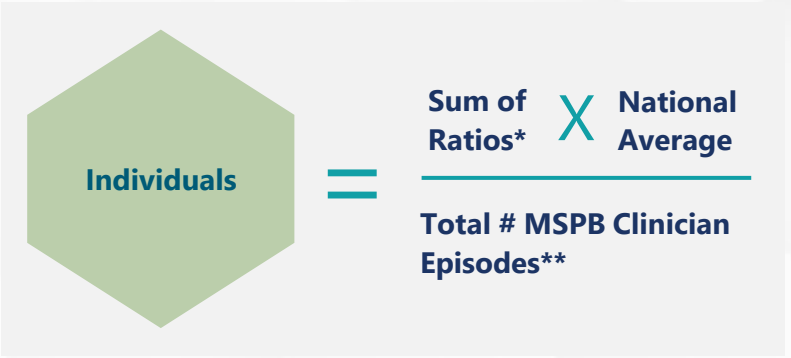
MSPB Clinician Calculation

The MSPB Clinician measure is calculated through the following steps:

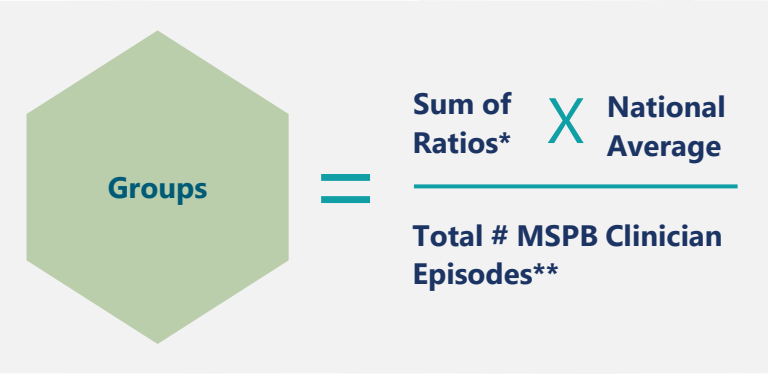
- **Step 1:** Define the population of index admissions
- **Step 2:** Attribute the episode to a clinician group/clinician
- **Step 3:** Exclude clinically unrelated services and calculate the episode observed costs
- **Step 4:** Exclude episodes
- **Step 5:** Calculate expected episode costs through risk adjustment
- **Step 6:** Calculate the measure score

The MSPB Clinician measure is calculated for each clinician (TIN-NPI) or group (TIN) by first calculating the ratio of standardized observed episode costs to final expected episode costs and then multiplying the average cost ratio across episodes for each TIN or TIN-NPI by the national average standardized episode cost. Multiplying the resulting ratio by the national average cost per episode converts the ratio into a more meaningful dollar amount. This dollar amount is then converted into points by comparing the score to a performance period benchmark. The points contribute to an overall cost performance category score.



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

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



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

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

TIP: For more detailed information, see the 2021 MIPS MSPB Clinician Measure Information Form (ZIP).

Total Per Capita Cost (TPCC)

This document describes the major components of the TPCC measure. For additional detail, please refer to the 2021 PY TPCC MIF and the associated measure codes list file.

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

The measure is attributed to clinicians using 4 steps:

Step 1: Identify Candidate Events

- A candidate event indicates the start of a primary care relationship between a clinician and patient. Each candidate event is composed of 2 parts:

  1) An initial "E&M primary care service" HCPCS/CPT code (there are 49 of them) billed on a Part B physician/supplier (aka "carrier") claim **AND**
  2) **EITHER** another primary care service (which doesn't have to be from the list of 49 "E&M primary care services") from any TIN occurring within 3 days prior or 3 days after the initial qualifying E&M primary care service **OR** a second E&M primary care service or another primary care service from the same TIN within 90 days after the initial E&M primary care service. Candidate events (in the form of beneficiary-months) are then attributed to TIN-NPIs based on their involvement in the candidate event.

TIP: See the "E&M_Prim_Care" tab in the TPCC measure codes list file for the list of E&M primary care services codes used to identify the first part of a candidate event. Some examples include codes for "New patient office or other outpatient visit, typically 60 minutes," and "Physician telephone patient service, 11-20 minutes of medical discussion." See the "Prim_Care_Services" tab for a list of CPT/HCPCS codes for primary care services used to identify the second part of a candidate event.

Total Per Capita Cost (TPCC) (Continued)

Step 2: Apply Service Category & Specialty Exclusions

- A TIN-NPI and their candidate events are removed from attribution if a clinician meets any of the following 4 service category thresholds for the same patient:
  - At least 15% of the clinician's candidate events are comprised of 10-day or 90-day global surgery services.
  - At least 5% of the clinician's candidate events are comprised of anesthesia services.
  - At least 5% of the clinician's candidate events are comprised of therapeutic radiation services.
  - At least 10% of the clinician's candidate events are comprised of chemotherapy services.
- Clinicians who are identified by one or more of the following 56 Health Care Finance Administration (HCFA) Specialty designation codes (see slides 23-24) are excluded from TPCC measure attribution. The HCFA specialty codes used for this purpose are found on Medicare Part B physician/supplier claims and are assigned by Medicare Administrative Contractors (MACs) when processing payment, based on the corresponding provider identification numbers. HCFA specialty codes aren't sourced from the PECOS database. Part B Physician/Supplier claims from up to one year prior to the start of the performance period to the end of performance period are used to identify HCFA specialty codes.

TIP: The CPT/HCPCS codes used for each of the service category exclusions are located in the tabs of the TPCC Measure Codes List file labeled: "HCPCS_Surgery," "HCPCS_Anesthesia," "HCPCS_Ther_Rad," and "HCPCS_Chemo."

Cost Measures

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Total Per Capita Cost (TPCC) (Continued)

HCFA Code	HCFA Code Description
04	Otolaryngology
05	Anesthesiology
07	Dermatology
09	Interventional Pain Management
13	Neurology
14	Neurosurgery
15	Speech Language Pathologists
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
21	Cardiac Electrophysiology
22	Pathology
23	Sports Medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery (formerly proctology)
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
48	Podiatry
64	Audiologist (Billing Independently)
65	Physical Therapist in Private Practice

Clinicians who are identified by one or more of the HCFA Specialty designation codes listed in this table are excluded from TPCC measure attribution.

Cost Measures

Total Per Capita Cost (TPCC) (Continued)

HCFA Code	HCFA Code Description
67	Occupational Therapist in Private Practice
68	Clinical Psychologist
71	Registered Dietician/Nutrition Professional
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
85	Maxillofacial Surgery
86	Neuropsychiatry
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
C0	Sleep Medicine
C3	Interventional Cardiology
C5	Dentist
C6	Hospitalist
C8	Medical Toxicology
C9	Hematopoietic Cell Transplantation and Cellular Therapy
D3	Medical Genetics and Genomics
D4	Undersea and Hyperbaric Medicine

Clinicians who are identified by one or more of the HCFA Specialty designation codes listed in this table are excluded from TPCC measure attribution.

TIP: The list of HCFA Specialty codes that identify clinicians that are included or excluded from TPCC measure attribution is found on the "Eligible_Clinicians" tab of the TPCC Measure Codes List.

Total Per Capita Cost (TPCC) (Continued)

Step 3: Construct Risk Windows

- A risk window begins on the date of the initial E&M primary care service of a candidate event (in other words, candidate events "initiate" risk windows). A risk window is a 12-month period.

- As a result, a risk window could span multiple performance periods. For example, a risk window could begin on July 1, 2021 and end on July 1, 2022. Only the 2021 performance period beneficiary-months that overlap with the risk window (July, August, September, October, November, and December of 2021) are attributable to a clinician or group.

Step 4: Attribute Beneficiary-Months to TINs and TIN-NPIs

For purposes of calculating the TPCC measure, the performance period (which is the static 2021 calendar year) is divided into 13, four-week blocks called beneficiary-months.

- Only the beneficiary-months that occur during a risk window **and** the performance period are attributable (i.e., count towards a clinician or group's measure score).

- 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 plurality (largest share) of candidate events provided to the patient within the TIN is attributed the beneficiary-months.

- What other rules are used to attribute patient costs to clinicians and groups for the TPCC measure?
  - If 2 different clinician groups each initiate risk windows for the same patient, the 2 risk windows will occur concurrently and will be attributed to their respective TINs. Within an attributed TIN, the beneficiary-months will be attributed to the TIN-NPI combination that performed the highest number of candidate events for the patient.
  - Multiple TINs may be attributed beneficiary-months for the same patient during a performance period.
  - Clinicians billing under different TINs may be attributed beneficiary-months during the same performance period for the same patient.
  - The same clinician can be attributed beneficiary-months for the same patient, spanning multiple performance periods, if multiple candidate events open multiple risk windows.

TPCC Beneficiary Exclusion Criteria

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

- Wasn't enrolled in both Medicare Parts A and B for every month of the performance year.
- Was enrolled in a private Medicare health plan (such as a Medicare Advantage or a Medicare private fee-for-service (FFS) plan) during any month of the performance year.
- Resided outside the United States (including territories) during any month of the performance year.
- Is covered by the Railroad Retirement Board.

If a patient was enrolled in Medicare Parts A and B for a partial year because he/she newly enrolled in Medicare or he/she died during the performance year, then the patient is included in the measure.

Cost Measures

TPCC Case Minimum

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

TPCC Risk Adjustment

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

- A risk score is generated for each beneficiary-month using diagnostic data from the 12 months immediately preceding each beneficiary-month. For example, to determine the risk score for a beneficiary-month of August 2021, diagnostic data from August 2020 to July 2021 will be used. A patient's risk score summarizes their expected cost of care relative to other patients.

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

TPCC Specialty Adjustment

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

TIP: See Appendix E of the 2021 TPCC MIF for an example of how specialty adjustment is applied to the TPCC measure.

Cost Measures

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TPCC Measure Calculation

After the 4-step attribution, the TPCC measure is calculated through the following steps:

Step 1
Calculate payment-standardized monthly observed costs

Step 2
Calculate risk scores

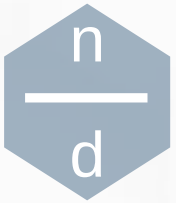
Step 3
Risk-adjust monthly costs

Step 4
Specialty-adjust monthly costs

Step 5
Calculate the TPCC measure score

NOTE: The TPCC measure score is expressed as a dollar amount. It's calculated by dividing each TIN and TIN-NPI's average, risk-adjusted monthly cost by their specialty adjustment factor, resulting in a ratio. This ratio is then multiplied by the average, non-risk-adjusted, winsorized, observed cost across the total population of attributed beneficiary-months to convert the ratio into a dollar figure.

REMEMBER: Your TPCC measure score will be compared to a 2021 performance period TPCC measure benchmark to determine how many achievement points your resulting measure score, a dollar amount, will contribute to your overall cost performance category score. At this time, CMS doesn't publicly provide PY MIPS cost measure benchmark information.



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

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

Cost Measures

Episode-based Cost Measure Basics

This document reviews the fundamental components of procedural and acute inpatient condition episode-based measures. For additional detail, please refer to the 2021 PY episode-based measure MIFs and the associated measure codes list files.

Episode-based measures are intended to assess and compare clinicians on the costs of care clinically related to their initial treatment of a patient and care provided during a specific time frame. Episode-based measures differ from the TPCC and MSPB Clinician measures because they only include items and services that are related to the episode of care for a clinical condition or procedure (as defined by procedure and diagnosis codes), as opposed to including all services provided to a patient over a given timeframe.

CMS has posted detailed methodology documents (ZIP) for the 18 episode-based measures in use for 2021.

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

Did you know? Cost is defined as the standardized allowed amounts on Medicare claims, which includes both Medicare trust fund payments and any applicable patient deductible and coinsurance amounts.

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

1. Trigger and define an episode. Episodes are defined by billing codes that trigger an episode, and episodes may be placed into mutually exclusive and exhaustive sub-groups for meaningful clinical comparison.

Procedural episodes are triggered or opened by CPT/HCPCS codes on Part B physician/supplier (A.K.A. "carrier") claims indicating that a procedure has been performed. The episode window is defined around the trigger and may include a period before the trigger to capture pre-procedure care.

AND

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

TIP: Refer to the "Triggers" and "Triggers_Detail" tab(s), if applicable, in a measure's codes list file. For example, consider the Inpatient COPD Exacerbation measure. Patients receiving care with MS-DRG codes for pulmonary edema and respiratory failure (189), COPD (190, 191, 192), and/or respiratory system diagnosis with ventilator support <96 hours (208) are eligible for inclusion in the measure. However, an episode for this measure is only "triggered" when the MS-DRG is also accompanied by a specific, relevant diagnosis code.

Cost Measures

Episode-based Cost Measure Basics (Continued)

2. **Attribute episodes to a clinician:** Additional codes are used together with episode triggers to attribute episode costs to a clinician.

Procedural episodes are attributed to any clinician who bills a trigger code for the episode group, and episodes are attributed to clinician groups by aggregating all episodes attributed to clinicians that bill to the clinician group.

AND

Acute inpatient medical condition episodes are attributed to clinician groups (TINs) that bill at least 30% of the inpatient E&M claim lines during the trigger inpatient stay, and to clinicians (TIN/NPI) who bill at least one inpatient E&M claim line under a TIN that met the 30% threshold. For some episode groups, additional codes aid in determining the attributed clinician. See slide 36 for more information about episode-based cost measure attribution.

3. **Assign costs to an episode and calculate total observed episode costs:** Clinically related services occurring during the episode window are assigned to the episode. The cost of these services is summed to determine each episode's standardized observed cost.

TIPS:

- See the "Service_Assignment" tab in a measure's codes list file. Each row in the service assignment tab is a possible instance of when a service could be assigned. Each row should be read from left to right to determine the rules for assignment for that particular service.
- To illustrate how to use a codes list file to interpret service assignment rules, look at Row 2320/Initial Sort Order 2313 in the "Service_Assignment" Tab for the Elective Outpatient Percutaneous Coronary Intervention (PCI) measure:
    - A service assignment rule applies to any time during the post-trigger period (columns C/D) for Clinical Classifications Software (CCS[5]) category 178: CT Scan Chest (columns E-G). If a rule is determined at the CCS category level and applies to all CPT/HCPCS codes within that CCS, then columns J and K will be blank; if a rule only applies to certain CPT/HCPCS codes within that CCS, then columns J-K would be filled in with specific codes in each relevant row. In this example, these columns are blank, which means all CPT/HCPCS within 178 will be assigned depending on the decision in Column H. The decision is to assign depending on diagnosis. This means that additional information, in further right columns, is required to determine whether a given CPT/HCPCS within CCS 178 should be assigned.
    - Scrolling right, Columns M-O and Q-S provide more information about diagnoses. Columns N-O list I21: Acute Myocardial Infarction as the parent/3-Digit diagnosis code, and Column P indicates to assign for all services with the diagnosis. This means that no further columns to the right are needed to determine the full service assignment rule. Based on all the information to the left in this row, the full service assignment rule is: Assign all CPT/HCPCS within CCS 178 if the CPT/HCPCS occurs with 3-digit diagnosis code I21: Acute Myocardial Infarction, when you see the CPT/HCPCS code plus the diagnosis code billed together any time in the post-trigger period.

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

Episode-based Cost Measure Basics (Continued)

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.

TIP: See the "Exclusions" and "Exclusions_Details" tab, if applicable, in a measure's codes list file and the "Exclude Episodes" section in Appendix A of the MIF. For example, consider the Inpatient COPD Exacerbation measure. Costs related to the following overarching clinical characteristics/events are excluded:

- COPD exacerbation after lung resection
- Inpatient COPD exacerbation in a lung transplant patient
- Leaving against medical advice
- Non-invasive positive pressure ventilation for more than 96 hours
- Patients receiving active treatment for lung cancer

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

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

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

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

Episode-based Cost Measure Basics (Continued)

5. **Calculate expected episode costs through risk adjustment:** 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. See slide 36 for more information on risk adjustment.

6. **Calculate measure scores:** The ratio of standardized total observed cost to risk-adjusted expected cost is calculated and averaged across all of a clinician's or clinician group's attributed episodes to obtain the average episode cost ratio. The average episode cost ratio is multiplied by the national average observed episode cost to generate a dollar figure for the cost measure score. The dollar figure is compared to a performance period measure benchmark and achievement points are assigned based on the decile.

Cost Measures

Episode-based Cost Measure Basics (Continued)

For each measure listed in the table below:

- An episode is opened (aka "triggered") by a certain clinical event, referred to in the table and other documentation as a trigger.
- An episode window may (but not always) include a period of time before the triggering clinical event, referred to as a "pre-trigger period," plus a period of time after the triggering clinical event (referred to as a "post-trigger period").
- Some episode windows begin when the triggering event occurs and don't include a pre-trigger period (therefore, they have a pre-trigger period of zero days). The episode window used to calculate each of the episode-based measures is listed below.

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk-Adjusted Cost to Medicare for….	Measure Can be Triggered Based on Claims Data from the Following Settings:
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural	Pre-Trigger Period=zero 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, hospital outpatient departments (HOPDs), 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, 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, ambulatory/office-based care, and HOPDs
Screening/Surveillance Colonoscopy	Procedural	Pre-Trigger Period=zero 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

Cost Measures

Quality Payment PROGRAM

Episode-based Cost Measure Basics (Continued)

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk-Adjusted Cost to Medicare for....	Measure Can be Triggered Based on Claims Data from the Following Settings:
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	Pre-Trigger Period= zero days Post-Trigger Period=30 days	Patients who receive their first inpatient dialysis service for acute kidney injury during the performance period.	Acute IP hospitals
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	Beneficiaries who undergo a CABG procedure during the performance period.	Acute inpatient 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 inpatient hospitals, HOPDs, ambulatory/office-based care centers, and ASCs
Intracranial Hemorrhage or Cerebral Infarction	Acute inpatient medical condition	Pre- Trigger Period=zero days Post- Trigger Period=90 days	Patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance period.	Acute inpatient hospitals

Episode-based Cost Measure Basics (Continued)

Measure Name	Measure Type	Episode Window	This Measure Evaluates a Clinician's Risk-Adjusted Cost to Medicare for....	Measure Can be Triggered Based on Claims Data from the Following Settings:
Simple Pneumonia with Hospitalization	Acute inpatient medical condition	Pre-Trigger Period=zero days Post-Trigger Period=30 days	Patients who receive inpatient treatment for simple pneumonia during the performance period.	Acute inpatient hospitals
ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	Pre-Trigger Period=zero days Post-Trigger Period=30 days	Patients who present with ST-Elevation Myocardial Infarction indicating complete blockage of a coronary artery who emergently receive Percutaneous Coronary Intervention as treatment during the performance period.	Acute inpatient hospitals
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	Pre-Trigger Period=zero days Post- Trigger Period=60 days	Patients who receive inpatient treatment for an acute exacerbation of COPD during the performance period.	Acute inpatient hospitals
Lower Gastrointestinal Hemorrhage (**applies to groups only**)	Acute inpatient medical condition	Pre-Trigger Period=zero 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 inpatient hospitals

Episode-based Measure Attraction

Acute Inpatient Medical Condition Episode Attribution

- Acute inpatient medical condition episodes are attributed to clinician groups (identified by TIN) that bill at least 30% of the inpatient E&M claim lines during the trigger inpatient stay, and to clinicians (identified by TIN-NPI) who bill at least one E&M claim line under a TIN that met the 30% threshold.

- All TIN-NPIs who bill at least one inpatient E&M service within a TIN that met the 30% threshold will be attributed the episode. As a result, an acute inpatient medical condition episode can be attributed to more than one individual clinician.

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

Procedural Episode-Based Cost Measure Attribution

- Procedural episodes are attributed to any TIN-NPI who bills a trigger code, defined by CPT/HCPCS codes, on the date of the procedure or during a concurrent related inpatient stay.

- As a result, procedural episodes can be attributed to more than one clinician.

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

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

Episode-based Measure Case Minimums

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

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

Risk Adjustment Methodology for Episode-based Measures

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

The risk adjustment methods for the episode-based measures:

- Adjust for differences in clinical complexity.
- Include variables from the CMS-HCC Version 22 Risk Adjustment Model.
- Include standard risk adjustors and variables for clinical factors outside the influence of the attributed clinician.

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

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

Reporting Requirements

Reporting Requirements

Quality Payment PROGRAM

Overview

CMS will use data from Medicare Parts A and B claims—with dates of service from January 1, 2021 to December 31, 2021—to calculate your cost performance category score.

AND

You **don't need** to submit any data or take any separate actions for this performance category.

Scoring

Overview

The cost performance category is weighted at 20% for individuals, groups, and virtual groups reporting traditional MIPS. The cost performance category is weighted at 0% for APM Entities reporting traditional MIPS.

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

1

If **only one** cost measure can be scored, that measure's score will be used to compute a cost performance category score.

multiple

If **multiple** cost measures are scored, the cost performance category score is the equally-weighted average points assigned to the scored measures. For example, if 7 out of 20 cost measures are scored, the cost performance category score is the equally-weighted average of the 7 scored measures.

none

If **none** of the cost measures can be scored, the cost performance category will count toward 0% of your MIPS final score, and we'll reweight your performance category scores as follows: quality to 55%; improvement activities to 15%; and Promoting Interoperability to 30%.

Cost

0%

Quality

55%

Improvement Activities

15%

Promoting Interoperability

30%

Overview (Continued)

To calculate the cost performance category score in 2021, CMS will assign **1 to 10 achievement points** to each scored measure based on the MIPS eligible clinician or group's performance on the measure compared to the PY benchmark. As a result, the achievement points assigned for each measure depends on which decile range you or your group's performance on the measure is between.

REMEMBER: An individual or group's cost measure performance is expressed as a dollar amount. A measure *score* (expressed as up to 10 points from a benchmark decile) is derived by comparing your performance on the measure to the performance of all individual MIPS eligible clinicians, groups, and virtual groups who were evaluated on the measure.

Note, the cost performance category score won't include improvement scoring until the 2022 MIPS performance year and corresponding 2024 MIPS payment year.

2021 Cost Performance Category Illustrative Scoring Example for a Group

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

Overview (Continued)

2021 Cost Performance Category Illustrative Scoring Example for a Group

Measure	Measure Achievement Points Earned by the Group	Total Measure Achievement Points Available
18. Renal or Ureteral Stone Surgical Treatment	Not scored	N/A-not scored
19. Inpatient COPD Exacerbation	5	10
20. Lower Gastrointestinal Hemorrhage (applies to groups only)	8.8	10
TOTAL	**70.8**	**100**

In the example above, the group was scored on 10 out of 20 available cost measures. Each measure receives a score of up to 10 points. So, 100 achievement points are available to this group.

The group's cost performance category score is (70.8/100=0.708), which is equal to a cost performance category score of 70.8%. Because the cost performance category is worth 20 points in the MIPS final score, this group would earn 14.16 points towards their final score (70.8 x .20=14.16).

Scoring

Reweighting the Cost Performance Category

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

Assume the clinician doesn't have sufficient cost measures applicable.

AND

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

If other performance categories are reweighted, the cost performance category will always be weighted at either 20% or 0%—we won't redistribute weight to the cost performance category for the 2021 performance year, except in cases when the cost and the improvement activities performance categories are the only 2 categories scored. In this case, both categories will receive a weight of 50%.

Note, the quality, cost, improvement activities and Promoting Interoperability performance categories will be reweighted to 0% for MIPS eligible clinicians who join an existing practice (i.e., an existing TIN) during the final 3 months of the PY that isn't participating in MIPS as a group, or a practice that's newly formed (i.e., a new TIN) during the final 3 months of the performance year regardless of whether the clinicians in the practice participate in MIPS as individual clinicians or as a group.

Facility-Based Scoring

Facility-based measurement offers certain clinicians and groups that primarily work within an inpatient setting the opportunity to receive MIPS quality and cost performance categories scores based on their assigned facility's Hospital Value-Based Purchasing (VBP) Program score instead of receiving scores based on MIPS quality and cost measures. For more information on facility-based measurement, please review the 2021 Facility-based Quick Start Guide (PDF).

Cost Performance Category Feedback

For the 2021 MIPS performance year, cost performance category feedback and additional patient-level data will be provided in the summer of 2022.

Help, Resources, and Version History

Help, Resources, and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

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

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

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

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

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

Help, Resources, and Version History

Quality Payment PROGRAM

Additional Resources

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

- 2021 MIPS Cost Measure Codes List (ZIP)
- 2021 MIPS Cost Measure Information Forms (ZIP)
- 2021 MIPS Summary of Cost Measures (PDF)
- 2021 Cost Quick Start Guide (PDF)

Version History

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

Date	Description
04/28/2021	Original Version

Appendix

Appendix

Appendix A

Inpatient E&M Services used for Acute Inpatient Condition Episode- Based Measure Attribution	
CPT/HCPCS Codes	**Code Label**
99221	Initial Hospital Inpatient Care, Typically 30 Minutes Per Day
99222	Initial Hospital Inpatient Care, Typically 50 Minutes Per Day
99223	Initial Hospital Inpatient Care, Typically 70 Minutes Per Day
99231	Subsequent Hospital Inpatient Care, Typically 15 Minutes Per Day
99232	Subsequent Hospital Inpatient Care, Typically 25 Minutes Per Day
99233	Subsequent Hospital Inpatient Care, Typically 35 Minutes Per Day
99234	Hospital Observation Or Inpatient Care Low Severity, 40 Minutes Per Day
99235	Hospital Observation Or Inpatient Care Moderate Severity, 50 Minutes Per Day
99236	Hospital Observation Or Inpatient Care High Severity, 55 Minutes Per Day
99238	Hospital Discharge Day Management, 30 Minutes Or Less
99239	Hospital Discharge Day Management, More Than 30 Minutes
99291	Critical Care Delivery Critically Ill Or Injured Patient, First 30-74 Minutes