

2023 Cost Measures Field Testing Frequently Asked Questions (FAQ)

Winter 2023 Field Testing



Table of Contents

- 1.0 Overview 4**
 - 1.1 What is field testing? 4
 - 1.2 Which cost measures are being field tested?..... 4
 - 1.3 Do the cost measures being field tested affect my 2022 or 2023 MIPS score?..... 5
 - 1.4 How were these cost measures developed? 5
 - 1.5 Why were these measures selected for field testing? 5
- 2.0 Participating in Field Testing 7**
 - 2.1 When does field testing take place? 7
 - 2.2 Do I need to register to participate in field testing? 7
 - 2.3 Why should I participate? 7
 - 2.4 What feedback are you looking for? 7
 - 2.5 How can I give feedback?..... 7
 - 2.6 How will you use my feedback?..... 8
 - 2.7 Can I still provide feedback on the measures even if I didn't receive a report? 8
 - 2.8 Is this the first time that cost measures have been field tested? 8
- 3.0 Field Test Reports..... 9**
 - 3.1 Who can receive a Field Test Report?..... 9
 - 3.2 What is the format of the Field Test Reports?..... 9
 - 3.3 How can I access my Field Test Report(s)? 9
 - 3.4 What data were used to calculate the measures for the Field Test Reports?..... 10
 - 3.5 How many Field Test Reports are there? 10
 - 3.6 How many clinicians/clinician groups received one or multiple Field Test Reports?.... 11
 - 3.7 How can I use the information in the Field Test Report?..... 11
- 4.0 Background on Episode-Based Cost Measures 12**
 - 4.1 What are episode-based cost measures?..... 12
 - 4.2 How are episodes attributed to a clinician?..... 12
 - 4.3 What is a high-level summary of the measures being field tested? 12
 - 4.4 What services and costs are included in an episode?..... 12
 - 4.5 Do the measures use standardized costs? 13
 - 4.6 Which measures include Part D costs? 13
 - 4.7 What is risk adjustment? 14
 - 4.8 Do the measures risk adjust for social risk factors? 14
 - 4.9 How are episode-based cost measures calculated? 15
 - 4.10 Where can I find the draft measure specifications and testing results? 15
- 5.0 Cost Measures in MIPS 16**
 - 5.1 When will these cost measures be used in MIPS?..... 16
 - 5.2 How would these cost measures fit within MIPS? 16
 - 5.3 Can these cost measures be used in MVPs now? 16
 - 5.4 How many cost measures are in MIPS? 16
- 6.0 Who Can I Contact for More Information? 18**

Acronyms and Abbreviations

Table 1.1 Acronyms and Abbreviations

Acronym and/or Abbreviation	Description
CKD	Chronic Kidney Disease
CMS	Centers for Medicare & Medicaid Services
CMS-HCC ESRD	CMS Hierarchical Condition Category End-Stage Renal Disease
CMS-HCC V24	CMS Hierarchical Condition Category Version 24
COPD	Chronic Obstructive Pulmonary Disease
CPT/HCPCS	Current Procedural Terminology/Healthcare Common Procedure Coding System
CSV	Comma-Separated Values
E&M	Evaluation and Management
ESRD	End-Stage Renal Disease
GPCI	Geographic Prices Cost Index
HARP	Health Care Quality Information Systems (HCQIS) Access Roles and Profile
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
MVPs	MIPS Value Pathways
NPI	National Provider Identifier
PFE	Person and Family Engagement
PFP	Person and Family Partners
QPP	Quality Payment Program
SRFs	Social Risk Factors
TEP	Technical Expert Panel
TIN	Taxpayer Identification Number

1.0 Overview

1.1 What is field testing?

Field testing is an opportunity for clinicians and other interested members of the public to learn about episode-based cost measures and to provide input on the draft specifications. Conducting field testing is part of the measure development process. It also helps us to assess each measure's importance, scientific acceptability, and clinical validity.

During field testing, we'll:

- Calculate the measures as currently specified for all clinicians (group practices and individuals) who have at least 20 episodes
- Summarize results in Field Test Reports which are available to group practices and individuals on the [Quality Payment Program \(QPP\) website](#)¹
- Post draft measure specifications (i.e., measure methodology and codes lists) and supplemental documentation, such as testing results, on the [MACRA Feedback page](#)²
- Collect feedback on the draft specifications for each measure through an online survey:
 - [2023 Cost Measures Field Testing Feedback Survey](#)³ for most feedback, including input on the measures, their draft specifications, the Field Test Reports, and other field testing materials
 - [Person and Family Engagement \(PFE\) Field Testing Survey](#)⁴ for people with lived experience, as a patient or a caregiver, with the conditions represented in the measures undergoing field testing

Field testing is being conducted as part of the MACRA Cost Measure Development Project. The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC (referred to as "Acumen") to develop new episode-based cost measures for potential use in the Merit-based Incentive Payment System (MIPS).

1.2 Which cost measures are being field tested?

The 5 chronic condition episode-based cost measures that are being field tested include:

- Chronic Kidney Disease (CKD)
- End-Stage Renal Disease (ESRD)
- Kidney Transplant Management
- Prostate Cancer
- Rheumatoid Arthritis

¹ CMS, "Quality Payment Program Account," Quality Payment Program, <https://qpp.cms.gov/login>.

² These documents will be available on the MACRA Feedback Page once field testing begins. <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

³ The general field testing online survey will open beginning January 17, 2023, at this link: https://acumen.qualtrics.com/jfe/form/SV_a2Zlh0EmpjkJJjM

⁴ The person and family field testing online survey will open beginning January 17, 2023, at this link: https://acumen.qualtrics.com/jfe/form/SV_d4OV0CJ62raRQX4

1.3 Do the cost measures being field tested affect my 2022 or 2023 MIPS score?

No. These measures aren't part of MIPS, so they don't count toward your cost performance category or MIPS final score. As such, they don't affect any payment adjustments. The purpose of field testing is to gather feedback on the draft specifications during the measure development process so that we can make any updates before CMS considers whether to use these measures in MIPS.

1.4 How were these cost measures developed?

Acumen's measure development approach involves gathering input from clinical experts and other interested parties through multiple channels, empirically testing the measures, and conducting environmental scans. We develop measures in cycles ("Waves") where we undertake these activities iteratively to build out and test measures. Table 1 describes the role of the different input channels in this process.

Table 1. Input Gathered to Date

Input Channel	Description of Role
Technical Expert Panel (TEP)	Serves as a high-level advisory role across the project. Provided guidance on the framework for assessing the costs of chronic condition care and measure prioritization at 4 meetings in 2018, 2020, 2021, and 2022.
Public Comment	Provided input on candidate measure concepts, how to address clinical and coding challenges, and what types of expertise would be needed to compose a workgroup for Wave 5 measures in February - April 2022.
Clinician Expert Workgroups ("Workgroups")	Provided input on each aspect of measure specifications for Wave 5 measures through meetings in July - October 2022. Composed of clinicians with experience and expertise for the specific condition.
Patient and Family Partners (PFPs)	Provided input on aspects of measures via focus groups and interviews, and shared the input with Workgroups. PFPs are caregivers and individuals with lived experience with particular health conditions.

For more information on measure development, refer to the 2023 Episode-Based Cost Measures Field Testing Wave 5 Measure Development Process document.⁵

1.5 Why were these measures selected for field testing?

The 5 cost measures listed in Question 1.2 are being field tested as part of the measure development process, prior to being considered for potential use in MIPS. These measures were chosen for development because they represent new clinical areas, prioritize specialty gap areas, and build more in-depth measurement for high-cost areas. They also meet the general criteria for measure prioritization as they are clinically coherent and impactful, offer opportunities for improvement, and can align with quality. These measures have all gone through iterative development and testing and are now at the field testing stage of the development process, from which we'll gather feedback on the measures prior to measure refinement and finalization.

⁵ CMS, "2023 Cost Measures Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

The CKD and ESRD measures were developed in 2020-2021 but are being field tested along with the Wave 5 measures (Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis) in 2023. Testing and finalizing the specifications of the 3 measures related to kidney care (CKD, ESRD, and Kidney Transplant Management) on the same timeline would be beneficial to ensure a cohesive set of kidney care measures, and to facilitate public review of and feedback on the draft measure specifications.

2.0 Participating in Field Testing

2.1 When does field testing take place?

Field testing will last for 4 weeks, from January 17 to February 14, 2023 (11:59 p.m. ET).

2.2 Do I need to register to participate in field testing?

No, you don't need to register to participate in field testing. You may submit your feedback on the measures' draft specifications using the general field testing [online survey](#).⁶ If you're eligible to receive a Field Test Report, you'll need a QPP account to access the report(s). The 2023 Cost Measure Field Test Report User Access Guide on the MACRA Feedback Page⁷ contains more information about the QPP website and how to register for an account.

2.3 Why should I participate?

Field testing is a chance for all interested members of the public to provide feedback on the measures during the development process. Your participation allows us to consider your feedback as part of refining and finalizing the measures in 2023 before CMS considers these for use in MIPS.

2.4 What feedback are you looking for?

We're looking for feedback on:

- The draft measure specifications of the 5 episode-based cost measures.
- Whether the information presented in the Field Test Report helps you identify actionable improvements to patient care and cost efficiency.
- Whether the field testing materials present the information in a way that explains the measures.

The survey contains specific questions about each measure. The questions are also listed in the Questions for Field Testing Measure Specifications document on the MACRA Feedback Page.⁸

2.5 How can I give feedback?

You can share your feedback through this online [2023 Cost Measures Field Testing Feedback survey](#).⁹ You can answer questions about the measures or upload a PDF or Word document. You may submit comments anonymously if you prefer.

There's a separate online survey meant for Person and Family Engagement (PFE), which is the [2023 PFE Cost Measures Field Testing Feedback Survey](#).¹⁰ Patients, caregivers, and family

⁶ There's a separate online survey meant for Person and Family Engagement (PFE). See Question 2.5 for more details.

⁷ CMS, "2023 Cost Measures Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

⁸ CMS, "2023 Cost Measures Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

⁹ The online 2023 Field Testing Feedback Survey will be open beginning January 17, 2023, at this link: https://acumen.qualtrics.com/jfe/form/SV_a2Zlh0EmpjkJJjM

¹⁰ The PFE Cost Measures Field Testing Feedback Survey will be open beginning January 17, 2023, at this link: https://acumen.qualtrics.com/jfe/form/SV_d4OV0CJ62raRQX4

members with applicable lived experiences with the conditions of the cost measures are encouraged to provide their input in this survey to help inform refinement discussions.

2.6 How will you use my feedback?

After field testing, we'll summarize your feedback and share it with the measure-specific Clinician Expert Workgroups. They'll be able to consider this input as they work to finalize the measure specifications to wrap up the development process. After this, CMS may consider the final measure for use in MIPS.

We'll also produce a summary report of all the field testing feedback that will be publicly posted. Your feedback will also be used to inform how the measures can be improved to provide clinicians with actionable information to ensure high quality and high-value care.

2.7 Can I still provide feedback on the measures even if I didn't receive a report?

Yes. We encourage all interested parties to review publicly available field testing materials and provide feedback by completing the online 2023 Cost Measures Field Testing Feedback Survey¹¹ when they become available on the [MACRA Feedback page](#).¹²

- Field Test Report User Access Guide
- Measure Development Process Document
- Questions for Field Testing Measure Specifications
- Methodology Documents and Codes Lists for each measure
- Mock Field Test Reports
- Measure Testing Form for each measure

2.8 Is this the first time that cost measures have been field tested?

No. This is the 5th time that we have conducted field testing for episode-based cost measures. Previous rounds of field testing included:

- Wave 1 (2017): 8 episode-based measures
- Wave 2 (2018): 11 episode-based cost measures and 2 revised population-based cost measures
- Wave 3 (2020): 5 episode-based cost measures
- Wave 4 (2022): 5 episode-based cost measures

Field testing resources from 2017, 2018, 2020, and 2022 are on the [MACRA Feedback Page](#).¹³

¹¹ The field testing online survey will be open beginning January 17, 2023, at this link:

https://acumen.qualtrics.com/jfe/form/SV_a2Z1h0EmpjkJJM

¹² CMS, "2023 Cost Measures Field Testing," MACRA Feedback Page,

<https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

¹³ CMS, "Prior feedback requests," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

3.0 Field Test Reports

3.1 Who can receive a Field Test Report?

Individual clinicians and clinician group practices who have at least 20 episodes for the measures will receive a Field Test Report. Clinicians are identified by a unique TIN and NPI combination (TIN-NPI), while clinician groups are identified by their TIN. If you meet this criterion for receiving a Field Test Report for more than one cost measure, you'll receive more than one measure-specific report.

3.2 What is the format of the Field Test Reports?

The Field Test Reports will be compiled and available for download in one zip file containing:

- A measure-specific report [including a summary of the measure specifications for quick reference] (PDF file format)
- Episode-level information (Comma-Separated Values [CSV] file format)
- A data dictionary for the episode-level file (Excel file format)

3.3 How can I access my Field Test Report(s)?

You or your group's authorized representative can access the Field Test Report(s) using a [Quality Payment Program website](#) account and the same account information that you use to submit data and view performance feedback. If you don't have an account, you'll need to register for a Health Care Quality Information Systems [HCQIS] Access Roles and Profile (HARP) account in order to sign in.¹⁴ Once you have access, you can connect with your organization by navigating to the "Sign In" tab of the Quality Payment Program website. If you're part of a clinician group, you'll select the "practice" organization type, and if you're an individual clinician, you'll select the "individual clinician" organization type.

The [Quality Payment Program Access User Guide \(ZIP\)](#) provides more information on how to sign up for a Quality Payment Program account and how to connect with the appropriate organization.¹⁵

Groups are identified by their Medicare billing TIN. A group consists of 2 or more eligible clinicians, as identified by their NPIs that bill under the same TIN. A group will receive a Field Test Report if the TIN is attributed the minimum number of cases for a measure among all NPIs billing under the TIN. For a Quality Payment Program account, a group can have either of the following roles:

- Security Official
- Staff User

Users who have a Security Official role will be able to see all TIN-NPI reports within their TIN, as well as the TIN's overall report, so it's a role that's more appropriate for someone who is in an administrative position at the TIN. Each organization must have a Security Official role before any other group members can request a Staff User role. The group-level users (i.e., Security

¹⁴ CMS, "Quality Payment Program Account," Quality Payment Program, <https://qpp.cms.gov/login?page=register>

¹⁵ CMS, "Quality Payment Program Access User Guide," Quality Payment Program, <https://qpp.cms.gov/resource/2019%20QPP%20Access%20User%20Guide>.

Official and Staff Users) have access to the group practice’s reports and the individual-level reports for the solo practitioners within the group practice.

An individual eligible clinician (or a solo practitioner) is identified by a single NPI that bills under the TIN. They’ll receive a Field Test Report if the NPI is attributed the minimum number of cases for a measure. Clinicians looking to view only their TIN-NPI report should connect to the individual clinician organization type, regardless of whether they’re a part of a group practice or they practice on their own. The Field Test Report Access User Guide on the [MACRA Feedback Page](#) provides more information on accessing a Field Test Report.¹⁶

Note: Field test reports are separate from the Quality Payment Program Performance Feedback Reports; however this is the same website where those reports are made available. Additionally, individuals using assistive technology may not be able to fully access information in this file. To request a fully accessible report, contact macra-cost-measures-info@acumenllc.com.

3.4 What data were used to calculate the measures for the Field Test Reports?

The measurement period for the Field Test Reports is January 1 to December 31, 2021.

Episodes are constructed and measures are calculated using the following data:

- Medicare Parts A, B, and D claims data from the Common Working File
- Enrollment Data Base
- Long Term Care Minimum Data Set

3.5 How many Field Test Reports are there?

Table 2 includes the number of Field Test Reports available for each measure.

Table 2. Number of Field Test Reports for Each Measure

Episode-Based Cost Measure	Number of TIN Reports	Number of TIN-NPI Reports
Chronic Kidney Disease (CKD)	2,311	2,112
End-Stage Renal Disease (ESRD)	2,511	2,858
Kidney Transplant Management	719	559
Prostate Cancer	3,576	5,630
Rheumatoid Arthritis	3,342	3,874

¹⁶ CMS, “2023 Cost Measures Field Testing,” MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

3.6 How many clinicians/clinician groups received one or multiple Field Test Reports?

Table 3 below presents the number of clinicians (TIN-NPIs) and clinician groups (TINs) by the number of cost measures for which they received a Field Test Report.

Table 3. Number of TINs/TIN-NPIs by the Number of Episode-based Cost Measures Attributed to Them During 2023 Field Testing

Number of Episode-Based Cost Measures	Number of TINs	Number of TIN-NPIs
1	4,341	12,557
2	1,140	1,166
3	730	48
4	442	0
5	376	0

3.7 How can I use the information in the Field Test Report?

You may use the data in your Field Test Report(s) to understand the cost measures and provide us feedback on them.

The Field Test Reports present information intended to:

- Illustrate the types of services that comprise a large or small share of episode costs.
- Show the variation in clinician cost measure performance across different types of services or Medicare settings (claim types).
- Show which other Medicare clinicians account for patient costs during the episode.

4.0 Background on Episode-Based Cost Measures

4.1 What are episode-based cost measures?

Episode-based cost measures represent the cost to Medicare for the items and services furnished to a patient during an episode of care (“episode”). The term “cost” generally means the Medicare allowed amount, which includes both Medicare and trust fund payments and any applicable deductible and coinsurance amounts on traditional, fee-for-service claims.

An episode includes the costs from services that are clinically related to the care being assessed during a defined period, called the episode window. They include services that identify the clinician who is managing or treating a patient’s condition, routine care services, and consequences of care. Episodes don’t include services that are clinically unrelated.

The measure sums up the costs during the episode window, and risk-adjusts them. Risk adjustment neutralizes the effects of risk factors deemed to be outside a clinician’s influence (e.g., age, pre-existing conditions).

4.2 How are episodes attributed to a clinician?

Attribution is based on identifying the start of a clinician-patient relationship for the care being assessed. We use service and diagnosis information from claims to attribute episodes to clinicians. The codes used in the attribution methodology are specific to each measure. For example, a measure focused on a chronic care condition can identify a clinician group responsible for the care through the clinician group billing a pair of certain Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes for the treatment or management of that condition. Question 4.3 summarizes the attribution methodology for the measures being field tested.

4.3 What is a high-level summary of the measures being field tested?

The measures make use of the chronic condition framework where each measure focuses on the ongoing, outpatient treatment and management of the particular condition. The start of a clinician-patient care relationship is identified by a trigger event, which is a pair of services for the treatment or management of the condition (e.g., outpatient services evaluation and management [E&M] codes) with relevant diagnosis codes billed by the same clinician group within 180 days. This opens an attribution window of 365 days, which can be extended if there are additional services that indicate an ongoing, continuing care relationship. The total attribution window is divided into episodes or segments of at least 365 days, which allows a clinician to be assessed in different performance periods. Once an episode is defined, it’s attributed to the clinician group that billed the trigger event services, and attributed to the clinician(s) within the attributed clinician group who billed at least 30% of the trigger/confirming claims (they must also have seen the patient for the condition prior to the performance year in which they are assessed).

4.4 What services and costs are included in an episode?

Services are assigned to an episode only when clinically related to the management and treatment of a patient’s condition during the episode. Assigned services might include treatment and diagnostic services, and ancillary items and services directly related to treatment (e.g.,

anesthesia for a surgical procedure). Services furnished as a consequence of care, such as complications, readmissions, unplanned care, and emergency department visits may also be included. Related outpatient services (e.g., follow-up consultations, patient home visits, therapeutic procedures) are also included in the measures.

The measures don't include clinically unrelated services. For example, a measure focused on the outpatient management of prostate cancer wouldn't include the costs of a cataract removal procedure as it's clinically unrelated to the care for prostate cancer. Similarly, a cataract removal cost measure wouldn't include biopsy services provided for prostate cancer treatment, since that's clinically unrelated to the procedure to remove a cataract.

The Draft Measure Codes Lists files that will be available on the [MACRA Feedback Page](#) at the start of field testing provide more information on services included in an episode.¹⁷

4.5 Do the measures use standardized costs?

Yes. Payment standardization for Parts A and B adjusts the allowed amount for a Medicare service to facilitate cost comparisons and limit observed differences in costs to those that may result from healthcare delivery choices. Payment standardized costs remove the effect of differences in Medicare payment among healthcare providers that are the result of differences in regional healthcare provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments, such as those for teaching hospitals.¹⁸

Part D standardization is designed to remove non-clinical sources of cost variation. This allows for resource use comparisons across providers who prescribe the same drug, even if the drug products are covered under different Part D plans, produced by different manufacturers, or dispensed by separate pharmacies.¹⁹ The Part D standardization methodology also incorporates rebates into standardized amounts.²⁰

4.6 Which measures include Part D costs?

All 5 measures being field tested this year include Part D costs. The workgroup for each measure considered the inclusion of Part D costs and recognized its importance based on various criteria, including: (i) the type of care being assessed, (ii) whether Part D costs make up a substantial portion of care, and (iii) if the inclusion of Part D costs is necessary to assess clinician performance.

¹⁷ CMS, "2023 Cost Measures Field Testing," MACRA Feedback Page,

<https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

¹⁸ CMS, "CMS Part A and Part B Price (Payment) Standardization - Detailed Methods,"

<https://resdac.org/sites/datadocumentation.resdac.org/files/CMS%20Part%20A%20and%20Part%20B%20Price%20%28Payment%29%20Standardization%20-%20Detailed%20Methods%20%28updated%20May%202022%29.pdf>

¹⁹ CMS, "CMS Part D Price (Payment) Standardization,"

<https://resdac.org/sites/datadocumentation.resdac.org/files/CMS%20Part%20D%20Price%20%28Payment%29%20Standardization%20Methodology%20%28October%202021%29.pdf>

²⁰ CMS, "Learn About the Cost Measures & the Development Process," MACRA Feedback Page,

<https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

4.7 What is risk adjustment?

Risk adjustment is a statistical technique to neutralize the effects of risk factors deemed to be outside of a clinician's influence. When we adjust for risk factors, we aim to isolate the variation in clinicians' costs to Medicare to those costs that clinicians can reasonably control. Accounting for these factors is one way to make sure the measures are fairly comparing clinicians with different patient case mixes on cost performance.

Each measure has its own risk adjustment model to control for variables that affect expected costs for that condition. The CMS Hierarchical Condition Category Version 24 (CMS-HCC V24) 2021 Risk Adjustment Model is the base model for the CKD, Prostate Cancer, and Rheumatoid Arthritis measures. The CMS Hierarchical Condition Category End-Stage Renal Disease (CMS-HCC ESRD) 2021 Risk Adjustment Model is the base model for the ESRD and Kidney Transplant Management measures. The Workgroups provide input based on clinical expertise and review of empirical data to customize each model with additional variables specific to the measure.

4.8 Do the measures risk adjust for social risk factors?

At this stage of measure development, the measures don't risk adjust for social risk factors (SRFs). As part of field testing, we're conducting a series of tests to determine whether it's appropriate to risk adjust for SRFs. If the evidence suggests that it's appropriate to risk adjust for SRFs, the measures will be updated to include SRF risk adjustors prior to implementation in MIPS. For example, the Diabetes and Asthma/Chronic Obstructive Pulmonary Disease (COPD) episode-based cost measures, which were finalized for use in the MIPS Cost Performance category starting in the 2022 MIPS performance period, include a risk adjustor for dual status. Additionally, at the program level, MIPS adjusts for SRFs using the MIPS Complex Patient Bonus to ensure clinicians or groups treating more complex patients are not disadvantaged.

Generally, our testing aims to navigate the tension between ensuring fairness for clinicians treating higher caseloads of vulnerable patients and the possibility of masking poor performance and perpetuating disparity if clinicians are held to different standards. Measures may risk adjust for SRFs when there's evidence indicating that patients' needs or vulnerability is the predominant driver of the observed cost differences rather than the clinicians' performance.

Our testing approach systematically examines a range of SRF variables (e.g., sex, race, dual eligibility status, socioeconomic status) through the following series of tests:

- (i) Whether SRFs are associated with higher episode costs,
- (ii) Whether higher costs are likely due to the costliness of treating vulnerable patients rather than the clinicians' poor performance,
- (iii) Whether there are many clinicians who perform equally well or better on their vulnerable patients compared to their other patients, and
- (iv) Whether there's a large impact on provider ranking if SRFs are risk adjusted

Please see the Measure Testing Forms on the [MACRA Feedback Page](#) at the start of field testing for these results.²¹

²¹ CMS, "2023 Cost Measures Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

4.9 How are episode-based cost measures calculated?

An episode-based cost measure score is the clinician's or clinician group's average risk-adjusted cost for the measure. To calculate the score, we calculate the average ratio of observed cost to expected cost (as predicted through the risk adjustment model) across all attributed episodes, and multiply it by the national average observed episode cost.

A lower measure score indicates that the observed episode costs are lower than or similar to expected costs for the care provided for the particular patients and episodes included in the calculation, whereas a higher measure score indicates that the observed episode costs are higher than expected for the care provided for the particular patients and episodes included in the calculation. Therefore, a lower score is better (i.e., this is an inverse measure).

4.10 Where can I find the draft measure specifications and testing results?

These are posted on the [MACRA Feedback Page](#) at the start of field testing.²²

²² CMS, "2023 Cost Measures Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

5.0 Cost Measures in MIPS

5.1 When will these cost measures be used in MIPS?

The earliest that these measures could be used or implemented in MIPS would be in the 2025 MIPS performance period / 2027 MIPS payment year.

5.2 How would these cost measures fit within MIPS?

If these measures are implemented in MIPS, they would be used in the cost performance category. By statute, the Cost Performance category is weighted at 30% of the MIPS final score starting from the 2022 performance period onward. In the 2023 MIPS performance period, the category includes 23 episode-based cost measures across a wide range of conditions and procedures, and 2 population-based measures focusing on inpatient hospital care and outpatient primary care.

The cost performance category is one of 4 categories, so these measures would be considered alongside other metrics. Clinicians participating in MIPS receive a payment adjustment based on a MIPS final score that assesses evidence-based and practice-specific data in 4 performance categories: (i) quality, (ii) cost, (iii) improvement activities, and (iv) Promoting Interoperability.

The cost measures being field tested could also potentially be used in future, applicable MIPS Value Pathways (MVPs) if they're finalized for use in MIPS. MVPs is a participation framework that aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories. Cost is an essential component in assessing value and it's important to consider how to align cost with quality.

5.3 Can these cost measures be used in MVPs now?

MVPs must include at least one cost measure relevant and applicable to the MVP topic. MVPs must include cost measures currently in use in MIPS in order to be considered feasible. Therefore, the cost measures currently being field tested could be considered for inclusion in viable MVPs if they're used or implemented in MIPS and cover an applicable specialty/clinical topic for MVP development. The MVP Candidate Development & Submission webpage contains more information on MVP development resources/criteria.²³

5.4 How many cost measures are in MIPS?

In the 2023 MIPS performance period, there are 25 cost measures in the MIPS cost performance category, listed in Table 4 below. The Medicare Spending Per Beneficiary (MSPB) Clinician and Total Per Capita Cost (TPCC) measures are population-based measures that focus on inpatient and primary care, respectively. The remaining 23 measures are episode-based measures that span a range of procedures, and chronic and acute inpatient medical

²³ QPP MVPs Page, <https://qpp.cms.gov/mips/mips-value-pathways/submit-candidate>. Direct downloadable link to resources page within the above link can be found here: [https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1803/MIPS%20Value%20Pathways%20\(MVPs\)%20Development%20Resources.zip](https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1803/MIPS%20Value%20Pathways%20(MVPs)%20Development%20Resources.zip)

conditions. Detailed measure specifications for these cost measures are available on the MACRA Feedback Page²⁴ and the QPP Resource Library Page.²⁵

Table 4. Cost Measures in Use in MIPS in the 2023 MIPS Performance Period

ISO	Cost Measure	Type of Cost Measure	First Year in Use in MIPS
1	Total Per Capita Cost	Population-Based (primary care)	2017; refined measure from 2020
2	Medicare Spending Per Beneficiary Clinician	Population-Based (inpatient care)	2017; refined measure from 2020
3	Elective Outpatient Percutaneous Coronary Intervention (PCI)	Episode-based (procedural)	2019
4	Knee Arthroplasty	Episode-based (procedural)	2019
5	Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Episode-based (procedural)	2019
6	Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Episode-based (procedural)	2019
7	Screening/Surveillance Colonoscopy	Episode-based (procedural)	2019
8	Intracranial Hemorrhage or Cerebral Infarction	Episode-based (acute inpatient medical condition)	2019
9	Simple Pneumonia with Hospitalization	Episode-based (acute inpatient medical condition)	2019
10	ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Episode-based (acute inpatient medical condition)	2019
11	Acute Kidney Injury Requiring New Inpatient Dialysis	Episode-based (procedural)	2020
12	Elective Primary Hip Arthroplasty	Episode-based (procedural)	2020
13	Femoral or Inguinal Hernia Repair	Episode-based (procedural)	2020
14	Hemodialysis Access Creation	Episode-based (procedural)	2020
15	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Episode-based (acute inpatient medical condition)	2020
16	Lower Gastrointestinal Hemorrhage (at group level only)	Episode-based (acute inpatient medical condition)	2020
17	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Episode-based (procedural)	2020
18	Lumpectomy, Partial Mastectomy, Simple Mastectomy	Episode-based (procedural)	2020
19	Non-Emergent Coronary Artery Bypass Graft (CABG)	Episode-based (procedural)	2020
20	Renal or Ureteral Stone Surgical Treatment	Episode-based (procedural)	2020
21	Melanoma Resection	Episode-based (procedural)	2022
22	Colon and Rectal Resection	Episode-based (procedural)	2022
23	Sepsis	Episode-based (acute inpatient medical condition)	2022
24	Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Episode-based (chronic condition)	2022
25	Diabetes	Episode-based (chronic condition)	2022

²⁴ MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

²⁵QPP Resource Library Page, <https://qpp.cms.gov/resources/resource-library>.

6.0 Who Can I Contact for More Information?

If you have further questions, please contact the QPP Service Center:

- Email: gpp@cms.hhs.gov
- Telephone: 1-866-288-8292, Monday – Friday, 8 a.m. – 8 p.m. ET

To receive assistance more quickly, please consider calling during non-peak hours – before 10 a.m. and after 2 p.m. ET.

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