Quality Payment
PROGRAM

2022 Cost Measures Field Testing Frequently Asked Questions (FAQ)

Winter 2022 Field Testing

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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 V22	CMS Hierarchical Condition Category Version 22 (2016)
COPD	Chronic Obstructive Pulmonary Disease
CPT/HCPCS	Current Procedural Terminology/Healthcare Common Procedure Coding System
CSV	Comma-Separated Values
CY	Calendar Year
E&M	Evaluation and Management
ESRD	End-Stage Renal Disease
PFP	Person and Family Partners
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
NPI	National Provider Identifier
QPP	Quality Payment Program
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 stakeholders 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 measures' 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 testing results on the MACRA Feedback page[2]
- Collect stakeholder feedback on the draft specifications for each measure through this online survey[3]

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?

Five cost measures are being field tested as part of the development process, prior to being considered for potential use in MIPS. Table 1 lists the measures.

Table 1. Cost Measures Undergoing Field Testing in 2022

No.	Episode-Based Cost Measure	Description
1	Emergency Medicine	This measure focuses on the care provided by clinicians in the emergency department and includes visits leading to both discharge and hospital admission.
2	Low Back Pain	These measures focus on the outpatient treatment and management of the particular condition.
3	Heart Failure	
4	Major Depressive Disorder	
5	Psychoses/Related Conditions	This measure focuses on the inpatient treatment and care for psychoses or related conditions.

[1] CMS, "Quality Payment Program Account," Quality Payment Program, https://qpp.cms.gov/login.
[2] CMS, "Cost Measure Field Testing," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback.
[3] The field testing online survey will be open beginning January 10, 2022 at this link: https://acumen.qualtrics.com/jfe/form/SV_7VByoPD9BPTdR3w

1.3 Do the cost measures being field tested affect my 2021 or 2022 MIPS score?

No. These measures aren't part of MIPS, so they don't count towards 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 them in MIPS.

1.4 How were these cost measures developed?

Acumen's measure development approach involves gathering stakeholder input 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 2 describes the role of different stakeholders in this process.

Table 2. Stakeholder Input Gathered to Date

Stakeholders	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 2 meetings in 2018 and 2020.
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 in December 2020 - February 2021.
Clinician Expert Workgroups ("Workgroups")	Provided input on each aspect of measure specifications through meetings in June - August 2021. 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. The group comprises caregivers and individuals with lived experience of particular health conditions.

For more information on measure development, refer to the 2022 Episode-Based Cost Measures Field Testing Measure Development Process document.[4]

1.5 Why were these measures selected for field testing?

The Emergency Medicine, Low Back Pain, Heart Failure, and Major Depressive Disorder measures represent Wave 4 of development. This process began in December 2020 and is scheduled to conclude in May 2022. 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, impactful, offer opportunities for improvement, and can align with quality.

[4] This document 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

The Psychoses/Related Conditions measure was developed as part of Wave 2 in 2018, along with 10 other episode-based cost measures. This measure was considered for use in MIPS but wasn't implemented due to stakeholder concerns about the scope of the measure. We have been refining the measure since then with more input and testing. Even though the refinements are minor, we believe it's valuable to field test this updated version of the measure to give clinicians another chance to review the measure, especially as there's an outpatient mental and behavioral health measure also being field tested.

1.6 Why are the Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD) episode-based cost measures not being field tested?

These measures will be field tested in early 2023 along with the Wave 5 measures, instead of January-February 2022. CMS has decided to extend the timeline for these two measures to align with Wave 5 to allow for additional research and empirical testing, and to consider potential concurrent development of a kidney transplant management cost measure. This way, there would be a cohesive set of kidney care cost measures under development and consideration for MIPS on the same timeline.

As background, we developed measures assessing the costs of CKD and ESRD care for the Kidney Care First (KCF) Option in the Kidney Care Choices (KCC) Alternative Payment Model throughout 2020. In 2021, we began work to re-specify these measures for use in MIPS. This included convening a workgroup to provide input on each aspect of the measure specifications. During this process, the workgroup shared feedback about the importance of including the kidney transplant recipient patient population in cost measures to represent the full spectrum of kidney care which is necessary to holistically assess value. We conducted analyses to explore this, and identified that this would need to be a separate measure because different care settings and medical codes would be used to define a patient-clinician relationship, and rules around adjusting for severity and including the appropriate costs would need to be modified for this group. In addition, we would need to test measure specifications and seek input from experts with experience in transplant-related care.

To gather input from transplant nephrologists and others who directly manage kidney transplant care, Acumen will need to recruit new members, which will not be possible to complete before January 2022. Since CKD, ESRD, and kidney transplant management are all closely related, we believe that developing three measures on the same timeline and with the same Clinician Expert Workgroup could be beneficial to ensure a cohesive set of kidney care measures. Even without a separate transplant management measure, additional workgroup members with expertise on post-transplant management would be important to include as Acumen refines the CKD/ESRD measures under development. As such, an extended development timeframe will allow us to complete measure specification, stakeholder engagement, and measure testing (including field testing in 2023) for the measures.

2.0 Participating in Field Testing

2.1 When does field testing take place?

Field testing will last from January 10 to February 25, 2022 (11:59 p.m. ET). We extended the length of field testing to a 7-week period to give stakeholders more time to review and provide input on the draft specifications.

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 measure specifications using this online survey. If you're eligible to receive a Field Test Report, you'll need a QPP account to access the report(s). More information about the QPP portal and how to register for an account can be found in the Cost Measure Field Test Report User Access Guide on the MACRA Feedback Page.[5]

2.3 Why should I participate?

Field testing is a chance for all stakeholders 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 2022 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.[6]

2.5 How can I give feedback?

You can share your feedback through this online survey.[7] You can answer questions about the measures or upload a PDF or Word document. You may submit comments anonymously if you prefer.

2.6 How will you use my feedback?

After field testing, we'll summarize your feedback and share it with the 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.

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[5] This document 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

[6] This document 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

[7] The field testing online survey will be open beginning January 10, 2022 at this link: https://acumen.qualtrics.com/jfe/form/SV_7VByoPD9BPTdR3w

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 stakeholders to review publicly available field testing materials and provide feedback by completing this online survey[8] when they become available on the MACRA Feedback page:[9]

- 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
- National Summary Data Report

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

No. This is the 4th time that we have conducted field testing for episode-based cost measures. Previous rounds of field testing took place in:

- Wave 1: 8 episode-based measures (October 16 to November 15, 2017)
- Wave 2: 11 episode-based cost measures and 2 revised population-based cost measures (October 3 to October 31, 2018)
- Wave 3: 5 episode-based cost measures (August 17 to September 18, 2020)

Field testing resources from 2017, 2018, and 2020 can be found on the MACRA Feedback Page.[10]

[8] The field testing online survey will be open beginning January 10, 2022 at this link: https://acumen.qualtrics.com/jfe/form/SV_7VByoPD9BPTdR3w

[9] CMS, "Cost Measure Field Testing," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback

[10] 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 will 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:

- 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)
- Data dictionary for the episode-level file (CSV 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 HCQIS Access Roles and Profile (HARP) account in order to sign in.[11] Once you have access, you can connect with your organization by navigating to the "Manage Access" 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 provides more information on how to sign up for a Quality Payment Program account and how to connect with the appropriate organization.[12]

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 is 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

[11] CMS, "Quality Payment Program Account," Quality Payment Program, https://qpp.cms.gov/login?page=register

[12] 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.[13]

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, 2019.

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

- Medicare Parts A, B, and D claims data from the Common Working File (as a note, not all cost measures use Part D data)
- Enrollment Data Base
- Long Term Care Minimum Data Set

3.5 How many Field Test Reports are there?

Table 3 includes the number of Field Test Reports available for each measure.

Table 3. Number of Field Test Reports for Each Measure

Episode-Based Cost Measure	Number of TIN Reports	Number of TIN-NPI Reports
Emergency Medicine	4,071	79,540
Low Back Pain	49,949	69,742
Heart Failure	10,667	19,829
Major Depressive Disorder	17,237	23,927
Psychoses/Related Conditions	2,041	5,131

3.6 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.

[13] CMS, "Cost Measure Field Testing," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback

- 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 procedures can identify a clinician responsible for the care through the clinician billing the Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code for that procedure. The table in 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?

Table 4 below summarizes key aspects of the measures. The trigger and attribution methodology describes how we identify the start of a care relationship between a clinician and patient.

Table 4. Summary of Key Features of Measures

No.	Measure	Trigger and Attribution Methodology	Setting	Episode Window
1	Emergency Medicine	An evaluation and management (E&M) code for an ED visit.	Emergency department (ED)	30 days
2	Low Back Pain	A pair of services for the treatment or management of low back pain (e.g., outpatient E&Ms, therapy services, manipulation) with relevant diagnosis codes billed by the same TIN within 60 days.	Outpatient	120 days (can be extended if there's ongoing care)

No.	Measure	Trigger and Attribution Methodology	Setting	Episode Window
3	Heart Failure	A pair of services for the treatment or management of heart failure (e.g., outpatient E&Ms, transitional care codes, advanced care planning) with relevant diagnosis codes billed by the same TIN within 180 days.	Outpatient	365 days (can be extended if there's ongoing care)
4	Major Depressive Disorder (MDD)	A pair of services for the treatment or management of MDD (e.g., outpatient E&Ms, behavioral health visits) with relevant diagnosis codes billed by the same TIN within 180 days.	Outpatient	365 days (can be extended if there's ongoing care)
5	Psychoses / Related Conditions	30% of inpatient E&Ms billed by a TIN during an inpatient stay for Medicare Severity-Diagnosis Related Group (MS-DRG) 885.	Acute care hospitals and inpatient psychiatric facilities (IPFs)	From admission to 45 days after admission

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 low back pain wouldn't include the costs of a cataract removal procedure as it's clinically unrelated to the care for low back pain. Similarly, a cataract removal cost measure wouldn't include physical therapy services provided for low back pain 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.[14]

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 health care delivery choices. Payment standardized costs remove the effect of differences in Medicare payment among health care providers that are the result of differences in regional health care provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments such as those for teaching hospitals.[15]

[14] CMS, "Cost Measure Field Testing," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback

[15] CMS, "CMS Part A and Part B Price (Payment) Standardization - Detailed Methods", https://resdac.org/articles/cms-price-payment-standardization-overview

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.[16]

4.6 Which measures include Part D costs?

Three of the measures being field tested include Part D costs: Major Depressive Disorder, Low Back Pain, and Heart Failure.

The TEP's guidance was that Part D should be considered on a case-by-case basis, so not all measures include Part D costs. The TEP noted that Part D costs may not be relevant to all measures, depending on the type of care being assessed. Measures where Part D makes up a substantial portion of care or where assessing clinician performance may be incomplete without Part D could be candidates for including Part D drugs.

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 base model is the CMS Hierarchical Condition Category Model, which is used in Medicare Advantage. 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?

Currently, the measures don't adjust for social risk factors. As part of field testing, we're examining the impact of social risk factors on the measures as currently specified. Please see the Measure Testing Form on the MACRA Feedback Page for these results.[17]

In general, we conduct social risk factor testing on all cost measures as part of the development process. We routinely test the impact of adding a range of variables (e.g., sex, race, dual eligibility, income, education, employment) to the risk adjustment model. Across almost all of the episode-based cost measures that are in MIPS now, we have found that social risk factor variables have little impact on clinician performance after adjusting for a robust set of clinical and other risk factors. For some measures, we have also seen inconsistent impacts of social risk factor variables which could result in unintended consequences (e.g., where dual status predicts lower costs).

For some measures, empirical social risk factor testing showed that there was an impact and that it was driven by dual status. Based on these analyses, the Diabetes and Asthma/Chronic

[16] CMS, "CMS Part D Price (Payment) Standardization", https://resdac.org/articles/cms-price-payment-standardization-overview

[17] CMS, "Cost Measure Field Testing," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback

Obstructive Pulmonary Disease (COPD) episode-based cost measures in the MIPS Calendar Year (CY) 2022 cost performance category include a risk adjustor for dual status.

Generally, risk adjusting for social risk factors is challenging, given their inconsistent direction and limited impact under the risk adjustment model, and their inclusion may mask the differences between providers that we want to observe.

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 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.[18]

[18] CMS, "Cost Measure 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 2024 MIPS performance period / 2026 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 from the 2022 performance period onward. In CY 2022, 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.

5.3 How do these cost measures relate to the MIPS Value Pathways?

MIPS Value Pathways (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. The cost measures being field tested could potentially be used in future, applicable MVPs if they're finalized for use in MIPS.

5.4 How many cost measures are in MIPS?

In CY 2022, there are 25 cost measures in the MIPS cost performance category, listed in Table 5, 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 acute and chronic conditions.

Table 5. CY 2022 MIPS Cost Measures

Measure Title	
Acute Kidney Injury Requiring New Inpatient Dialysis	Lumpectomy, Partial Mastectomy, Simple Mastectomy
Asthma/ Chronic Obstructive Pulmonary Disease (COPD)	Medicare Spending Per Beneficiary Clinician
Colon and Rectal Resection	Melanoma Resection
Diabetes	Non-Emergent Coronary Artery Bypass Graft (CABG)
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Renal or Ureteral Stone Surgical Treatment
Elective Primary Hip Arthroplasty	Revascularization For Lower Extremity Chronic Critical Limb Ischemia
Femoral or Inguinal Hernia Repair	Routine Cataract Removal with Intraocular Lens (IOL) Implantation

Measure Title	
Hemodialysis Access Creation	Screening/Surveillance Colonoscopy
Inpatient Chronic Obstructive Pulmonary Disease (COPD)	Sepsis
Intracranial Hemorrhage or Cerebral Infarction	Simple Pneumonia with Hospitalization
Knee Arthroplasty	ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)
Lower Gastrointestinal Hemorrhage	Total Per Capita Cost
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	

6.0 Who can I contact for more information?

Should you have further questions, the QPP Service Center is available via the following methods:

- Email: qpp@cms.hhs.gov
- Telephone: 1-866-288-8292, Monday – Friday, 8:00 a.m. – 8:00 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.