

## 2020 Cost Measures Field Testing Frequently Asked Questions (FAQ)

Summer 2020 Field Testing



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## Acronyms and Abbreviations

Table 1.1 Acronyms and Abbreviations

Acronym and/or Abbreviation	Description
Advanced APMs	Advanced Alternative Payment Models
CMS	Centers for Medicare & Medicaid Services
CMS-HCC V22	CMS Hierarchical Condition Category Version 22 (2016)
CPT/HCPCS	Current Procedural Terminology/Healthcare Common Procedure Coding System
CY	Calendar Year
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics & Supplies
E&M	Evaluation and Management
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 Policy Context

## 1.1 What is the Quality Payment Program?

MACRA established the Quality Payment Program. Under the Quality Payment Program, clinicians are incentivized to provide high-quality and high-value care through Advanced Alternative Payment Models (APMs) or the Merit-based Incentive Payment System (MIPS). MIPS eligible clinicians will receive a performance-based adjustment to their Medicare payments. This payment adjustment is based on a MIPS final score that assesses evidence-based and practice-specific data across the following categories: (i) Quality, (ii) Cost, (iii) Improvement Activities, and (iv) Promoting Interoperability.

The Quality Payment Program is currently in its fourth year (2020), and this is the third year the Cost performance category will have an impact on the MIPS final score. For the 2020 performance period, the Cost performance category is weighted at 15% of the final score.

Through the fifth year of the MIPS, the Bipartisan Budget Act of 2018 provides flexibility in establishing the weight of the Cost performance category. Instead of requiring the Cost performance category to have a weight of 30% in the third year of the program (as originally required in MACRA), the weight is required to be between 10% and 30% for the third, fourth, and fifth years of Quality Payment Program. By the sixth year, the Cost performance category weight is required to be 30%.

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 MIPS. Throughout the measure development process, Acumen seeks input from clinicians and other stakeholders to inform the development of episode-based cost measures.

## 1.2 Do the cost measures being field tested affect my 2020 MIPS score?

No. Field testing is part of the measure development process, so measures being field tested are not part of the Cost performance category. As such, they do not count towards your final score, and do not affect any payment adjustments. The purpose of field testing is to gather feedback on the draft measure specifications.

## 1.3 Which cost measures are being field tested and how do they relate to the Quality Payment Program?

Acumen is developing 5 episode-based cost measures for potential use in MIPS based on 3 types of episode groups, listed in Table 1 below. Episode groups:

- represent a clinically cohesive set of medical services rendered to treat a given medical condition;
- aggregate all items and services provided for a defined patient cohort to assess the total cost of care; and
- are defined around treatment for a condition (i.e., acute inpatient or chronic) or performance of a procedure.

**Table 1. Cost Measures Undergoing Field Testing**

Episode Group Type	Clinical Subcommittee	Episode-Based Cost Measure
Procedural	Dermatologic Disease Management	Melanoma Resection
Procedural	General and Colorectal Surgery	Colon and Rectal Resection
Acute Inpatient Medical Condition	Hospital Medicine	Sepsis
Chronic Condition	Chronic Condition and Disease Management	Asthma/Chronic Obstructive Pulmonary Disease (COPD)
Chronic Condition	Chronic Condition and Disease Management	Diabetes

This third wave of measure development began in May 2019 and is scheduled to conclude in October 2020. The episode-based cost measures are being developed with extensive input from a Technical Expert Panel, Clinical Subcommittees, Clinician Expert Workgroups, and a Person and Family Committee. The Technical Expert Panel serves a high-level advisory role and provides guidance on the overall direction of measure development. The 4 Clinical Subcommittees make recommendations on which episode groups are best suited for cost measure development and the composition of the 5 Clinician Expert Workgroups.<sup>1</sup> These 5 Workgroups make recommendations on clinical specifications for each cost measure.<sup>2</sup> The Person and Family Committee provides feedback from persons and families to inform key components of cost measure development with patient and caregiver perspectives. The field testing period offers all stakeholders an opportunity to provide input on the cost measures.

#### 1.4 When will these cost measures be used in MIPS?

These measures may be implemented in the 2022 performance period or beyond. The 5 episode measures are being field tested as part of the measure development process and are **not** included in the 2020 performance period. Following the measures' completed development, CMS will consider stakeholder feedback before considering the measures' potential use in the Cost performance category for a future year. This would involve submission of the measures through the pre-rulemaking process and proposing the measures for use through the notice-and-comment rulemaking process.

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

Cost measures in the Cost performance category will be incorporated into the MIPS Value Pathways (MVPs), which are a participation framework that will create connections between

<sup>1</sup> The Clinical Subcommittee meeting summaries are available here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-wave3-cs-meeting-summaries.zip>

<sup>2</sup> The Clinician Expert Workgroup meeting summaries are available here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Summary-of-wave-3-workgroup-meetings.zip>

quality, cost, and improvement activity categories. As such, these cost measures could potentially be used in MVPs in the future if they are finalized for use in MIPS.

## 2.0 Field Testing

### 2.1 What is field testing?

As part of the measure development process, 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. During field testing, we will:

- distribute Field Test Reports on the [Quality Payment Program website](#)<sup>3</sup> for group practices and solo practitioners who meet the minimum number of cases for each measure;
- post draft measure specifications (i.e., measure methodology and codes lists), and supplemental documentation, such as testing results, on the [MACRA Feedback page](#)<sup>4</sup>; and
- collect stakeholder feedback on the draft specifications for each measure.

### 2.2 When does field testing take place?

Field testing will last from August 17 to September 18, 2020. During this period, stakeholders may submit feedback on the 5 episode-based cost measures under development.

### 2.3 What is new for 2020 field testing?

We have heard your feedback from previous testing in 2017 and 2018. This year:

- you can access Field Test Reports on the Quality Payment Program website using the same account information that you use to submit data and view performance feedback;
- we extended the length of field testing to a 5-week period to give you more time to review and provide input on the draft specifications; and
- we updated the structure and format of the Field Test Report to a portable document format (PDF) to streamline the information and make it accessible across phone and computer platforms. An accompanying comma-separated values (CSV) file provides episode-level details for attributed clinicians and groups interested in more granular data. The report also contains a summary of the measure specifications for quick reference.

### 2.4 How can I give feedback?

Acumen is collecting feedback on the draft measure specifications of the 5 episode-based cost measures during the field testing period, from August 17 to September 18, 2020, through this [online survey](#).<sup>5</sup> When submitting feedback through the online survey, stakeholders can also attach a PDF or Word document with their comments. Comments may be submitted anonymously if preferred. Specific questions about the measure specifications are available in the Questions for Field Testing Measure Specifications document,<sup>6</sup> which stakeholders can use as a reference while reviewing the field testing materials. Feedback received on these specifications will be used to refine the measures.

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<sup>3</sup> CMS, "Quality Payment Program Account," Quality Payment Program, <https://qpp.cms.gov/login>.

<sup>4</sup> CMS, "Cost Measure Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

<sup>5</sup> The field testing online survey will be open beginning August 17, 2020 at this link: <https://www.surveymonkey.com/r/2020-cost-measures-field-testing>

<sup>6</sup> 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>

In addition, we are also looking for whether the information presented in the Field Test Report helps you identify actionable improvements to patient care and cost efficiency, and whether the field testing materials present the information in a way that explains the measures.

## 2.5 What will my feedback be used for?

CMS will use this feedback to refine the cost measures prior to their consideration for potential use in the MIPS Cost performance category. It 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.

We appreciate the feedback stakeholders have shared during previous field testing. We shared this feedback with the Clinical Subcommittees and Clinician Expert Workgroups who considered it when making refinement recommendations to all episode-based cost measures field tested in Wave 1 and Wave 2 of measure development. The Technical Expert Panel also considered feedback on the field test reports and in refining the revised population-based cost measures. Summaries of all the feedback we received during field testing are posted to the [MACRA Feedback page](#).<sup>7</sup> We will share this year’s field testing feedback with the Clinician Expert Workgroups again, to inform any potential recommendations for refinements of the 5 episode-based cost measures currently undergoing development.

## 2.6 Who can receive a Field Test Report(s) and what is the format?

Field Test Reports will be available at the clinician group practice and solo practitioner (or clinician) level. Clinicians are identified by a unique TIN and NPI combination (TIN-NPI), while clinician groups are identified by their TIN. For clinician group practices, the group practice must meet the minimum number of cases for the measures across all clinicians billing under the group practice TIN. For solo practitioners, the individual clinician must meet the minimum number of cases for the measures.

**Table 2. Field Test Report Information**

	<b>Procedural Episode Group</b>	<b>Acute Inpatient Medical Condition Episode Group</b>	<b>Chronic Condition Episode Group</b>
<b>Types of clinicians likely to receive a Field Test Report</b>	Clinicians who perform melanoma resection or colon and rectal resection procedures	Clinicians who manage the acute inpatient hospitalization for the treatment of sepsis	Clinicians who manage the ongoing treatment of chronic COPD or diabetes
<b>Number of cases clinicians and clinician groups need to receive a Field Test Report</b>	10 episodes	10 episodes	20 episodes
<b>Measurement period</b>	January 1 to December 31, 2019	January 1 to December 31, 2019	January 1 to December 31, 2019
<b>Field Test Reports will be available for download in a zip file containing:</b>	<ul style="list-style-type: none"> <li>Measure-specific report (PDF file format)</li> <li>Episode-level information (CSV file format)</li> </ul>	<ul style="list-style-type: none"> <li>Measure-specific report (PDF file format)</li> <li>Episode-level information (CSV file format)</li> </ul>	<ul style="list-style-type: none"> <li>Measure-specific report (PDF file format)</li> <li>Episode-level information (CSV file format)</li> </ul>

<sup>7</sup> CMS, “Cost Measure Field Testing,” MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

If you meet the criteria for receiving a Field Test Report for more than one cost measure, you will receive more than one measure-specific report. These reports will be compiled into one zip file with a corresponding CSV file of detailed episode-level information for each measure that you have received a report.

## 2.7 How can group practices and solo practitioners access their Field Test Report(s)?

You or your group's authorized representative can access the Cost Measure Field Test Report(s) using a [Quality Payment Program website](#) account. If you do not have an account, you will need to register for a HCQIS Access Roles and Profile (HARP) account in order to sign in.<sup>8</sup> 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 are part of a clinician group, you will select the "practice" organization type, and if you are an individual clinician, you will select the "individual clinician" organization type.

More information on how to sign up for a Quality Payment Program account or how to connect with the appropriate organization is available in this [Quality Payment Program Access User Guide](#).<sup>9</sup>

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 is 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 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 will 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 are a part of a group practice or whether they practice on their own. More information on accessing a Field Test Report is available in this Field Test Report Access User Guide on the MACRA Feedback Page.

**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.

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<sup>8</sup> CMS, "Quality Payment Program Account," Quality Payment Program, <https://qpp.cms.gov/login?page=register>

<sup>9</sup> CMS, "Quality Payment Program Access User Guide," Quality Payment Program, <https://qpp.cms.gov/resource/2019%20QPP%20Access%20User%20Guide>.

## 2.8 What data were used for the Field Test Reports?

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

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

The measurement period for the Field Test Reports is January 1 to December 31, 2019.

## 2.9 How can group practices and solo practitioners use the information in their Field Test Report(s)?

Group practices and solo practitioners may use the data in their Field Test Report(s) to understand what contributes to the costs of their patients' care and identify areas to improve efficiency and care coordination.

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); and
- show which other Medicare clinicians account for patient costs during the episode.

Please reference the “Overview and Results” section and the “Appendix B – Glossary” section of the Field Test Report for more information about how to use and interpret the report.

## 2.10 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](#)<sup>10</sup> when they become available on the [MACRA Feedback page](#).<sup>11</sup>

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

The survey will be open from August 17 to September 18, 2020 at 11:59 p.m. ET.

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<sup>10</sup> The field testing online survey will be open beginning August 17, 2020 at this link: <https://www.surveymonkey.com/r/2020-cost-measures-field-testing>

<sup>11</sup> CMS, “Cost Measure Field Testing,” MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

## 3.0 Episode-Based Cost Measures

### 3.1 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”). Episode-based cost measures inform clinicians about the cost of the care they are responsible for providing to a patient during the episode’s timeframe. In the Field Test Reports and their supplemental documentation, 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.

Episode-based cost measures are calculated with Medicare Parts A and B fee-for-service claims data and are based on episode groups. Episode groups:

- represent a clinically cohesive set of medical services rendered to treat a given medical condition;
- aggregate all items and services provided for a defined patient cohort to assess the total cost of care; and
- are defined around treatment for a condition (i.e., acute inpatient or chronic) or performance of a procedure.

Services in the episode group could be treatment services, diagnostic services, and ancillary items and services directly related to treatment (such as anesthesia for a surgical procedure). They can also be services that happen after the initial treatment period that may be given to patients as follow-up care or to treat complications resulting from the treatment.

An episode is a specific instance of an episode group for a given patient and clinician. For example, in a given year, a clinician might be attributed 20 episodes (instances of the episode group) from the episode group for sepsis.

To make sure there is a more accurate comparison of cost across clinicians, episode costs are payment standardized and risk-adjusted.

- **Payment standardization** 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.
- **Risk adjustment** accounts for patient characteristics that can influence spending and are outside of clinician control, which are identified through clinician input.

### 3.2 What are the types of episode groups?

Cost measures can be based on 3 types of episode groups:

- **Procedural episode groups** focus on procedures of a defined purpose or type, such as surgeries. Of the 5 measures in field testing, 2 are based on procedural episode groups: Colon and Rectal Resection and Melanoma Resection.
- **Acute inpatient medical condition episode groups** represent treatment for self-limited acute illness or treatment for flares or an exacerbation of a condition that requires a

hospital stay. Of the 5 measures in field testing, one is based on an acute inpatient medical condition episode group: Sepsis.

- **Chronic condition episode groups** account for the ongoing management of a disease or condition. Of the 5 measures in field testing, 2 are based on chronic episode groups: Diabetes and Asthma/ Inpatient Chronic Obstructive Pulmonary Disease. This is the first wave of measure development where chronic condition episode groups are being developed.

### 3.3 How were the conditions and procedures for the 5 episode-based cost measures in field testing chosen?

The measure development process, including selection of the 5 episode-based cost measures, involved extensive stakeholder input. Acumen convened Clinical Subcommittees composed of clinicians with experience in relevant clinical areas to select and provide detailed input on these measures.

As a starting point, Clinical Subcommittee members used the draft list of episode groups and episode trigger codes that was posted for public comment, as required by MACRA, in December 2016.<sup>12</sup> The Subcommittee members considered the following criteria, based on stakeholder feedback, to recommend conditions and procedures for cost measure development:

- (i) Potential impact on Medicare spending (e.g., number of patients impacted by the condition or procedure, number of clinicians and clinician groups attributed)
- (ii) Clinical coherence (i.e., the degree to which a measure's patient population has a similar stage and severity of a particular illness or condition)
- (iii) The measure's opportunity for improvement (i.e., clinicians' ability to exercise influence on a significant share of episode costs)
- (iv) The measure's opportunity for alignment with established quality indicators

Summaries of the Clinical Subcommittee meetings held in May-June 2019 where these topics were discussed are available on the [MACRA Feedback Page](#).<sup>13</sup> Because this is the first cycle where chronic episode-based cost measures are being developed, Acumen also gathered additional feedback from the Technical Expert Panel in December 2018 and February 2020 on the framework for defining chronic episode groups and the prioritization of chronic episode groups for development.

### 3.4 Where can I find more information on the 5 episode-based cost measures being field tested?

Detailed specifications on the 5 episode-based cost measures can be found in each measure-specific Draft Measure Codes List file and Draft Measure Methodology, which will be available on the [MACRA Feedback Page](#) at the start of field testing.<sup>14</sup> Descriptions of the 5 episode-based cost measures are outlined in Table 3 below.

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<sup>12</sup> CMS, "Draft List of MACRA Episode Groups and Trigger Codes," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Draft-list-of-episode-groups-and-trigger-codes-December-2016.zip>

<sup>13</sup> Acumen, "Wave 3 Clinical Subcommittee Meeting Summaries file," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-wave3-cs-meeting-summaries.zip>

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

**Table 3. Descriptions of Cost Measures Undergoing Field Testing**

Episode-Based Cost Measure	Measure Description
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Assesses the clinician's risk adjusted cost to Medicare for patients who have chronic asthma or COPD for one year beginning on the earliest date of a trigger event.
Colon and Rectal Resection	Assesses the clinician's risk-adjusted cost to Medicare for patients who undergo colon and/or rectal resection procedures and includes the costs of services clinically related to the attributed clinician's role in managing care from 15 days prior to the procedure to 90 days after the procedure.
Diabetes	Assesses the clinician's risk-adjusted cost to Medicare for patients who have diabetes for one year beginning on the earliest date of a trigger event.
Melanoma Resection	Assesses the clinician's risk-adjusted cost to Medicare for patients who undergo melanoma resection and includes the costs of services clinically related to the attributed clinician's role in managing care from 30 days prior to the procedure to 90 days after the procedure.
Sepsis	Assesses the clinician's risk-adjusted cost to Medicare for patients who are hospitalized for sepsis and includes the costs of services clinically related to the attributed clinician's role in managing care from inpatient hospitalization that triggers an episode through 30 days after the trigger.

### 3.5 How are episodes attributed to a clinician?

Once an episode begins, or is triggered, it is attributed to a clinician(s) responsible for the costs of care during the episode window. Information from claims (i.e., services billed on the claim) are used to identify the clinician(s). The Clinical Subcommittees and Clinician Expert Workgroups provide input on the types of clinicians who would likely be responsible for costs and care during an episode given its scope. The method of attribution varies by episode type:

- For procedural episode groups, episodes are attributed to the clinician(s) or clinician group(s) billing the Part B Physician/Supplier claims for the service(s) provided during the trigger event.
- For acute inpatient medical condition episode groups, an episode is attributed to a clinician group if the TIN bills at least 30% of the inpatient E&M services on the identified Part B Physician/Supplier claim lines during the episode, and to clinicians who bill at least one inpatient E&M service under a TIN that meets the 30% threshold.
- For chronic condition episode groups, an episode is attributed to the clinician group(s) who bills the trigger services as identified by a primary care E&M code<sup>15</sup> with a chronic diagnosis,<sup>16</sup> followed by either a second primary care E&M code with a chronic diagnosis code or a chronic CPT/HCPCS code with a chronic diagnosis.<sup>17</sup> An episode is then attributed to any clinician within the attributed clinician group who bills at least 30% of the

<sup>15</sup> A primary care E&M is a specific subset of E&M codes for physician visits in the outpatient, physician office, nursing facility, or assisted living intended to identify primary care.

<sup>16</sup> A chronic diagnosis is an ICD-10 diagnosis code that indicates the presence of the chronic disease in either the primary diagnosis field or full diagnosis array.

<sup>17</sup> A chronic CPT/HCPCS code is a CPT/HCPCS procedure code related to the treatment of a chronic condition.

primary care E&M with a chronic diagnosis and/or chronic CPT/HCPCS codes with a chronic diagnosis on the Part B Physician/Supplier claim lines during the episode.

Detailed specifications can be found in each measure-specific Draft Measure Codes List file and Draft Measure Methodology, which will be available on the [MACRA Feedback Page](#) at the start of field testing.<sup>18</sup>

### **3.6 What services and costs are included in an episode?**

After episodes are attributed to one or more clinicians, services and their respective Medicare costs are assigned to an episode group if they are considered to be clinically related to the attributed clinician's role in managing patient care during an episode and reasonably within their influence. Clinician Expert Workgroup members provided detailed clinical input on the services that should be included in episode.

Assigned services might include diagnostic services, treatment services, and ancillary items and services directly related to treatment (e.g., anesthesia for a surgical procedure), as well as services following the initial treatment period that may be rendered to patients as follow-up care. Services furnished as a consequence of care, such as complications, readmissions, unplanned care, and emergency department visits may also be included. Related telehealth services (e.g., follow-up consultations, patient home visits, therapeutic procedures) are also included in the measures, informed by CMS guidance and measure-specific clinical input. The episode group does not include clinically unrelated services, such as care for a chronic condition that occurs in the episode window for a procedure or acute inpatient medical condition but is not related to the clinical management of the patient relative to the procedure or condition.

More information on services included in an episode is available in the Draft Measure Codes Lists file, available on the [MACRA Feedback Page](#) at the start of field testing.<sup>19</sup>

### **3.7 What is the purpose of risk adjustment?**

Risk adjustment is a regression analysis that accounts for specific risk factors that are clinically relevant to the episode group. We calculate risk-adjusted costs for each episode to try to get a more accurate cost comparison across clinicians by taking into account factors clinicians cannot control but that can affect cost. For example, risk adjustment takes into account factors like a patient's:

- Illness severity
- Age
- Comorbidities

When we adjust for risk, 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 cost measures are valid and avoid unintended consequences.

### **3.8 What risk adjustment methodology was used?**

Risk-adjusted costs for each episode are calculated using 2 types of risk adjustors:

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<sup>18</sup> CMS, "Cost Measure Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

<sup>19</sup> CMS, "Cost Measure Field Testing," MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

- Standard risk adjustors used commonly in risk adjustment for all of the episode-based cost measures. These standard risk adjustors include:
  - factors included in the CMS-HCC V22 2016 Risk Adjustment Model,<sup>20</sup> and
  - additional standard variables, such as patient age and original reason for enrollment in Medicare.
- Other risk adjustors that are clinically relevant to a specific episode group, often identified by the measure-specific Clinician Expert Workgroups as a cost outside the influence of the attributed clinician.

Detailed specifications (i.e., codes specifying each risk adjustment variable) can be found in each measure-specific Draft Measure Codes List file, which will be available on the [MACRA Feedback Page](#) at the start of field testing.<sup>21</sup>

### 3.9 How are episode-based cost measures calculated?

An episode-based cost measure score is the clinician’s average, risk-adjusted cost for the episode group. To calculate the score, we sum the ratio of observed to expected payment-standardized costs to Medicare for all episodes attributed to a clinician and divide this sum by the total number of episodes attributed to a clinician. The average episode cost ratio is then multiplied by the national average observed episode cost to generate a dollar figure for the cost measure score.

Chronic episode-based cost measure calculations vary slightly from the acute and procedural episode-based cost measure calculations because they calculate the observed and expected daily costs, rather than the total observed and expected costs. This is to account for the ongoing nature of the care clinicians provide for chronic conditions. Below are the detailed steps we perform to calculate the cost measure scores, using all episodes in an episode group that are attributed to a clinician or clinician group.

#### **Acute and Procedural Episode-Based Cost Measure Calculation Steps:**

**Step 1:** Determine observed costs for each episode by aggregating standardized allowed amounts for services determined to be clinically related to a given condition or procedure that occur within the episode window.

**Step 2:** Determine expected costs for each episode through risk adjustment by taking into account factors that are included in the CMS-HCC V22 2016 Risk Adjustment Model as well as additional risk adjustors recommended by Clinical Subcommittee workgroups for each episode group. If a measure has sub-groups, this includes only episodes within the same sub-group nationally.

**Step 3:** Divide the observed cost for each episode by the expected cost to obtain the observed/expected ratio for each episode.

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<sup>20</sup> CMS uses a Hierarchical Condition Category (HCC) risk adjustment model to calculate risk scores. The HCC model ranks diagnoses into categories that represent conditions with similar cost patterns. Higher categories represent higher predicted healthcare costs, resulting in higher risk scores. There are 79 HCC codes included in the CMS-HCC V22 model. Some examples include Morbid Obesity, Dialysis Status, and Schizophrenia. For more information about this risk adjustment model, please refer to: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>.

<sup>21</sup> CMS, “Cost Measure Field Testing,” MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

**Step 4:** Sum the observed/expected ratios for all the episodes across the entire episode group (i.e., across all sub-groups) for the TIN or TIN-NPI.

**Step 5:** Divide by the total number of episodes attributed to the TIN or TIN-NPI across the episode group to obtain the average observed/expected ratio for all episodes.

- This average ratio's standing relative to one is what indicates whether a clinician's episodes cost more or less than expected on average.

**Step 6:** Multiply the result by the national average observed episode cost for all episodes across all sub-groups to obtain the cost measure score.

- This is done to convert the average ratio into a figure that is more meaningful from a cost perspective by having the clinician's average cost measure score represented as a dollar amount rather than a ratio.

### **Chronic Episode-Based Cost Measure Calculation Steps:**

**Step 1:** Determine observed costs for each episode by aggregating standardized allowed amounts for services determined to be clinically related to a given chronic condition within the episode. Calculate the average observed daily cost for each episode and multiply it by 365 to determine each episode's annualized observed cost.

**Step 2:** Determine annualized expected costs for each episode through risk adjustment by taking into account factors that are included in the CMS-HCC V22 2016 Risk Adjustment Model as well as additional risk adjustors recommended by Clinical Subcommittee workgroups for each episode group. If a measure has sub-groups, this includes only episodes within the same sub-group nationally.

**Step 3:** Determine the number of days assigned to the TIN or TIN-NPI for each episode in the performance period.

**Step 4:** Divide the annualized observed cost by the annualized expected cost to obtain the observed/expected ratio for each episode. Multiply this ratio by the respective number of assigned days for the TIN or TIN-NPI, determined in Step 3.

**Step 5:** Divide by the total number of days assigned to the TIN or TIN-NPI across the episode group to obtain the weighted average observed/expected ratio for all episodes.

- This average ratio's standing relative to one is what indicates whether a clinician's episodes cost more or less than expected on average.

**Step 6:** Multiply the result by the national average annualized observed episode cost for all episodes to obtain the cost measure score.

## **Where can I get more information?**

Should you have further questions, please contact the Quality Payment Program Service Center via telephone at 1-866-288-8292 or via email at [gpp@cms.hhs.gov](mailto:gpp@cms.hhs.gov). The Help Desk is available Monday – Friday, 8:00 a.m. – 8:00 p.m. Eastern Time.