2022-2024 Merit-based Incentive Payment System (MIPS) Cost Measure FAQs

Purpose

This document answers key questions about Merit-Based Incentive Payment System (MIPS) cost measures in use for the 2022, 2023, and 2024 performance periods. The document is intended for practice representatives, individual clinicians, and other interested parties.

Cost Measure Inventory

How are cost measure specifications maintained for use in MIPS?

All MIPS cost measures undergo annual maintenance. This process ensures that the measures are functioning as intended and makes minor updates (e.g., for coding changes). The Measure Codes Lists that detail the specific codes used to construct the measures are also updated annually and made publicly available on the QPP website for any interested parties to review.

In addition, after three years in MIPS, cost measures are considered for comprehensive reevaluation. CMS can holistically review each aspect of the measure, including the measure's intent and importance, which is a broader scope than routine annual maintenance.

Why are deleted or retired codes still in cost measure specifications?

Service and diagnosis codes used to calculate cost measures (e.g., Medicare Severity Diagnosis Related Groups (MS-DRGs), Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases, Tenth Revision (ICD-10) codes) that are not in effect in a particular year due to updates to code sets may be intentionally retained in the measure specifications for completeness. Deleted codes or superseded codes (codes that are replaced by another code) are sometimes still billed despite being deleted; as such, they are visible in claims data. It is therefore important to retain codes as part of measure specifications to avoid skewing any results due to billing anomalies.

What maintenance changes were made for the 2023 and 2024 performance periods?

The measure specifications were updated and made publicly available on the QPP website under 2024 MIPS Cost Measure Information Forms (ZIP) and 2023 MIPS Cost Measure Information Forms (ZIP). As part of the annual maintenance process, CMS added new Evaluation and Management (E/M) and other CPT codes to the measure specifications when the new codes aligned with the original intent of the measure and did not constitute a substantive change.

Additionally, starting with the 2023 performance period, the attribution methodology was updated for the Asthma/Chronic Obstructive Pulmonary Disease (COPD) measure and the Diabetes measure. CMS updated both measures to incorporate a medication billing requirement for group-level attribution. Please refer to the MIPS Chronic Condition Episode-Based Cost Measures Attribution Methodology (ZIP) file for a comprehensive outline of the updated attribution logic for chronic condition measures.

How does CMS decide which cost measures to add to MIPS?

CMS considers each measure in accordance with the pre-rulemaking process before deciding whether to propose it through the notice-and-comment rulemaking process. This includes considering the Meaningful Measures 2.0 initiative and program priorities. Cost measures meet the healthcare priority of healthcare affordability and efficiency.

What review do cost measures undergo before being added to MIPS?

First, the current set of cost measures underwent detailed review during the development process through the measure development contractor's stakeholder engagement activities. This involved a rigorous 18-month process where the development contractor convened a Clinician Expert Workgroup for each measure, composed of clinical experts with experience in the condition or procedure being assessed. They provided detailed input on each aspect of the specifications across an average of three meetings, reviewing measure testing and considering

the input from persons with lived experience. In addition, all cost measures undergo field testing during the development process, when clinicians can download sample field test feedback reports from the QPP portal to review how they would have performed, and share input with CMS to help finalize the measure specifications.

After the development process is completed, there are multiple reviews during pre-rulemaking and rulemaking. During pre-rulemaking, there are two public comment periods for interested parties to comment on whether measures should be used in a CMS program. A multi-stakeholder group reviews the measures and provides recommendations to CMS about the measures under consideration. The group's discussions are typically conducted at all-day meetings which are open to the public. If CMS decides to propose a measure, it will be included in the annual Physician Fee Schedule proposed rule along with other MIPS proposals. Interested parties may review the proposals and submit comments during the 60-day comment period. CMS considers all comments during this period, and summarizes and responds to them in a final rule which also establishes whether or not a measure is going to be used in MIPS.

Cost Measure Attribution

Which specialties are being attributed to each cost measure?

The cost measures are attributed based on who bills service and diagnosis codes that indicate a clinician-patient relationship within the scope of each measure. These codes are different for each measure. Please reference the 2024 MIPS Cost Measure Codes Lists (ZIP) for more information.

How will I know which cost measures will be attributed to me?

Please review the measure specifications, including the 2024 MIPS Cost Measure Codes Lists (ZIP), to help you anticipate when an episode may be attributed to you or your clinician group. CMS provides the measure specifications publicly so that clinicians can review this information prior to receiving their final performance feedback and determine if they will be scored on a cost measure, and which episodes they may be attributed.

Cost Performance Category Scoring

How does CMS decide which cost measures will be used to calculate MIPS Final Scores for a performance period?

CMS normally uses all cost measures implemented in MIPS to calculate MIPS final scores. However, CMS can exclude individual measures within the cost performance category if the data used to calculate the score was impacted by significant changes during the performance period such that calculating the cost measure would lead to misleading or inaccurate results. For the 2023 and 2024 performance periods, CMS will assess whether any measures should be excluded from scoring after each performance period ends. CMS will release information about whether any cost measures will be excluded from the upcoming performance period once it is available.

Why am I being scored for the same patients under a population-based and episode-based cost measure?

Episode-based cost measures and the population-based measures (MSPB Clinician and TPCC) are designed to capture different aspects of clinical care. MSPB Clinician and TPCC are intentionally broader. MSPB Clinician assesses almost all costs related to inpatient care. TPCC focuses on primary care and assesses the overall cost of care delivered to a patient. Episode-

based cost measures are centered around a particular condition (e.g., diabetes, inpatient stroke) or procedure (e.g., screening or surveillance colonoscopy), and assess only clinically related costs. Using only one type of cost measure in MIPS would not accurately account for all types of care that clinicians provide.

Why did I perform differently on a MIPS measure and a similar measure in a CMMI model?

Cost measures in CMS Innovation Center models and MIPS serve distinct purposes, and are constructed and scored differently to reflect their respective uses. CMS is exploring alignment opportunities between MIPS and CMS Innovation Center models where appropriate, such as through MIPS Value Pathways (MVPs). Clinicians should reference their program-specific feedback reports to better understand their performance on each measure and in each program.

The 2022 QPP Experience Report Infographic showed that cost measure scores were lower than quality measure scores. Why?

Cost and quality measures are translated into points in different ways, which results in differences in mean and median scores. The starting point for any single cost or quality measure is similar; namely, that performance on each measure is compared with that of peers across the nation who are scored on the same measure. However, quality measure scoring can include bonus points, points floors, and other scoring policies that the cost performance category does not have. Cost measure performance is translated directly into points based on where your cost measure score falls in the distribution of all clinicians. This implies that median performance is at approximately an unweighted score of 50% – i.e., roughly half of participants score below five points and roughly half of participants score above five points, and mean and median performance is similar. However, median and mean performance on the quality performance category is much higher than five points.

There is nothing inherent about the cost measures that result in lower scores than quality measures. Rather, the differences in mean and median scores for cost and quality performance categories reflect differences in how measures translate into points.

Will CMS add more cost measures so that all clinicians will be scored on the cost performance category?

Yes. MIPS intends to assess your performance across categories: quality, improvement activities, Promoting Interoperability, and cost. While the cost performance category has increased from 2 measures in the first year of MIPS to 29 measures in 2024, this is still far less than the 199 quality measures available to participants. CMS may continue to add cost measures so that more MIPS participants are able to be evaluated on their cost performance.

Interested parties may develop and submit their own cost measures for consideration for inclusion in the MIPS cost performance category. Please reference the 2023 Call for Cost Measures for more information.

Further Support

Who can I contact with feedback about the cost measure specifications, such as code changes?

For more information on opportunities for providing input on measure specifications during cost measure development, please reference the Cost Measure Input Opportunities document. If you

have feedback about cost measure specifications outside of these public comment periods, you can email the developer at macra-cost-measures-info@acumenllc.com. The developer will consider this feedback with CMS as part of future measure development and maintenance processes.

What options are available to clinicians and groups who disagree with their cost measure scores?

If you have general questions about your cost measure scores, you can contact the Quality Payment Program Service Center by email or by phone. Contact information for the Quality Payment Program Service Center is included below.

You can also file for a targeted review if the targeted review deadline has not passed. Targeted review is the process through which Quality Payment Program (QPP) participants can request that CMS review the calculation of their MIPS payment adjustment factor(s) and, if applicable, their additional MIPS payment adjustment factor for exceptional performance.

Learn More

Where can I find information about the MIPS cost performance category?

The Quality Payment Program (QPP) website has many resources available to learn more about MIPS and the cost performance category:

- 2022 MIPS Performance Feedback FAQs
- 2022 MIPS Performance Feedback Patient-Level Data Reports Supplement
- 2024 MIPS Summary of Cost Measures
- MIPS Cost Performance Category Fact Sheet
- 2022 MIPS Cost Measure Exclusion Fact Sheet
- MIPS Cost Quick Start Guide:
  - For the 2023 performance period, please refer to the 2023 Cost Quick Start Guide
  - For the 2022 performance period, please refer to the 2022 Cost Quick Start Guide

Who can I contact for more information?

If you have questions about MIPS, the cost performance category, or cost measures currently in use in MIPS, please contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, create a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET).

People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.