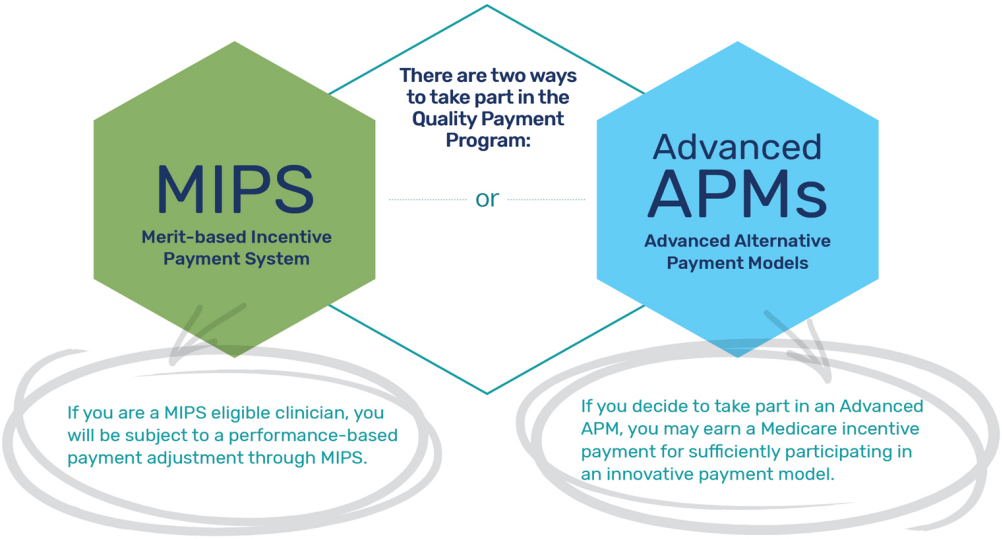
Quality Payment
PROGRAM

2022 Call for Cost Measures Fact Sheet

Overview

1. What is the Quality Payment Program (QPP)?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (H.R. 2, Pub.L. 114–10) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. In response to MACRA, the Centers for Medicare & Medicaid Services (CMS) created a federally mandated Medicare program, the Quality Payment Program (QPP) that seeks to improve patient care and outcomes while managing the costs of services patients receive. Clinicians providing high value/high quality patient care are rewarded through Medicare payment increases, while clinicians not meeting performance standards have a reduction in Medicare payments. Clinicians may participate in the QPP through the following 2 ways:



Under the Merit-based Incentive Payment System (MIPS), performance is assessed across 4 performance categories: quality, cost, improvement activities, and Promoting Interoperability. The performance categories have different "weights" and the scores from each of the performance categories are added together, resulting in a MIPS Final Score. The MIPS payment adjustment assessed for MIPS eligible clinicians is based on the MIPS Final Score. The weight for the quality and cost performance categories at 30% each is required by statute for the 2022 performance period, which is Year 6 of MIPS. The weight for the improvement activities category is 15% and the weight for the Promoting Interoperability category is 25%.

2. What is the MIPS Call for Cost Measures?

The "Call for Cost Measures" process provides stakeholders with an opportunity to identify and submit measures for CMS to consider whether to use them in the MIPS cost performance category. Stakeholders include:

- Clinicians
- Professional associations and medical societies that represent eligible clinicians
- Researchers
- Consumer groups
- Other stakeholders

CMS encourages all stakeholders to submit cost measures through the pre-rulemaking process described in Question 3 for consideration during this period. The timeframe for measures to be considered for inclusion on the annual list of cost measures is a 2-year process. Only cost measures submitted by May 20, 2022 will be considered for inclusion on the annual list of cost measures for the 2024 performance period.

While stakeholders were previously able to submit cost measures through the pre-rulemaking process, the Call for Cost Measures is a new process to provide stakeholders with more guidance about measurement priorities and requirements. This process was established through the CY 2022 Physician Fee Schedule Final Rule (86 FR 65455). The 2022 Call for Cost Measures is the first year that this process is in place, and will be an annual process like the Annual Call for Quality Measures.

3. How do I submit candidate cost measures for CMS to consider for use in MIPS?

Stakeholders responding to the Call for Cost Measures can submit candidate measures through the pre-rulemaking process. The pre-rulemaking process involves the following steps:

- CMS invites the submission of candidate measures from stakeholders through the Call for Cost Measures. In 2022, the submission period closes on May 20, 2022 to allow CMS time to review measures and select measures being considered for use in Medicare programs.
- CMS publicly releases the Measures Under Consideration (MUC) List no later than December 1 each year.
- The National Quality Forum (NQF) Measure Applications Partnership (MAP) reviews measures on the MUC List. The MAP meets every year, usually in December and January, to provide input on measures being considered for use in public reporting and performance-based programs.
- The MAP provides its recommendations to CMS by February 1 on whether the measures under consideration should be used in various programs.
- CMS considers the MAP's input in selecting measures to propose for use in a Medicare program in a notice of proposed rulemaking in the Federal Register. This allows for public comment and further consideration before a final rule is issued by November 1 of the year before the first day of a performance year.

Stakeholders can submit measures for CMS consideration by completing the required fields in the CMS MUC Entry/Review Information Tool (CMS MERIT). Measures need to be fully specified and tested for reliability and validity to be considered for use. For details on how to submit candidate measures and what

information is required for the submission, please see the CMS Pre-Rulemaking website.[1]

When stakeholders submit measures that don't make the final MUC list, they or their point of contact will be contacted regarding such status. The notice will outline the reasons why the measure is not recommended for MAP review. If it is recommended that the measure be revised and resubmitted, the stakeholder can resubmit the measure during a subsequent Call for Cost Measures cycle.

Cost Performance Category

4. What are cost measures?

Cost measures are measures that assess the amount, usually in dollars, related to providing and receiving medical care. Costs can include the direct costs of treatment, the total costs borne by a patient across all providers, follow-up care, outcomes after treatment, or some mixture of these.[2]

There are different types of cost measures. Section 1848(r) of the Social Security Act, as added by section 101(f) of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 requires the development of episode-based cost measures that take into consideration patient condition groups and care episode groups ("episode groups"), which serve as units of comparison. Care episode groups consider the "patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished." Patient condition groups consider the "patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history."

There are 23 episode-based measures in the MIPS cost performance category in 2022 which represent various types of care episode and patient condition groups. Specifically, they cover:

- Care episode groups, defined to focus on:
  - Procedures of a defined purpose or type. These can be performed in different settings depending on the specific measure's intended focus (e.g., outpatient, inpatient).
  - Acute inpatient medical conditions involving a hospital stay. These can represent treatment for a self-limited acute illness or treatment for a flare-up or an exacerbation of a condition.
- Patient condition groups, defined to focus on:
  - Chronic or long-term health conditions that can involve ongoing management and care.

There are also 2 global or population-based cost measures in the MIPS cost performance category. These focus broadly on inpatient care and primary care.

5. How are cost measures selected for MIPS?

CMS reviews submissions to consider whether measures should be included on the MUC List. This process includes consideration of whether the submitted measure has complete specifications and required testing information. In addition, CMS considers how the submitted measure would potentially fit within the MIPS

[1] CMS, Pre-Rulemaking. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rulemaking
[2] National Quality Forum, "Glossary of Terms." https://www.qualityforum.org/Measuring_Performance/Submitting_Standards/NQF_Glossary.aspx

cost performance category and furthers the goals of CMS's Meaningful Measures Initiative. An aspect of this is that a measure should not be duplicative or redundant with an existing cost measure.

In addition, CMS will consider the following factors:

- Is the measure based on measure specifications that have clinical face validity? Are the specifications consistent with practice standards?
- Does the measure have clear, ex ante attribution to clinicians? Could clinicians anticipate when their responsibility for a patient begins under the measure?
- Does the measure include the cost of services that reflect the role of attributed clinicians?
- Is the construction methodology readily understandable to clinicians?
- Can the measure be presented in a way that conveys clear information on how clinicians can alter their practice to improve measured performance?
- Do the measure specifications allow for consistent calculation and reproducibility using Medicare claims data?
- Does the testing information in the submission demonstrate variation to help distinguish cost performance across individual clinicians?
- Can the measure be used in an existing or future potential MIPS Value Pathway (MVP) to assess the value of care for a defined clinical topic?

Beyond these factors, CMS will also consider the extent to which the measure shares the same components as current cost measures and any other factors as appropriate. This helps to promote consistency within the MIPS cost performance category. The MIPS cost measures share the following features: (i) define episodes based on medical codes that determine the patient cohort and identify a clinician-patient relationship for the particular type of care being assessed (i.e., attribution), (ii) specify what costs are included in the measure, (iii) apply exclusions to ensure completeness of data and a fairly comparable patient cohort, and (iv) use a risk adjustment approach to account for differences in clinical and other risk factors that affect cost.

6. Which cost measures are currently in MIPS?

In the MIPS 2022 performance period, there are 25 cost measures. These are listed in Table 1. CMS is the measure steward for all these measures.

Table 1. Cost Measures in MIPS

ISO	Cost Measure	Type of Cost Measure	First Year of Use
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

Cost Measure Development

7. Is CMS currently developing any cost measures?

Yes. CMS is currently developing episode-based cost measures with measure development contractor Acumen, LLC. The following 5 measures are being field tested in January 2022 as part of the measure development process:

- Emergency Medicine
- Heart Failure
- Low Back Pain
- Major Depressive Disorder
- Psychoses/Related Conditions

These were selected with input from stakeholders based on the following prioritization criteria and an assessment of measurement gaps:

- The clinical coherence of measure concept to ensure valid comparisons across clinicians.
- The impact and importance to MIPS, including cost coverage, clinician coverage, and patient coverage.
- The opportunity for performance improvement.
- The potential alignment with quality measures and improvement activities to ensure meaningful assessments of value.

In addition, CMS is developing the following 2 measures - these will be field tested in the future:

- Chronic Kidney Disease (CKD)
- End Stage Renal Disease (ESRD)

CMS is also starting the measure prioritization and conceptualization process for an additional 4 episode-based cost measures. These will be developed throughout 2022 and 2023.

8. What is the difference between this Call for Cost Measures and CMS's own measure development process?

Stakeholders who submit a measure in response to this Call for Cost Measures undertake all steps of measure development and testing themselves. They would then present a fully developed and tested measure for CMS to consider for use in MIPS. The stakeholder would be the measure steward; this means that the stakeholder would own the measure and be responsible for determining the measure specifications and for conducting measure maintenance.

In contrast, CMS's cost measure development process involves a development contractor who gathers stakeholder input and conducts all measure testing. For those measures, CMS is the measure steward.

9. Do I need to follow a particular process to develop a cost measure?

CMS encourages measure developers who do not currently hold CMS contracts to use the CMS Measures Management System (MMS) Blueprint as a guide in their measure development process, especially if they have a future interest in working within CMS programs. The Blueprint process produces high-caliber measures that stand up to review for reliability, validity, and importance.[3]

10. Can I access claims data to develop a cost measure?

The new process for cost measure development by stakeholders is intended to align with the process that has been available to developers of quality measures. To support cost measure development, interested parties can access publicly available data, such as the Physician and Other Supplier Public Use Files (Physician and Other Supplier PUFs), on Data.CMS.gov.

In addition, measure developers may request restricted data through the CMS Research Data Request process. The process for requesting CMS data for research purposes varies depending on the privacy level and type of data requested. Information on available Limited Data Sets (LDS) and instructions for requesting these data can be found on the CMS LDS website.[4] CMS's Research Identifiable Files (RIFs) are requested through the CMS Research Data Assistance Center (ResDAC).[5] This website contains information on available RIF data and the process for requesting these data can be found. Please note that fees associated with requesting and accessing research data files will be assessed and must be collected prior to CMS providing access to either LDS or RIF datasets.

11. What types of cost measures need to be developed?

We have conducted empirical analyses as part of a scan to identify measurement gaps by specialty. We encourage stakeholders interested in measure development to consider the factors listed above under Questions 5 and 7 to identify performance gaps and opportunities for improvement in clinical topics that could apply to their and other specialties. In addition, we identify high priority MVP areas which may benefit from episode-based measures.

Specialties with Limited Episode-based Cost Measures

Based on empirical analyses using administrative claims data, we identified a list of specialties where the current MIPS episode-based cost measures and CMS's measures under development have limited applicability. To examine the extent to which episode-based measures apply to a specialty, we identify all TINs with at least 1 episode for an episode-based cost measure. Then, we identify all TIN-NPIs who are attributed 1 episode under those TINs. The list of specialties below represent those where the specialty has fewer than ten percent of clinicians who are attributed at least 1 episode. This analysis is on 2019 data and does not apply restrictions for MIPS participation.

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[3] CMS, MMS Blueprint v17.0 (September 2021). https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf

[4] CMS, Limited Data Set Files. https://www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets

[5] CMS, ResDAC. https://resdac.org/

While the global cost measures may apply to these specialties, we nonetheless include the specialties here as many stakeholders have expressed interest in having measures focused on particular types of care in addition to the broad, population-based measures. The specialties that have clinical topics as part of CMS's Wave 5 development prioritization are indicated with an asterisk (*).

- Anesthesiology*
- Audiology
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist (CRNA)*
- Dentist
- Diagnostic Radiology*
- Hand Surgery
- Maxillofacial Surgery
- Nuclear Medicine
- Obstetrics/Gynecology
- Optometry
- Oral Surgery (dentists only)
- Pathology
- Pediatric Medicine
- Podiatry
- Radiation Oncology*
- Registered Dietician/Nutrition Professional
- Speech Language Pathology

Within each specialty, there may be multiple clinical topics; for example, podiatry could include evaluating and treating foot injury, managing foot infections, and treating foot changes such as bunions. There may also be clinical topics that involve multiple specialties. For instance, screening for female preventive health (e.g., screening Papanicolaou (Pap) tests and pelvic exams) could involve obstetrics/gynecology, family medicine, internal medicine, and other specialties.

High Priority MVP Clinical Topics

CMS has identified high priority clinical topics for future MVP development described further in MVP Needs and Priorities.[6] These are also listed in Table 2, below, along with information about potential applicability of episode-based cost measures currently in use in MIPS or under development. Measures under development are indicated with a double asterisk (**).

Stakeholders may use this information to identify whether additional episode-based cost measures would benefit the MVP clinical topic based on their expertise and understanding of value improvement opportunities and quality metrics that could pair with cost measures within each topic. We note that the MSPB Clinician and TPCC measures could also apply to these clinical topics, but for the purposes of this document have focused just on episode-based measures.

[6] The MVP Needs and Priorities document is available for download from the QPP Resource Library: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1803/MIPS%20Value%20Pathways%20(MVPs)%20Development%20Resources.zip

Table 2. High Priority MVP Clinical Topics and Potential Applicability of Episode-based Cost Measures

ISO	Specialties/ Clinical Topics	Episode-based Cost Measures
1	Allergy/Immunology	• Asthma/COPD
2	Audiology	• n/a
3	Chiropractic Medicine	• Low Back Pain**
4	Clinical Social Work	• Major Depressive Disorder**
5	Dentistry	• n/a
6	Dermatology	• Melanoma Resection
7	Endocrinology	• Diabetes
8	Gastroenterology	• Lower Gastrointestinal Hemorrhage • Screening/Surveillance Colonoscopy
9	General Surgery	• Colon and Rectal Resection • Femoral or Inguinal Hernia Repair • Lumpectomy, Partial Mastectomy, Simple Mastectomy • Melanoma Resection
10	Heart Failure	• Heart Failure**
11	Hospitalists	• Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation • Intracranial Hemorrhage Or Cerebral Infarction • Lower Gastrointestinal Hemorrhage • Sepsis • Simple Pneumonia with Hospitalization
12	Infectious Disease	• Sepsis
13	Interventional Cardiology	• Elective Outpatient Percutaneous Coronary Intervention (PCI) • ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)
14	Mental/ Behavioral Health	• Major Depressive Disorder** • Psychoses/Related Conditions**
15	Nephrology	• Acute Kidney Injury Requiring New Inpatient Dialysis • Chronic Kidney Disease (CKD)** • End-Stage Renal Disease (ESRD)**
16	Neurology	• Intracranial Hemorrhage or Cerebral Infarction
17	Neurosurgery	• Intracranial Hemorrhage Or Cerebral Infarction • Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
18	Non-patient Facing Specialties	• n/a
19	Nutrition/Dietician	• n/a
20	Obstetrics, Gynecology, Certified Nurse Midwife (Women's Health)	• n/a

ISO	Specialties/ Clinical Topics	Episode-based Cost Measures
21	Oncology/Hematology	• Sepsis
22	Ophthalmology	• Routine Cataract Removal with Intraocular Lens (IOL) Implantation
23	Pain Management	• Low Back Pain**
24	Pediatrics	• Episode-based cost measures are calculated for Medicare beneficiaries, so can include pediatric patients
25	Physical Therapy/Occupational Therapy	• Low Back Pain**
26	Plastic Surgery	• Melanoma Resection
27	Podiatry	• n/a
28	Preventive Medicine	• Asthma/COPD • Diabetes
29	Pulmonology	• Asthma/COPD • Inpatient COPD Exacerbation • Sepsis • Simple Pneumonia with Hospitalization
30	Speech Language Pathology	• n/a
31	Substance Use Disorder	• n/a
32	Thoracic Surgery	• Asthma/Chronic Obstructive • Non-Emergent Coronary Artery Bypass Graft (CABG) • Pulmonary Disease (COPD)
33	Urology	• Renal or Ureteral Stone Surgical Treatment • Sepsis
34	Vascular Surgery	• Hemodialysis Access Creation • Revascularization for Lower Extremity Chronic Critical Limb Ischemia

Note: Measures with an asterisk (*) are currently under development.

12. Where can I learn more?

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

The following resources provide additional information:

- Quality Payment Program Resource Library
- CMS Pre-Rulemaking Website
- CMS Call for Measures Website
- CMS Measures Management System Blueprint
- CMS Meaningful Measures Hub
- 2022 MIPS Summary of Cost Measures
- 2022 MIPS Cost Measure Information Forms
- 2022 MIPS Cost Measure Codes Lists