Frequently Asked Questions (FAQ)

Chronic Condition Episode-Based Cost Measures Attribution Methodology

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Overview

This document provides information about the attribution methodology used for chronic condition episode-based cost measures developed for the Merit-based Incentive Payment System (MIPS) in a question-and-answer format.

1.1 How are chronic condition measures attributed?

Attribution is based on identifying a clinician-patient care relationship. Like other episode-based cost measures for procedures and hospitalizations, this is done by looking at service and diagnosis information from administrative claims data. An episode is attributed to a clinician group when it performs 2 services indicating care for a particular condition within a certain number of days (e.g., 180 days). Both claims must have a diagnosis code for the relevant chronic condition.

1.2 Do all chronic condition cost measures use the same attribution methodology?

Yes, all the measures use the same basic methodology, customizing it as needed to make sure that the measure is capturing the intended care relationship. For example, the codes used in the algorithm that indicate care relationship are specific to each condition.

1.3 Can both primary care providers and specialists be attributed?

Yes, any clinician can be attributed if we see evidence of the care relationship being assessed. If both primary care clinicians and specialists provide chronic condition care management, then both can be attributed.

1.4 Can the same patient be attributed to multiple clinicians and clinician groups?

Yes, the same patient can be attributed to multiple clinicians and clinician groups. This ensures that the measure encourages care coordination and holds all clinicians and clinician groups accountable for the care that they provide to manage the patient's condition.

At the individual clinician level (within one clinician group), a patient can be attributed to up to 3 different clinicians managing the patient's chronic condition. At the clinician group level, a patient can be attributed to multiple clinician groups if multiple groups billed the trigger events for that patient during the measurement period.

1.5 Is there an attribution methodology at both the group and individual clinician levels?

Yes. Clinicians can choose how they want to participate in MIPS: either as individual clinicians (identified by their Taxpayer Identification Number and National Provider Identifier pair [TIN-NPI]) or as part of a clinician group (identified by their TIN). Therefore, each measure can be attributed at both levels.

1.6 Is the attribution methodology different for groups and individuals?

Yes, because the attribution methodology for groups and individuals needs to reflect the care provided by a group and individual, respectively. The methodology for attributing individuals builds on the group attribution methodology. That is, once we identify the attributed group practice, we then look for the individual clinicians within that group who played an important role in that episode. The methodology uses a 30% threshold to indicate this role: in other words, an episode is attributed to each clinician within the group that rendered at least 30% of the total number of qualifying services during the episode.

Chronic Condition Measure Coverage

1.7 What chronic condition cost measures have been developed to-date?

There are 10 episode-based cost measures focusing on chronic conditions. They're at different stages of development and use:

- In MIPS for the 2022 performance period
  - Asthma/Chronic Obstructive Pulmonary Disease (COPD)
  - Diabetes
- Finished development in 2022 and received "conditional support for rulemaking" recommendation from the Measure Applications Partnership (MAP)[1]
  - Low Back Pain
  - Heart Failure
  - Depression
- Finished development in 2023
  - Kidney Transplant Management
  - Prostate Cancer
  - Rheumatoid Arthritis
  - Chronic Kidney Disease
  - End-Stage Renal Disease (ESRD)
- Began development in 2023
  - Movement Disorders
  - Non-Pressure Ulcers

1.8 How do you decide which chronic condition measures to develop?

We identify cost measures for development through empirical analyses and public comment. The measures chosen for development should cover clinical topics and clinicians with limited or no applicable cost measures, and support the transition from transitional MIPS to MIPS Value Pathways (MVPs) by allowing for new MVPs to be created and enhancing existing MVPs. Additionally, the measures address interested parties' feedback about the need for more clinically refined episode-based cost measures, and increase the cost coverage by moving closer towards the statutory goal of covering 50 percent of expenditures under Medicare Parts A and B, as specified under section 1848(r)(2)(i)(I) of the Act.

[1] For more information on the MAP's recommendations on the Low Back Pain, Heart Failure, and Depression measures, please refer to the "MAP 2022-2023 Final Recommendations" document available for download here: https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports

1.9 Which specialties are being attributed?

Table 2 below details the top 5 specialties that are attributed to each of the 10 chronic condition cost measures developed to date.

Table 2. Top 5 Specialties Attributed to each of the Chronic Condition Cost Measures

Measure Name	Rank	Specialty
Asthma/COPD	1	Family Practice
	2	Internal Medicine
	3	Nurse Practitioner
	4	Physician Assistant
	5	Pulmonary Disease
Depression	1	Family Practice
	2	Internal Medicine
	3	Nurse Practitioner
	4	Licensed Clinical Social Worker
	5	Clinical Psychologist
Diabetes	1	Family Practice
	2	Internal Medicine
	3	Nurse Practitioner
	4	Cardiology
	5	Physician Assistant
Heart Failure	1	Internal Medicine
	2	Family Practice
	3	Nurse Practitioner
	4	Cardiology
	5	Physician Assistant
Low Back Pain	1	Physical Therapist in Private Practice
	2	Family Practice
	3	Chiropractic
	4	Internal Medicine
	5	Nurse Practitioner
Chronic Kidney Disease	1	Nephrology
	2	Internal Medicine
	3	Nurse Practitioner
	4	Family Practice
	5	Physician Assistant
End-Stage Renal Disease	1	Nephrology
	2	Internal Medicine
	3	Nurse Practitioner
	4	Vascular Surgery
	5	Neurology
Kidney Transplant Management	1	Nephrology
	2	Nurse Practitioner
	3	Internal Medicine
	4	Physician Assistant
	5	General Surgery
Prostate Cancer	1	Urology
	2	Radiation Oncology
	3	Hematology/Oncology
	4	Internal Medicine
	5	Medical Oncology

Measure Name	Rank	Specialty
Rheumatoid Arthritis	1	Rheumatology
	2	Internal Medicine
	3	Nurse Practitioner
	4	Physician Assistant
	5	Family Practice

Services and Codes Used in Attribution Methodology

1.10 What codes are used to identify a care relationship for a chronic condition?

The codes used to trigger and attribute episodes are Part B physician/supplier services. They include outpatient services codes and procedure codes that indicate care for a particular condition. The first code is an outpatient service code and the second code is another outpatient service code or a procedure code. An example is an outpatient office visit and diabetes self-management training. These codes must also be paired with International Classification of Diseases, 10th Revision (ICD-10 diagnosis codes for the condition.

1.11 Are there checks to ensure that clinicians are appropriately being attributed?

There are 2 checks to ensure that the measure is appropriately capturing individual clinicians. The clinician(s) who play a substantive role in the care for the patient (i.e., those who rendered 30% of the qualifying services during the episode) must also have:

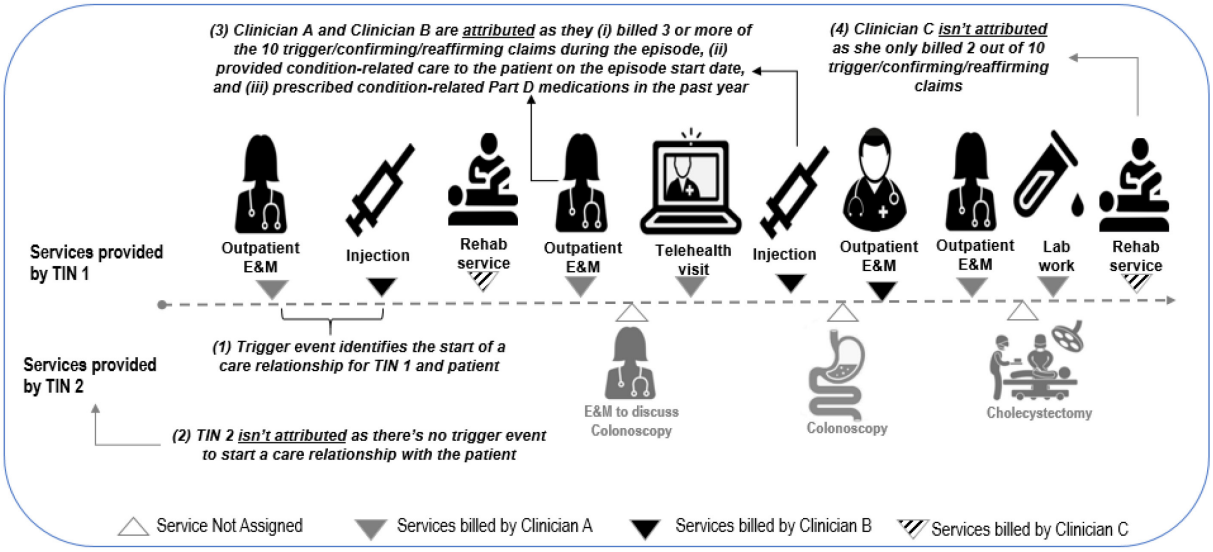
1. Provided condition-related care to this patient prior to or on the episode start date (to ensure that clinicians are attributed an episode *after* they met the patient), and
2. For some measures, prescribed at least 2 condition-related prescriptions on different days to 2 different patients during the previous years (to ensure that attributed clinicians are actually involved in providing ongoing chronic care management).
    - This check is only used in measures where the use of prescriptions is informative about the nature of care that the clinician provides. That is, the types of clinicians that manage the condition do not always prescribe the relevant medication (e.g., the Low Back Pain and Depression cost measures are attributed to physical therapists, clinical psychologists, and other non-prescribing clinicians), so they would never meet this criterion and be attributed the episode. In those cases, the measure doesn't use this check.

These checks carry over to the TIN-level attribution. Specifically, the TIN will always meet the first check by construction (i.e., there will always be a TIN-NPI under the TIN that has provided care to the patient prior to or on the episode start date). And the TIN must have at least one potentially attributable TIN-NPI under it who meets the second check.

1.12 What is an example of services used in the attribution methodology?

The set of services is tailored for each measure. Figure 1 below provides an example of services that a clinician group furnishes for a patient in a Diabetes episode. The set of services indicating a care relationship include: outpatient evaluation & management (E&M) codes and procedure codes. Each code must also have the relevant diagnosis code for the condition to be present on the claim.

Figure 1. Illustration of the Attribution Methodology at the TIN and TIN-NPI Levels



In the example above:

- At the TIN level:
  (1) TIN 1 is attributed because it billed the initial 2 claims indicating a care relationship and met the 2 checks
  (2) TIN 2 isn't attributed, because there were no initial claims that indicated a care relationship.
- At the TIN-NPI level:
  (3) Clinicians A and B are also attributed the episode, as they both met the 30% threshold of the qualifying services and the 2 checks (i.e., both of them provided related care prior to or on the episode start date and prescribed condition-related medications in the past year).
  (4) Clinician C isn't attributed, as she didn't meet the 30% threshold of the qualifying services.

Patient Case-Mix

1.13 How do you account for the fact that some clinicians will be attributed more complex patients?

There are 4 ways we use to account for differences in the patient case-mix, to ensure that clinicians aren't penalized for treating sicker patients. These include service assignment, sub-grouping, exclusions, and risk adjustment.

- **Service Assignment** only includes costs related to the condition under evaluation to ensure that the measure focuses on resource use related to the treatment of the specific condition.
- **Episode sub-groups** divide the patients into mutually exclusive stratifications. These stratifications represent more granular, mutually exclusive and exhaustive patient populations defined by clinical criteria. Sub-groups help ensure that the measure fairly compares clinicians with a similar patient case-mix.
- **Episode exclusions** exclude populations whose clinical characteristic affect a relatively small subpopulation that's very different from the rest of the population in terms of clinical characteristics and cost, and that can't be accounted for through other means.
- **Risk adjustment** accounts for factors that are outside of a clinician's influence. They include comorbidities, age brackets, disability status, ESRD status, and factors specific to the condition, among others.

1.14 Does the measure differentiate between specialists and primary care clinicians, since specialists tend to treat sicker patients?

Each measure risk adjusts for the number and types of specialties that provide care to a patient. This accounts for complexity at the patient level, rather than just adjusting based on the specialty of the attributed clinician.

Comparison with the Total Per Capita Cost (TPCC) Measure Attribution

1.15 How is the attribution methodology different from the attribution methodology used for the TPCC measure?

Although certain components of the chronic condition and TPCC cost measure frameworks are similar (e.g., identifying the start of an ongoing relationship between the clinician and patient, or capturing the clinician's ongoing, long-term care management of their patients), there are 4 ways in which the attribution methodologies are different, as noted in Table 1.

Table 1. Comparison of TPCC and Chronic Condition Cost Measure Attribution Methodologies

Methodology Component	TPCC	Chronic Condition Measures
Trigger Codes	Uses 2 Current Procedural Terminology/ Healthcare Common Procedure Coding System (CPT/HCPCS) codes for primary care services The codes can be billed by the same TIN or different TINs	Use 2 CPT/HCPCS with ICD diagnosis codes present on the claims representing the care for the relevant chronic condition The codes must be billed by the same TIN
Clinician-Level Attribution	Only one clinician under the attributed clinician group can be attributed, based on the plurality of the trigger events billed by that clinician	Up to 3 clinicians under the attributed clinician group can be attributed

Specialty Exclusions	Excludes clinicians: (i) who frequently perform non-primary care services such as anesthesia, surgery, therapeutic radiation, and chemotherapy, and (ii) are in one of the 56 specialties unlikely to be responsible for providing primary care[2]	Excludes clinicians who don't meet the Part D prescription check, regardless of the clinician's specialty

Stakeholder Engagement

1.16 What high-level input from interested parties was gathered on the overall attribution methodology?

The attribution methodology for chronic condition measures was developed over several years, drawing from the experience gained from developing measures for procedures and acute inpatient medical conditions.

The Technical Expert Panel (TEP) met several times to work through preliminary questions on the development of chronic condition cost measures. For example, the TEP discussed the attribution rules (i.e., the algorithms and the types of codes used in each algorithm) that would demonstrate relationship between a clinician group and a patient with a chronic condition(s), and considered the trade-offs between clinician/patient coverage and clinician's involvement in treating the patient for each of the attribution rules. The TEP also discussed the benefits of using medication prescriptions to accurately identify the attributed clinician.

We then convened a Chronic Condition and Disease Management Clinical Subcommittee (CS) in 2019 as part of Wave 3 to develop the first set of chronic condition measures. The members discussed how many services would indicate a care relationship between a patient and a clinician, and recommended specialties for the measure-specific workgroups that would provide further detailed input on each measure's attribution methodology.

1.17 How do you determine what codes are used in the measure specifications?

Within the overall framework from the TEP and the CS, each measure-specific workgroup determines and refines the codes through a robust iterative measure development process, that combines extensive empirical testing and input from person and family committee members. Specifically, the measure-specific clinical expert workgroups discuss the individual codes from the initial set of draft codes to ensure that the codes are capturing the type of care that is intended. Each panel also incorporates perspective from the person and family committee members, who describe the clinicians/specialties who help them manage their chronic disease.

[2] The list of specialty codes that identify clinicians that are excluded from the TPCC measure attribution can be found in the "Eligible_Clinicians" tab of the TPCC Measure Codes List, found using the following direct link from the MACRA Feedback Page: https://www.cms.gov/files/zip/2023-cost-measure-codes-lists.zip.

Further Information

1.18 Where can I find more information on the attribution methodology?

For more information on the attribution methodology for chronic condition episode-based cost measures, please refer to the following resources on the MACRA Feedback Page:

- Detailed measure specifications (i.e., measure information forms and codes list files);
- The *Chronic Condition Cost Measures Attribution Methodology* one-pager;
- The *Chronic Condition Cost Measure Framework* poster.

1.19 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.