

MACRA Cost Measures: Call for Public Comment for Measure Reevaluation

Acute Kidney Injury Requiring New Inpatient Dialysis
Elective Primary Hip Arthroplasty
Femoral or Inguinal Hernia Repair
Hemodialysis Access Creation
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
Lower Gastrointestinal Hemorrhage
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
Lumpectomy, Partial Mastectomy, Simple Mastectomy
Non-Emergent Coronary Artery Bypass Graft (CABG)
Renal or Ureteral Stone Surgical Treatment
Medicare Spending Per Beneficiary Clinician
Total Per Capita Cost

2023



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1.0 Introduction

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, to develop and maintain cost measures for clinicians and clinician groups. Participants in the Merit-based Incentive Payment System (MIPS) receive an adjustment to their Medicare payments based on a 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. In performance year 2023, the MIPS cost performance category has 23 episode-based cost measures and 2 population-based cost measures which have been gradually added over the past years.

The measure maintenance process allows developers to ensure measures continue to function as intended and to consider refinements to the measure. On an annual basis, we review the MIPS measures that have been adopted and make minor updates to the cost measures to keep them up-to-date (e.g., coding updates). Every three years, measures are considered for comprehensive reevaluation. During comprehensive reevaluation, measure developers can more holistically review the measure, seek public comment, and consider many aspects of the measure specifications, not just the updates done through annual maintenance. In some instances, a measure might only need minor or no change to specifications, while other measures may undergo more substantive changes to improve the measure’s importance, scientific acceptability, or usability.

The first cycle of comprehensive reevaluation for MIPS cost measures began in early 2022, with a public comment period on eight episode-based cost measures first added to the MIPS cost performance category in performance year 2019. CMS selected three episode-based cost measures for comprehensive reevaluation based on the potential to address measurement gaps and fulfill program objectives. These three measures are currently undergoing comprehensive reevaluation and will go through the notice-and-comment rulemaking process before being finalized for use in MIPS.

We are now seeking public comment on a second cycle of comprehensive reevaluation for MIPS cost measures. Twelve measures were added to the MIPS cost performance category in performance year 2020, including 10 episode-based cost measures (EBCMs) and 2 population-based cost measures. These 12 measures have been in MIPS for 3 years and are being considered for comprehensive reevaluation. The measures are listed in Table 1.

Table 1. Cost Measures Considered for Comprehensive Reevaluation

ISO	Cost Measure	Measure Type
1	Acute Kidney Injury Requiring New Inpatient Dialysis	EBCM - Procedural
2	Elective Primary Hip Arthroplasty	EBCM - Procedural
3	Femoral or Inguinal Hernia Repair	EBCM - Procedural
4	Hemodialysis Access Creation	EBCM - Procedural

ISO	Cost Measure	Measure Type
5	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	EBCM - Acute Inpatient Medical Condition
6	Lower Gastrointestinal Hemorrhage (at group level only)	EBCM - Acute Inpatient Medical Condition
7	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	EBCM - Procedural
8	Lumpectomy, Partial Mastectomy, Simple Mastectomy	EBCM - Procedural
9	Non-Emergent Coronary Artery Bypass Graft (CABG)	EBCM - Procedural
10	Renal or Ureteral Stone Surgical Treatment	EBCM - Procedural
11	Medicare Spending Per Beneficiary Clinician	Population-Based Cost Measure
12	Total Per Capita Cost	Population-Based Cost Measure

During comprehensive reevaluation, we will:

- Collect feedback from interested parties through a public comment process,
- Conduct additional information gathering and testing to determine the scope of reevaluation, and
- Reconvene Technical Expert Panels and/or Clinician Workgroups, as needed, to discuss feedback and other updates.

In this first phase of the process, we are gathering feedback on the current measure specifications. This document includes a series of questions about the measures that can be used as a starting point, but respondents can submit feedback about any aspect of the measures. The specifications for each measure, comprising a Measure Information Form document and Measure Codes List file, are available on the [QPP Resource Library](#).¹

Interested parties may submit feedback through this [online survey](#)² through the end of the public comment period.³ They can also attach a PDF or Word document with their comments. Comments may be submitted anonymously if preferred.

2.0 Background

This section provides background information about MIPS cost measures and the measure development and maintenance process. Section 2.1 describes measure development, implementation, and use of cost measures implemented in MIPS in 2020. Section 2.2 outlines the measure maintenance process and important considerations for comprehensive

¹ The specifications are available on the QPP Resource Library: <https://qpp.cms.gov/resources/resource-library>.

² Interested parties can submit feedback through this online survey: https://acumen.qualtrics.com/jfe/form/SV_1Oc6oL3JqK5zSoC.

³ Please refer to the web posting for the specific dates: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/PC-Currently-Accepting-Comments>.

reevaluation. Section 2.3 provides information about other MIPS cost measures as further context to consider during reevaluation.

2.1 Measure Development and Implementation

Section 1848(r) of the Social Security Act, as added by section 101(f) of MACRA, requires the development of episode-based cost measures that take into consideration patient condition groups and care episode groups (“episode groups”), which are units of comparison that represent a clinically coherent set of medical services rendered to treat a given medical condition. Episode-based cost measures represent the cost to Medicare for the items and services furnished to a patient during an episode of care (“episode”) and inform clinicians on the costs related to the management of a certain condition that occurred during a defined period.

Acumen developed the second wave of MIPS episode-based cost measures in 2018. First, Acumen convened meetings of the Wave 2 Clinical Subcommittees, in which members provided input on the selection of an episode group for development and the necessary composition of a smaller, measure-specific workgroup within each Clinical Subcommittee. Then, these measure-specific workgroups met to provide detailed input on each component of the episode-based cost measures selected for development.

Alongside these activities, Acumen also revised two population-based cost measures: the Medicare Spending Per Beneficiary (MSPB) measure and the Total Per Capita Cost (TPCC) measure. The MSPB measure is intended to assess inpatient care management, while the TPCC measure is intended to assess primary care management. Initial versions of these measures were used in the Value Modifier program, and were first included in the MIPS cost performance category in 2017. In 2017 and 2018, Acumen convened a Technical Expert Panel (TEP) to provide input on refinement and re-specification of these measures for use in MIPS, with the TEP providing guidance on the measures’ relationship to overall program goals and the measures’ broad clinical scope. In 2018, Acumen also convened a MSPB Service Refinement Workgroup to identify service assignment exclusions for the MSPB measure.

The Wave 2 episode-based cost measures and revised population-based cost measures were field tested between October-November 2018 to allow clinicians to provide feedback on the draft cost measure specifications. Acumen refined the measure specifications with input from workgroups, the TEP, and feedback received during field testing. Additional information about Acumen’s cost measure development process is available on the [Quality Payment Program](#)

[Cost Measure Information Page](#)⁴ and in the [Wave 1 and 2 Measure Development Process document](#).⁵

The measures went through the federal pre-rulemaking and rulemaking processes in 2018 and 2019. The 12 measures were included on CMS’s Measures Under Consideration (MUC) list released in December 2018. The Measure Applications Partnership (MAP) reviewed the measures and recommended the 10 episode-based cost measures and MSPB with “conditional support for rulemaking,” and designated TPCC as “do not support with potential for mitigation.” For TPCC, mitigating factors included the need for greater transparency about the model and testing results, concern about TPCC’s handling of small sample sizes and social risk factors, and concern about potential overlap with MSPB. All 12 measures were then proposed and finalized in the CY 2020 Physician Fee Schedule (PFS) Final Rule for use in the MIPS cost performance category.

2.2 Measure Use and Maintenance

The annual measure maintenance process provides avenues to keep measures up-to-date and ensure each measure remains meaningful. Since the measures were added to MIPS, annual maintenance has involved making coding updates. In addition, we proposed and finalized the addition of telehealth codes to the measures in the CY 2021 PFS rule.

Separate from the annual maintenance process is comprehensive reevaluation, which takes place every three years. This provides an opportunity to consider whether more substantive changes to specifications would improve the measure, such as by increasing its importance or its scientific acceptability. For example, this might involve changes to the patient cohort, new types of services to include (e.g., adding standardized Part D costs which were not available at the time of development), or other changes. While the MIPS cost performance category was weighted at 0% for the 2020 and 2021 performance periods, the measures in this posting have been available for use in the MIPS program for three years; as such, the measures are being considered for comprehensive reevaluation in 2023.

The annual maintenance and comprehensive reevaluation processes require striking a balance between keeping measures updated and clinicians’ ability to understand how performance is evaluated and to track performance over time. It is important to consider if proposed refinements may result in other unintended consequences, such as masking meaningful differences in clinician cost performance. Additionally, if a cost measure is substantively

⁴ The Quality Payment Program Cost Measure Information Page is available here:

<https://www.cms.gov/medicare/quality-payment-program/cost-measures>

⁵ CMS, “Episode-Based Cost Measure Field Testing Measure Development Process: October 2018 Field Testing”, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2018-measure-development-process.pdf>

changed, the reevaluated cost measure is required to go through the pre-rulemaking and rulemaking processes. As established in the CY 2022 PFS rule, a change is considered substantive if the change modifies the premise and/or objective of the measure, modifies the scope of the measure, or significantly impacts how a measure is calculated or otherwise assessed.⁶

2.3 MIPS Cost Measure Inventory

In performance year 2023, there are 23 episode-based cost measures and 2 population-based cost measures in the MIPS cost performance category. Table 2 lists the cost measures in use in MIPS; the first 23 listed are episode-based cost measures, while the final 2 are population-based cost measures. To review more information about cost measures currently in use in MIPS, visit the [QPP Resource Library](#).

Table 2. MIPS 2023 Cost Measures

ISO	Cost Measures	First Year of Use
1	Elective Outpatient Percutaneous Coronary Intervention (PCI)	2019
2	Knee Arthroplasty	2019
3	Revascularization for Lower Extremity Chronic Critical Limb Ischemia	2019
4	Routine Cataract Removal with Intraocular Lens (IOL) Implantation	2019
5	Screening/Surveillance Colonoscopy	2019
6	Intracranial Hemorrhage or Cerebral Infarction	2019
7	Simple Pneumonia with Hospitalization	2019
8	ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	2019
9	Acute Kidney Injury Requiring New Inpatient Dialysis	2020
10	Elective Primary Hip Arthroplasty	2020
11	Femoral or Inguinal Hernia Repair	2020
12	Hemodialysis Access Creation	2020
13	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	2020
14	Lower Gastrointestinal Hemorrhage (at group level only)	2020
15	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	2020
16	Lumpectomy, Partial Mastectomy, Simple Mastectomy	2020
17	Non-Emergent Coronary Artery Bypass Graft (CABG)	2020
18	Renal or Ureteral Stone Surgical Treatment	2020
19	Melanoma Resection	2022
20	Colon and Rectal Resection	2022
21	Sepsis	2022
22	Asthma/Chronic Obstructive Pulmonary Disease (COPD)	2022
23	Diabetes	2022

⁶ CY 2022 Physician Fee Schedule Final Rule (86 FR 65459) <https://www.federalregister.gov/d/2021-23972/p-4755>

ISO	Cost Measures	First Year of Use
24	Medicare Spending Per Beneficiary Clinician	2020
25	Total Per Capita Cost	2020

There are also 12 new episode-based cost measures under development for potential use in MIPS. These measures are listed in Table 3.

Table 3. Episode-based Cost Measures Under Development

ISO	Episode-based Cost Measures	Status
1	Depression	On 2022 MUC List
2	Emergency Medicine	On 2022 MUC List
3	Heart Failure	On 2022 MUC List
4	Low Back Pain	On 2022 MUC List
5	Psychoses/Related Conditions	On 2022 MUC List
6	Chronic Kidney Disease (CKD) Stage 4 and 5	Pending MUC Submission
7	End-Stage Renal Disease (ESRD)	Pending MUC Submission
8	Kidney Transplant Management	Pending MUC Submission
9	Prostate Cancer	Pending MUC Submission
10	Rheumatoid Arthritis	Pending MUC Submission
11	Movement Disorders (Amyotrophic Lateral Sclerosis, Huntington's Disease, Multiple Sclerosis, Parkinson's Disease)	In Development
12	Non-Pressure Ulcers	In Development

In addition to new measures under development, three measures currently in use in MIPS are undergoing comprehensive reevaluation as part of Wave 1 Reevaluation. These measures are listed in Table 4.

Table 4. Episode-based Cost Measures Undergoing Comprehensive Reevaluation

ISO	Current Episode-based Cost Measures	Reevaluated Episode-based Cost Measures
1	Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Cataract Removal with Intraocular Lens (IOL) Implantation
2	Simple Pneumonia with Hospitalization	Respiratory Infection Hospitalization
3	ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)	Inpatient Percutaneous Coronary Intervention (PCI)

Like newly developed measures, reevaluated measures are required to go through the notice-and-comment rulemaking process before being finalized for use in MIPS. Information about both new measure development and reevaluation is available on the [Quality Payment Program Cost Measure Information Page](#).

3.0 Feedback on Cost Measures

This section includes specific questions on measure components for which we are particularly interested in gathering feedback. The questions in this section are based on previous feedback

and information gathered through additional cost measure development and use. They are intended just as a starting point for respondents to consider; we welcome comments on any aspect of the measure specifications. When submitting comments, the [online survey](#) includes a general question for each measure for comments not directly covered in the targeted questions below.

Section 3.1 includes cross-cutting questions that are broadly applicable to the measures undergoing comprehensive reevaluation. Section 3.2 includes questions that are specific to individual cost measures. While not all measures are included in Section 3.2, the survey includes open response options for each individual measure, so that respondents may still submit measure-specific feedback.

3.1 Cross-cutting Questions

This section includes questions that are broadly applicable to the measures. While we have included several questions as a starting point, the [online survey](#) will also include a section for respondents to submit additional cross-cutting comments. Measure-specific comments will be addressed in the next section.

3.1.1 Defining Episode Groups

Episodes are defined by the codes that trigger (or open) the episode group and determine the patient cohort included in the episode group. Patient cohorts may further be refined through measure exclusions. The current measure specifications that determine the patient cohorts are available in the Measure Information Forms and the Measure Codes Lists posted in the [QPP Resource Library](#).

We are seeking input on potential opportunities to refine measures so that similar types of care are measured together, and that gaps in measurement are minimized. For example, respondents may suggest that additional trigger codes be added to a measure, or that a measure exclusion be removed. Note, if a change like this were to be made, measure specifications would still be created in a way that allows for comparisons between like episodes (e.g., creating sub-groups, risk adjustment).

Question 1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?

3.1.2 Accounting for Patient Heterogeneity

Risk adjustment is used to account for patient differences that could result in cost variation outside of a clinician's control. Each cost measure uses a set of standard risk adjustment variables based on the standard set of risk adjustors from the CMS-Hierarchical Condition Categories (HCC) risk adjustment model, as well as measure-specific risk adjustment variables.

To identify risk adjustment variables, we consider many factors including the following:⁷

- Clinical/conceptual relationship with the outcome of interest,
- Empirical association with the outcome of interest,
- Variation in prevalence of the factor across the measured entities,
- Present at the start of care,
- Is not an indicator or characteristic of the care provided (e.g., treatments, expertise of staff),
- Resistant to manipulation or gaming,
- Accurate data that can be reliably and feasibly captured,
- Contribution of unique variation in the outcome (i.e., not redundant),
- Potentially, improvement of the risk model (e.g., risk model metrics of discrimination, calibration), and
- Potentially, face validity and acceptability.

In addition to standard risk adjustment variables, measures may also use measure-specific variables to account for factors that may be uniquely applicable to that measure. To date, testing indicates that the existing risk adjustment models are accurately accounting for patient risk. For example, testing shows that predictive ratios for each of the Wave 2 measures are generally centered around 1.00.

Question 2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?

3.2 Measure-specific Questions

This section includes measure-specific questions for Lower Gastrointestinal Hemorrhage and Total Per Capita Cost. As noted above, the survey includes open response options for each individual measure, so that respondents may still submit measure-specific feedback.

⁷ NQF, "Committee Guidebook for the NQF Measure Endorsement Process, version 6.5," *National Quality Forum* (August 2021), https://www.qualityforum.org/Measuring_Performance/CDP_Standing_Committee_Guidebook.aspx.

3.2.1 Lower Gastrointestinal Hemorrhage – Measure Scope

The Lower Gastrointestinal Hemorrhage cost measure is intended to assess cost to Medicare for patients who receive inpatient non-surgical treatment for acute gastrointestinal bleeding, and its scope currently includes lower gastrointestinal bleeding, which is responsible for approximately 30-40% of all gastrointestinal bleeding cases.⁸ This section seeks input on the Lower Gastrointestinal Hemorrhage cost measure’s scope as it relates to the measure’s reliability.

Measure reliability is one of the metrics that CMS considers when determining whether to add a measure to MIPS. It refers to the degree to which repeated measurements of the same entity agree with each other, and can be assessed using a signal-to-noise metric. This metric evaluates the extent to which variation in a measure comes from clinician performance (“signal”) rather than random variation (“noise”). As established in the CY 2017 MACRA Final Rule and discussed in the CY 2022 PFS Final Rule, CMS considers reliability between 0.4 and 0.7 as “moderate”, and uses a threshold of 0.4 for mean reliability, noting that this continues to be appropriate.^{9 10}

Based on testing results, the Lower Gastrointestinal Hemorrhage episode-based cost measure is only used in MIPS at the TIN-level. As discussed in the CY 2020 PFS Final Rule, the measure performs well on reliability at the TIN level (measuring clinicians reporting in groups), with a mean reliability of 0.51 and with 74.6% of TINs meeting the 0.4 reliability threshold with a 20-episode case minimum. However, the reliability at the TIN-NPI level is low, with a mean reliability of 0.20, which is below CMS’ moderate reliability threshold of 0.4.¹¹ Monitoring on more recent study periods shows that the reliability for the Lower Gastrointestinal Hemorrhage measure continues to be low.

We are interested in ways to expand the measure’s patient cohort, as increasing the number of episodes per clinician may improve reliability. The goal is to allow TIN-NPIs to be assessed on costs related to inpatient, non-surgical gastrointestinal care.

⁸ CMS, “Lower Gastrointestinal Hemorrhage Measure - Merit-based Incentive Payment System: Measure Information Form, 2023 Performance Period,” *Centers for Medicare and Medicaid Services* (December 2022), https://qpp.cms.gov/docs/cost_specifications/2022-12-08-mif-ebcm-lgi-bleed.pdf

⁹ CY 2017 Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (81 FR 77008) <https://www.federalregister.gov/d/2016-25240> .

¹⁰ CY 2022 Physician Fee Schedule Final Rule (86 FR 64996) <https://www.federalregister.gov/d/2021-23972/p-4671>

¹¹ CY 2020 Physician Fee Schedule Final Rule (84 FR 62568) <https://www.federalregister.gov/d/2019-24086>

Expanding the measure cohort could entail including upper gastrointestinal bleeding alongside lower gastrointestinal bleeding, which could substantially increase the number of episodes attributed to a clinician under this measure. Table 5 below lists relevant figures concerning exclusion of upper gastrointestinal bleeding from the measure, from the measure’s Measure Justification Form, which used a full year of claims data from 2017.

Table 5. Exclusion of Upper Gastrointestinal Bleeding from the Lower Gastrointestinal Hemorrhage Measure

Episode Category	Episode Count	Observed Cost		
		Mean	Percentile	
			10th	90th
All Episodes Meeting Triggering Logic	200,341	\$12,494	\$6,443	\$23,977
Excluded for Principal Diagnosis of Upper GI Bleed	63,607	\$12,609	\$6,669	\$23,620
Excluded for Principal Diagnosis of Nonspecific GI Bleed, Upper GI Bleed in Array	25,064	\$11,911	\$6,645	\$22,280
<i>Final Episodes (TIN)</i>	58,389	\$10,700	\$6,086	\$19,867
<i>Final Episodes (TIN-NPI)</i>	3,086	\$10,700	\$6,150	\$20,055

These results suggest that including upper gastrointestinal bleeding in the measure could more than double the current sample size, and that episodes that include upper gastrointestinal bleeding have relatively similar observed cost to those limited to lower gastrointestinal bleeding. A full table and discussion of measure exclusions, including figures for measure exclusions not listed in the table above (namely Death in Episode, Inflammatory Bowel Disease, Leaving Against Medical Advice, and Outlier Cases), can be found in the “Wave 2 Measure Justification Forms” on the [Quality Payment Program Cost Measure Information Page](#).

Expanding the measure cohort could also entail including other gastrointestinal conditions treated in an inpatient setting in the measure. Aside from Gastrointestinal Hemorrhage, other frequent types of inpatient stays for which gastroenterologists provide care include:

- Base DRG 391 Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders
- Base DRG 393 Other Digestive System Diagnoses
- Base DRG 811 Red Blood Cell Disorders
- Base DRG 444 Disorders of the Biliary Tract
- Base DRG 438 Disorders of Pancreas except Malignancy

Question 3. What are ways to refine the measure scope to increase the number of episodes and be impactful inpatient non-surgical gastrointestinal care? For example, would it be appropriate to include upper gastrointestinal hemorrhage in the measure and sub-group between upper and lower hemorrhage? Why or why not? Are there

other similar conditions under a different MS-DRG that could be included in the measure?

3.2.2 Total Per Capita Cost – Defining Primary Care Relationships

The TPCC measure is intended to evaluate the overall cost of care delivered to a beneficiary with a focus on the primary care they receive from their providers. Given its broad scope, it includes all costs in the measurement period. The measure cohort includes primary care clinicians, internal medicine clinicians that frequently manage patients with chronic or ongoing care needs, and non-physician clinicians who provide primary care services.

To ensure a focus on primary care, clinicians are excluded from attribution if they meet the criteria for one or more service exclusions in the following categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy. They are also excluded based on their Health Care Finance Administration (HCFA) Specialty designation, if they identify as one or more of the specialties in the specialty exclusion list. Excluded specialties are:

- HCFA 02: General Surgery
- HCFA 04: Otolaryngology
- HCFA 05: Anesthesiology
- HCFA 07: Dermatology
- HCFA 09: Interventional Pain Management
- HCFA 13: Neurology
- HCFA 14: Neurosurgery
- HCFA 15: Speech Language Pathologists
- HCFA 18: Ophthalmology
- HCFA 19: Oral Surgery (dentists only)
- HCFA 20: Orthopedic Surgery
- HCFA 21: Cardiac Electrophysiology
- HCFA 22: Pathology
- HCFA 23: Sports Medicine
- HCFA 24: Plastic and Reconstructive Surgery
- HCFA 25: Physical Medicine and Rehabilitation
- HCFA 26: Psychiatry
- HCFA 27: Geriatric Psychiatry
- HCFA 28: Colorectal Surgery (formerly proctology)
- HCFA 30: Diagnostic Radiology
- HCFA 33: Thoracic Surgery
- HCFA 34: Urology
- HCFA 35: Chiropractic
- HCFA 36: Nuclear Medicine
- HCFA 37: Pediatric Medicine

- HCFA 40: Hand Surgery
- HCFA 41: Optometry
- HCFA 42: Certified Nurse Midwife (effective July 1, 1988)
- HCFA 43: Certified Registered Nurse Anesthetist (CRNA)
- HCFA 48: Podiatry
- HCFA 64: Audiologist (Billing Independently)
- HCFA 65: Physical Therapist in Private Practice
- HCFA 67: Occupational Therapist in Private Practice
- HCFA 68: Clinical Psychologist
- HCFA 71: Registered Dietician/Nutrition Professional
- HCFA 72: Pain Management
- HCFA 76: Peripheral Vascular Disease
- HCFA 77: Vascular Surgery
- HCFA 78: Cardiac Surgery
- HCFA 79: Addiction Medicine
- HCFA 80: Licensed Clinical Social Worker
- HCFA 81: Critical Care (Intensivists)
- HCFA 85: Maxillofacial Surgery
- HCFA 86: Neuropsychiatry
- HCFA 91: Surgical Oncology
- HCFA 92: Radiation Oncology
- HCFA 93: Emergency Medicine
- HCFA 94: Interventional Radiology
- HCFA C0: Sleep Medicine
- HCFA C3: Interventional Cardiology
- HCFA C5: Dentist
- HCFA C6: Hospitalist
- HCFA C8: Medical Toxicology
- HCFA C9: Hematopoietic Cell Transplantation and Cellular Therapy
- HCFA D3: Medical Genetics and Genomics
- HCFA D4: Undersea and Hyperbaric Medicine
- HCFA D7: Micrographic Dermatologic Surgery
- HCFA D8: Adult Congenital Heart Disease

Full specifications for the TPCC measure can be found in the TPCC Measure Codes List and TPCC Measure Information Form posted in the [QPP Resource Library](#).

We are interested in comments concerning TPCC measure attribution and methods for defining primary care relationships.

- Question 4.** The measure currently uses exclusions based on both services and HCFA Specialty to ensure that the measure only captures clinicians who provide primary care or care across multiple conditions. The advantage of service category exclusions is that it focuses on the care actually provided by clinicians, since HCFA Specialty lacks granularity for subspecialties who may provide different types of care. The disadvantage is that these definitions are more complex than HCFA Specialty exclusions. Should the measure use only one type of exclusion rule to simplify the specifications? If so, which exclusion method should be used and why?
- Question 5.** If the measure continues to use both service category and HCFA Specialty exclusions, what changes (if any) should be made to ensure that the measure is appropriately capturing clinicians who provide primary care type services?
- Question 6.** The trigger rule methodology uses outpatient evaluation and management (E&M) codes to identify a clinician-patient relationship. There are many types of clinicians who do not bill E&M codes, such as physical therapists, occupational therapists, speech language pathologists, clinical psychologists, licensed clinical social workers, etc. This means that these specialties are effectively excluded from the measure. Should the trigger methodology be expanded to include clinicians who do not bill E&M codes? If so, what services do these specialties provide that should be added to the trigger methodology to identify a primary care or similar relationship?

4.0 Next Steps

Please share your feedback by submitting a response to the [online survey](#) before the end of the public comment period. Respondents can also attach a PDF or Word document with their comments.

Acumen will review feedback, clinical input, and additional information gathered during the reevaluation process to determine with CMS which, if any, measures will be updated, and the scope of updates. As needed, Acumen may reconvene Technical Expert Panel(s) and/or Clinician Workgroups later in 2023 to provide more detailed input on specific questions about measure specifications. If the changes are substantive, measures would go through the pre-rulemaking and rulemaking processes before being implemented in MIPS.

If you have questions about these eight episode-based cost measures, the public comment process, or comprehensive reevaluation, please contact macra-cost-measures-info@acumenllc.com.