

Quality Payment  
PROGRAM

# Merit-based Incentive Payment System (MIPS)

2024 Cost Performance Category Quick  
Start Guide



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**Purpose:** This resource focuses on the cost performance category under the traditional MIPS and MIPS Value Pathways (MVPs) reporting options, providing high level information about the cost measures, including calculation and attribution for the 2024 performance period. For comprehensive information about these measures, please refer to the Measure Information Forms (linked in the Help, Resources, and Version History section). This resource doesn't address requirements under the Alternative Payment Model (APM) Performance Pathway (APP) since cost isn't evaluated under the APP.

**Already know what MIPS is?** Skip ahead by clicking the links in the Table of Contents.



# How to Use This Guide

## How to Use This Guide

**Please Note:** This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

### Table of Contents

The Table of Contents is interactive. Click on a Chapter in the Table of Contents to read that section.  You can also click on the icon on the bottom left to go back to the Table of Contents.

### Hyperlinks

Hyperlinks to the [Quality Payment Program website](#) are included throughout the guide to direct the reader to more information and resources.

# Overview

## OVERVIEW

# What is the Merit-based Incentive Payment System?

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). Under MIPS, we evaluate your performance across multiple categories that drive improved quality and value in our healthcare system.

### If you're eligible for MIPS in 2024:

- You generally have to report measure and activity data for the [quality](#), [improvement activities](#), and [Promoting Interoperability](#) performance categories. (We collect and calculate data for the [cost](#) performance category for you, if applicable.)
- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
- Your MIPS payment adjustment is based on your performance during the 2024 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2026.

### To Learn More About MIPS:

- Visit the [Learn about MIPS webpage](#).
- View the [2024 MIPS Overview Quick Start Guide](#).
- View the [2024 MIPS Quick Start Guide for Small Practices](#).

### To Learn More About MIPS Eligibility And Participation Options:

- Visit the [How MIPS Eligibility is Determined](#) and [Participation Options Overview](#) webpages on the Quality Payment Program website.
- View the [2024 MIPS Eligibility and Participation Quick Start Guide](#).
- Check your current participation status using the [QPP Participation Status Tool](#).



# What is the Merit-based Incentive Payment System (Continued)

There are **3 reporting options** available to MIPS eligible clinicians to meet MIPS reporting requirements:

## Traditional MIPS

- The original reporting option for MIPS.
- Visit the [Traditional MIPS Overview webpage to learn more.](#)

- You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS.

- You'll report the complete Promoting Interoperability measure set.

- We collect and calculate data for the cost performance category for you.

## MIPS Value Pathways (MVPs)

- The newest reporting option, offering clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition.
- Visit the [MIPS Value Pathways \(MVPs\) webpage to learn more.](#)

- You select an MVP that's applicable to your practice.
- Then you choose from the quality measures and improvement activities available in your selected MVP.
- You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.

- You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).

- We collect and calculate data for the cost performance category and population health measures for you.

## APM Performance Pathway (APP)

- A streamlined reporting option for **clinicians who participate in a MIPS Alternative Payment Model (APM).**
- Visit the [APM Performance Pathway webpage to learn more.](#)

- You'll report a predetermined set of quality measures.
- MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.

- You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).

- Cost isn't evaluated under the APP.



# What is the MIPS Cost Performance Category?

Individual, Group, Subgroup\*, and Virtual Group\*\* Participation

## Traditional MIPS and MVP Performance Category Weights in 2024:

### Quality



30% of MIPS Score

### Cost



30% of MIPS Score

### Improvement Activities



15% of MIPS Score

### Promoting Interoperability



25% of MIPS Score

\*Available for MVP reporting only.

\*\*Available for traditional MIPS reporting only.

## APM Entity Participation

## Traditional MIPS and MVP Performance Category Weights in 2024:

## Quality

55% of MIPS  
Score

## Cost

0% of MIPS  
ScoreImprovement  
Activities15% of MIPS  
ScorePromoting  
Interoperability30% of MIPS  
Score

## Standard Weighting for Small Practices (Promoting Interoperability Automatically Reweighted)

### Traditional MIPS and MVP Performance Category Weights in 2024:

**Quality**



**40%** of MIPS Score

**Cost**



**30%** of MIPS Score

**Improvement Activities**



**30%** of MIPS Score

**Promoting Interoperability**



**0%** of MIPS Score

## What's New with Cost in 2024?

- The maximum cost improvement score of 1 percentage point out of 100 percentage points will be available beginning with the 2023 performance period. The maximum cost improvement score available for the 2022 performance period is zero percentage points.
- Five new episode-based cost measures are available beginning with the 2024 performance period, each with a 20-episode case minimum. The measures are:
  - An acute inpatient medical condition measure (Psychoses and Related Conditions)
  - Three chronic condition measures (Depression, Heart Failure, and Low Back Pain)
  - A measure focusing on care provided in the emergency department setting (Emergency Medicine)
- We finalized the removal of the acute inpatient medical condition cost measure Simple Pneumonia with Hospitalization, beginning with the 2024 performance period.

### Reminders:

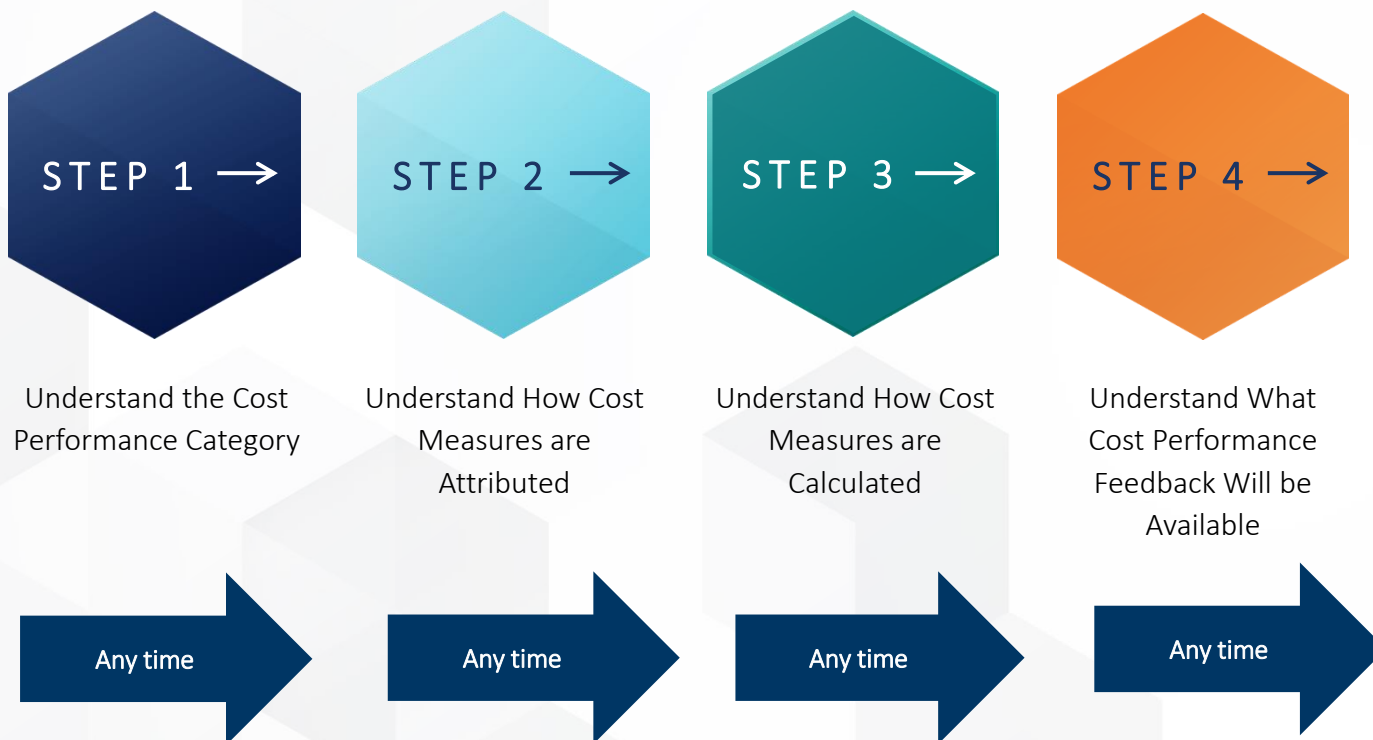
- We use Medicare administrative claims data to calculate your cost measure performance, which means you don't have to submit any data for this performance category when reporting traditional MIPS or MVPs.
- Under traditional MIPS, you'll be scored on each measure for which you meet or exceed the established case minimum.
- Each MVP includes cost measures that are relevant and applicable to the MVP clinical topic or episode of care. We'll calculate performance exclusively on the cost measures that are included in the selected MVP for which you meet or exceed the established case minimum.

The APP doesn't measure cost performance.



## Get Started with the Cost Performance Category in 4 Steps

## Overview



## Step 1. Understand the Cost Performance Category Measures

There are 29 total cost measures for the 2024 performance period.

| Measure Name/Type                                                                                   | Description                                                                                                                                                                      | Case Minimum                                                                                                                                       | Data Source                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Total Per Capita Cost (TPCC)</b>                                                                 | This population-based measure assesses the overall cost of care delivered to a Medicare patient with a focus on primary care received.                                           | 20 Medicare patients                                                                                                                               | Medicare Parts A and B claims data                                                                                                                         |
| <b>Medicare Spending Per Beneficiary Clinician (MSPB Clinician)</b>                                 | This measure assesses the cost of care for services related to qualifying inpatient hospital stays (immediately prior to, during, and after) for a Medicare patient.             | 35 episodes                                                                                                                                        | Medicare Parts A and B claims data                                                                                                                         |
| <b>15 procedural episode-based measures</b>                                                         | Assess the cost of care that's clinically related to a specific procedure provided during an episode's timeframe.                                                                | 10 episodes for all procedural episode-based measures <b>except</b> the Colon and Rectal Resection measure which has a case minimum of 20 episodes | Medicare Parts A and B claims data                                                                                                                         |
| <b>6 acute inpatient medical condition episode-based measures</b>                                   | Assess the cost of care clinically related to specific acute inpatient medical conditions and provided during an episode's timeframe.                                            | 20 episodes for acute inpatient condition episode-based measures                                                                                   | Medicare Parts A and B claims data (all acute inpatient condition episode-based cost measures), Medicare Part D claims (Sepsis episode-based cost measure) |
| <b>5 chronic condition episode-based measures</b>                                                   | Assess the cost of care clinically related to the care and management of patients' specific chronic conditions provided during a total attribution window divided into episodes. | 20 episodes for chronic condition episode-based measures                                                                                           | Medicare Parts A, B and D claims data                                                                                                                      |
| <b>1 measure focusing on care provided in the emergency department setting (Emergency Medicine)</b> | Evaluates a clinician's risk-adjusted cost to Medicare for patients who have an emergency department (ED) visit during the performance period.                                   | 20 episodes                                                                                                                                        | Medicare Parts A and B claims data                                                                                                                         |



# Step 1. Understand the Cost Performance Category Measures (Continued)

There are 27 MIPS Episode-Based Cost Measures available in the 2024 performance period.

| Measure Name                                                                | Measure Type | Episode Window                                                                                                        | This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for...                                                                | Measures Can Be Triggered Based on Claims Data from the Following Settings:                                            |
|-----------------------------------------------------------------------------|--------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Elective Outpatient Percutaneous Coronary Intervention (PCI)</b>         | Procedural   | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 0 days</li> <li>Post-Trigger Period = 30 days</li> </ul>  | Patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance period.           | Ambulatory/office-based care centers, outpatient hospitals, Ambulatory surgical centers (ASCs)                         |
| <b>Knee Arthroplasty</b>                                                    | Procedural   | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 30 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who receive an elective knee arthroplasty during the performance period.                                                         | Acute inpatient (IP) hospitals, hospital outpatient department (HOPDs), ambulatory/office-based care centers, and ASCs |
| <b>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</b> | Procedural   | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 30 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance period. | ASCs, HOPDs, and acute IP hospitals                                                                                    |
| <b>Routine Cataract Removal with Intraocular Lens (IOL) Implantation</b>    | Procedural   | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 60 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who undergo a procedure for routine cataract removal with intraocular lens implantation during the performance period.           | ASCs and HOPDs                                                                                                         |
| <b>Screening/Surveillance Colonoscopy</b>                                   | Procedural   | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 0 days</li> <li>Post-Trigger Period = 14 days</li> </ul>  | Patients who undergo a screening or surveillance colonoscopy procedure during the performance period.                                     | ASCs, ambulatory/office-based care, HOPDs                                                                              |
| <b>Acute Kidney Injury Requiring New Inpatient Dialysis</b>                 | Procedural   | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 0 days</li> <li>Post-Trigger Period = 30 days</li> </ul>  | Patients who receive an inpatient dialysis service for acute kidney injury during the performance period.                                 | Acute IP hospitals                                                                                                     |



# Step 1. Understand the Cost Performance Category Measures

## (Continued)

| Measure Name                                                    | Measure Type                      | Episode Window                                                                                                        | This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for...                                                             | Measures Can Be Triggered Based on Claims Data from the Following Settings: |
|-----------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <b>Elective Primary Hip Arthroplasty</b>                        | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 30 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who receive an elective primary hip arthroplasty during the performance period.                                               | Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs   |
| <b>Femoral or Inguinal Hernia Repair</b>                        | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 30 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who undergo a surgical procedure to repair a femoral or inguinal hernia during the performance period.                        | Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs   |
| <b>Hemodialysis Access Creation</b>                             | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 60 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis during the performance period. | Ambulatory/office-based care centers, OP hospitals, and ASCs                |
| <b>Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels</b> | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 30 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who undergo surgery for lumbar spine fusion during the performance period.                                                    | ASCs, HOPDs, and acute IP hospitals                                         |
| <b>Lumpectomy Partial Mastectomy, Simple Mastectomy</b>         | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 30 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who undergo partial or total mastectomy for breast cancer during the performance period.                                      | Ambulatory/office-based care centers, outpatient hospitals, and ASCs        |
| <b>Non-Emergent Coronary Artery Bypass Graft (CABG)</b>         | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 30 days</li> <li>Post-Trigger Period = 90 days</li> </ul> | Patients who undergo a CABG procedure during the performance period.                                                                   | Acute IP hospitals                                                          |
| <b>Renal or Ureteral Stone Surgical Treatment</b>               | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 90 days</li> <li>Post-Trigger Period = 30 days</li> </ul> | Patients who receive surgical treatment for renal or ureteral stones during the performance period.                                    | Acute IP hospitals, HOPDs, ambulatory/office-based care centers, and ASCs   |
| <b>Intracranial Hemorrhage or Cerebral Infarction</b>           | Acute inpatient medical condition | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 0 days</li> <li>Post-Trigger Period = 90 days</li> </ul>  | Patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance period.             | Acute IP hospitals                                                          |



# Step 1. Understand the Cost Performance Category Measures

## (Continued)

| Measure Name                                                                                    | Measure Type                      | Episode Window                                                                                                       | This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for...                                                                               | Measures Can Be Triggered Based on Claims Data from the Following Settings: |
|-------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <b>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</b> | Acute inpatient medical condition | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 0 days</li> <li>Post-Trigger Period = 30 days</li> </ul> | Patients who present with STEMI indicating complete blockage of a coronary artery who emergently receive PCI as treatment during the performance period. | Acute IP hospitals                                                          |
| <b>Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation</b>                      | Acute inpatient medical condition | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 0 days</li> <li>Post-Trigger Period = 60 days</li> </ul> | Patients who receive inpatient treatment for an acute exacerbation of COPD during the performance period.                                                | Acute IP hospitals                                                          |
| <b>Lower Gastrointestinal Hemorrhage (applies to groups only)</b>                               | Acute inpatient medical condition | <ul style="list-style-type: none"> <li>Pre-Trigger Period = 0 days</li> <li>Post-Trigger period = 35 days</li> </ul> | Patients who receive inpatient non-surgical treatment for acute bleeding in the lower gastrointestinal tract during the performance period.              | Acute IP hospitals                                                          |
| <b>Psychoses and Related Conditions</b>                                                         | Acute inpatient medical condition | <ul style="list-style-type: none"> <li>Pre-Trigger Window: None</li> <li>Post-Trigger Window: 45 days</li> </ul>     | Patients who receive inpatient treatment for psychoses or related conditions during the performance period.                                              | Acute IP hospitals and inpatient psychiatric facilities (IPFs)              |
| <b>Melanoma Resection</b>                                                                       | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 30 days</li> <li>Post-Trigger Window: 90 days</li> </ul>  | Patients who undergo an excision procedure to remove a cutaneous melanoma during the performance period.                                                 | ASCs, ambulatory/office-based care, and HOPDs.                              |
| <b>Colon and Rectal Resection</b>                                                               | Procedural                        | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 15 days</li> <li>Post-Trigger Window: 90 days</li> </ul>  | Patients who receive colon or rectal resection for either benign or malignant indications during the performance period.                                 | ASCs, HOPDs, and acute IP hospitals                                         |
| <b>Sepsis</b>                                                                                   | Acute inpatient medical condition | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 0 days</li> <li>Post-Trigger Window: 45 days</li> </ul>   | Patients who receive inpatient medical treatment for sepsis during the performance period.                                                               | Acute IP hospitals.                                                         |

# Step 1. Understand the Cost Performance Category Measures

## (Continued)

| Measure Name                                               | Measure Type      | Episode Window                                                                                                         | This Measure Evaluates a Clinician's Risk Adjusted Cost to Medicare for...                                                                                                                                                                       | Measures Can Be Triggered Based on Claims Data from the Following Settings:                                                                                                                                                                                                  |
|------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diabetes</b>                                            | Chronic condition | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 0 days</li> <li>Minimum Episode Window: 365 days</li> </ul> | Patients who receive medical care to manage and treat diabetes during the performance period.                                                                                                                                                    | The most frequent settings in which a Diabetes episode is triggered include: Office, skilled nursing facility (SNF), and OP hospital.                                                                                                                                        |
| <b>Asthma/Chronic Obstructive Pulmonary Disease (COPD)</b> | Chronic condition | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 0 days</li> <li>Minimum Episode Window: 365 days</li> </ul> | Patients who receive medical care to manage and treat asthma or COPD during the performance period.                                                                                                                                              | The most frequent settings in which an Asthma/COPD episode is triggered include: Office, SNF, and OP hospital.                                                                                                                                                               |
| <b>Depression</b>                                          | Chronic condition | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 0 days</li> <li>Minimum Episode Window: 365 days</li> </ul> | Patients receiving medical care to manage and treat depression. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Depression episode.       | The Depression measure focuses on the care provided by clinicians practicing in non-inpatient hospital settings for patients with depression. The most frequent settings in which a Depression episode is triggered include: Office, nursing facility, SNF, and OP hospital. |
| <b>Heart Failure</b>                                       | Chronic condition | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 0 days</li> <li>Minimum Episode Window: 365 days</li> </ul> | Patients receiving medical care to manage and treat heart failure. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Heart Failure episode. | The Heart Failure measure focuses on the care provided by clinicians practicing in non-inpatient hospital settings for patients with heart failure. The most frequent settings in which a Heart Failure episode is triggered include: office, OP hospital, and SNF.          |
| <b>Low Back Pain</b>                                       | Chronic condition | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 0 days</li> <li>Minimum Episode Window: 120 days</li> </ul> | Patients receiving medical care to manage and treat low back pain. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Low Back Pain episode. | The most frequent settings in which a Low Back Pain episode is triggered include: office, OP hospital, and ASC.                                                                                                                                                              |
| <b>Emergency Medicine</b>                                  | Care Setting      | <ul style="list-style-type: none"> <li>Pre-Trigger Window: 0 days</li> <li>Post-Trigger Window: 14 days</li> </ul>     | Patients who have emergency department (ED) visit during the performance period.                                                                                                                                                                 | Emergency department                                                                                                                                                                                                                                                         |



# Step 1. Understand the Cost Performance Category Measures (Continued)

## Cost Performance in the MVP Reporting Option

We'll calculate performance exclusively on the cost measures that are included in the selected MVP using administrative claims data, even if additional cost measures (outside your selected MVP) are available for scoring. You'll only be scored on measures for which you meet or exceed the established case minimum. The table below shows which cost measure(s) are evaluated in each MVP:

| MVP                                                                                | Cost Measure(s) Assessed                                                                                                                                                 |
|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Advancing Rheumatology Patient Care MVP                                            | <ul style="list-style-type: none"> <li>• TPCC</li> </ul>                                                                                                                 |
| Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP | <ul style="list-style-type: none"> <li>• Intracranial Hemorrhage or Cerebral Infarction</li> </ul>                                                                       |
| Advancing Care for Heart Disease MVP                                               | <ul style="list-style-type: none"> <li>• Elective Outpatient PCI</li> <li>• STEMI with PCI</li> <li>• TPCC</li> <li>• Heart Failure</li> <li>• MSPB Clinician</li> </ul> |
| Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP | <ul style="list-style-type: none"> <li>• Emergency Medicine</li> </ul>                                                                                                   |
| Improving Care for Lower Extremity Joint Repair MVP                                | <ul style="list-style-type: none"> <li>• Elective Primary Hip Arthroplasty</li> <li>• Knee Arthroplasty</li> </ul>                                                       |
| Patient Safety and Support of Positive Experiences with Anesthesia MVP             | <ul style="list-style-type: none"> <li>• MSPB Clinician</li> </ul>                                                                                                       |
| Advancing Cancer Care MVP                                                          | <ul style="list-style-type: none"> <li>• TPCC</li> </ul>                                                                                                                 |
| Optimal Care for Kidney Health MVP                                                 | <ul style="list-style-type: none"> <li>• Acute Kidney Injury Requiring New Inpatient Dialysis (AKI)</li> <li>• TPCC</li> </ul>                                           |
| Optimal Care for Patients with Episodic Neurological Conditions MVP                | <ul style="list-style-type: none"> <li>• MSPB Clinician</li> </ul>                                                                                                       |
| Supportive Care for Neurodegenerative Conditions MVP                               | <ul style="list-style-type: none"> <li>• MSPB Clinician</li> </ul>                                                                                                       |



# Step 1. Understand the Cost Performance Category Measures

## (Continued)

| MVP                                                                                | Cost Measure(s) Assessed                                                                                                                           |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Value in Primary Care MVP                                                          | <ul style="list-style-type: none"> <li>• Asthma/COPD</li> <li>• Diabetes</li> <li>• Depression</li> <li>• Heart Failure</li> <li>• TPCC</li> </ul> |
| Focusing on Women's Health MVP                                                     | <ul style="list-style-type: none"> <li>• MSPB Clinician</li> <li>• TPCC</li> </ul>                                                                 |
| Quality of Care for the Treatment of Ear, Nose and Throat Disorders MVP            | <ul style="list-style-type: none"> <li>• MSPB Clinician</li> </ul>                                                                                 |
| Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP | <ul style="list-style-type: none"> <li>• TPCC</li> </ul>                                                                                           |
| Quality Care in Mental Health and Substance Use Disorders MVP                      | <ul style="list-style-type: none"> <li>• MSPB Clinician</li> <li>• Depression</li> <li>• Psychoses and Related Conditions</li> </ul>               |
| Rehabilitative Support for Musculoskeletal Care MVP                                | <ul style="list-style-type: none"> <li>• Low Back Pain</li> </ul>                                                                                  |

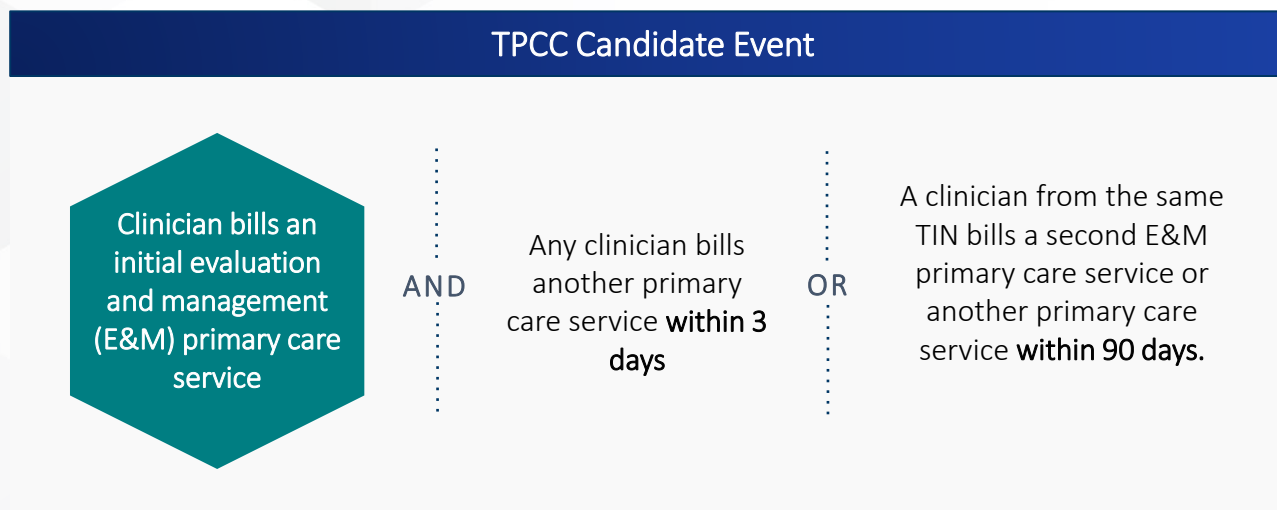


## Step 2. Understand How Cost Measures are Attributed

This section provides a brief overview of the steps used to attribute the TPCC and MSPB Clinician measures to individual clinicians and groups. For more information about how cost measures are attributed, please refer to the measure specifications.

### TPCC Measure Attribution\*

TPCC attribution begins with a “candidate event,” defined as a pair of services billed by the clinician to the patient within a short period of time. A candidate event marks the start of a primary care relationship between a patient and a clinician.



\*More information about attribution is available in the Total Per Capita Cost Measure Information Form (ZIP).

## Step 2. Understand How Cost Measures are Attributed

### TPCC Measure Attribution\*

- A risk window is a year-long window that begins on the date of a candidate event, during which time a clinician is responsible for a patient's costs.
- The performance period is a static calendar year that is divided into 13 4-week blocks called beneficiary months. Beneficiary months that occur during a risk window and the performance period are counted towards a clinician's (or clinician group's) measure scores. These beneficiary months are attributed to the TIN billing the initial E&M "primary care" service.
- For TIN-NPI-level attribution, only the TIN-NPI responsible for the largest share of candidate events provided to the patient within the TIN is attributed the beneficiary months.

### We exclude clinicians from attribution who:

Meet the criteria for one or more service exclusions in the following categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy

OR

Are designated as 1 or more of the 56 specialties unlikely to be responsible for primary care services (including but not limited to: dermatology)

\*More information about attribution is available in the Total Per Capita Cost Measure Information Form (ZIP).



## Step 2. Understand How Cost Measures are Attributed (Continued)

### TPCC Measure Attribution

| TIN-NPI Attribution When TIN Has 11 Candidate Events                                                                |                                                                                   |                                                                                                                                                               |                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Clinician: HCFA Specialty                                                                                           | Candidate Events                                                                  | Exclusions                                                                                                                                                    | TIN-NPI Attribution                                                                                                                                                                                                                   |
| <b>A: Cardiology</b><br>Over 15% of clinician's candidate events had 10- or 90-day global surgery with same patient | Candidate Event 1<br>Candidate Event 2                                            |  Excluded from attribution based on <b>global surgery service exclusion</b> | Clinicians A and B <b>will not be attributed</b><br>Beneficiary months for candidate events 1-6 will not be attributed at either the TIN or TIN-NPI level                                                                             |
| <b>B: Optometry</b>                                                                                                 | Candidate Event 3<br>Candidate Event 4<br>Candidate Event 5<br>Candidate Event 6  |  Excluded from attribution based on <b>optometry specialty exclusion</b>    |                                                                                                                                                                                                                                       |
| <b>C: Family Practice</b>                                                                                           | Candidate Event 7<br>Candidate Event 8<br>Candidate Event 9<br>Candidate Event 10 |  No exclusions apply                                                        | Clinician C who is responsible for the plurality of the patient's attributable candidate events <b>will be attributed</b> beneficiary months for candidate events 7 – 10                                                              |
| <b>D: Geriatric Medicine</b>                                                                                        | Candidate Event 11                                                                |  No exclusions apply                                                      | Clinician D <b>will not be attributed</b> any beneficiary months because they do not bill the plurality of candidate events for this patient<br>Beneficiary months for candidate event 11 will not be attributed at the TIN-NPI level |

## Step 2. Understand How Cost Measures are Attributed (Continued)

### MSPB Clinician Attribution

MSPB Clinician attribution begins by identifying the “episode,” triggered by an inpatient hospital admission.

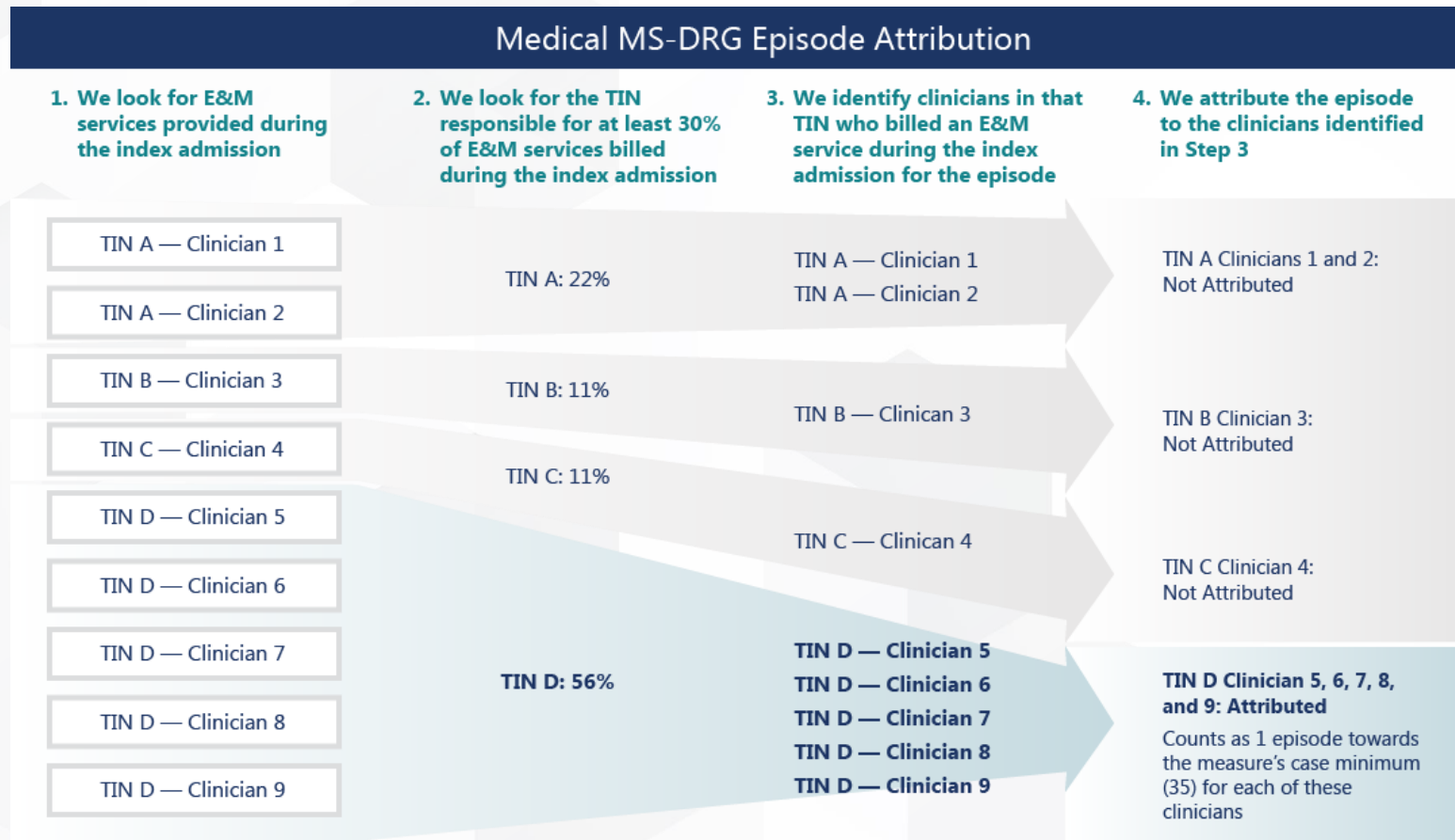


MSPB Clinician episodes are classified as either medical or surgical, based on the Medicare Severity-Diagnosis Related Group (MS-DRG) of the index admission.

- A **medical MSPB Clinician episode** is:
  - First attributed to a TIN if that TIN billed at least 30% of the E&M services on Part B physician/supplier claims during the inpatient stay.
  - Then attributed to any clinician in the TIN who billed at least one inpatient E&M service that was used to determine the episode's attribution to the TIN.
- A **surgical MSPB Clinician episode** is attributed to the clinician(s) who performed any related surgical procedure during the inpatient stay as well as to the TIN under which the clinician(s) billed for the procedure.

## Step 2. Understand How Cost Measures are Attributed (Continued)

MSPB Clinician: Medical Episode Attribution Example



## Step 2. Understand How Cost Measures are Attributed (Continued)

MSPB Clinician: Surgical Episode Attribution Example

### Surgical Episode Attribution Example

1. We identify TINs and Clinicians who billed CPT/HCPCS codes during Index Admission for a surgical episode

TIN A — Clinician 1

TIN A — Clinician 2

TIN B — Clinician 3

TIN C — Clinician 4

TIN C — Clinician 5

TIN C — Clinician 6

2. We identify TINs and Clinicians that billed relevant CPT/HCPCS codes for the surgical episode

TIN A: Yes  
Clinician 1: Yes  
Clinician 2: No

TIN B: No  
Clinician 3: No

TIN C: No  
Clinician 4: No  
Clinician 5: No  
Clinician 6: No

3. We attribute the episode to the TIN(s) and clinician(s) identified in step 2

TIN A: **Attributed**  
Clinician 1: **Attributed**  
Clinician 2: Not Attributed

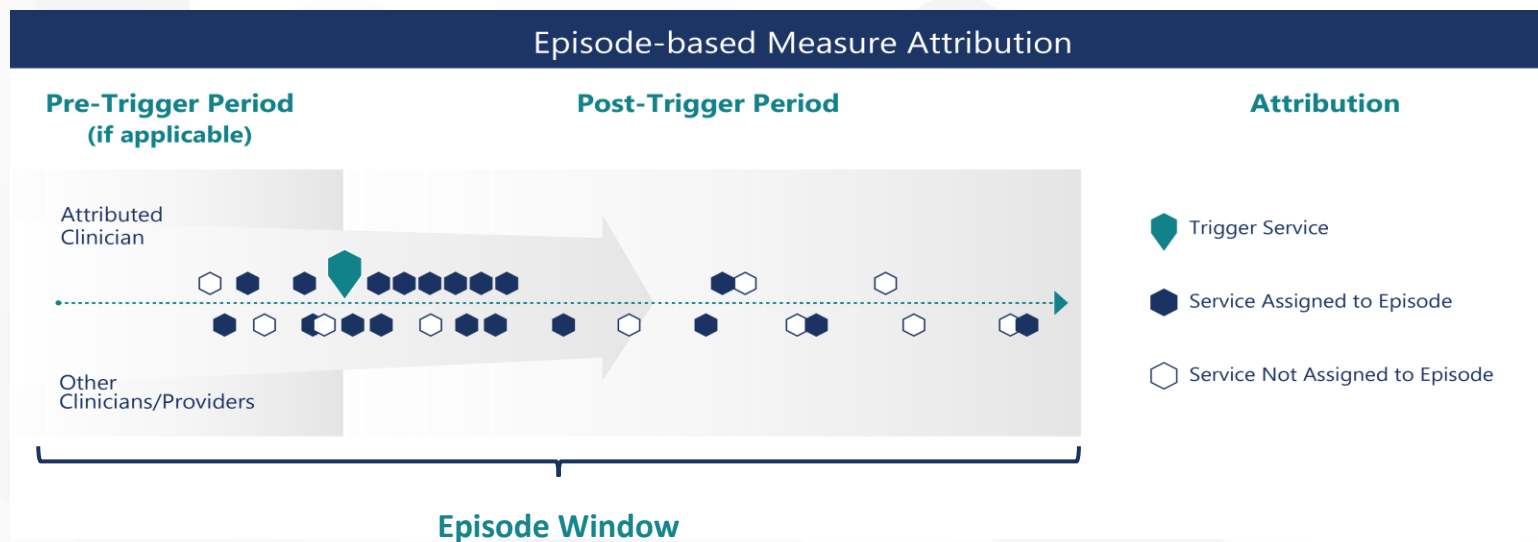
TIN B: Not Attributed  
Clinician 3: Not Attributed

TIN C: Not Attributed  
Clinician 4: Not Attributed  
Clinician 5: Not Attributed  
Clinician 6: Not Attributed

## Step 2. Understand How Cost Measures are Attributed (Continued)

### Episode-Based Measure Attribution

- For **acute inpatient condition episode-based measures**, an episode is:
  - First attributed to the TIN billing at least 30% of inpatient E&M services on Part B physician/supplier claims during the inpatient stay.
  - Then attributed to any clinician in that TIN who billed at least one inpatient E&M service during the inpatient stay.
- For **procedural episode-based measures**, we attribute the episode to any clinician who bills the code that triggers the episode.



## Step 2. Understand How Cost Measures are Attributed (Continued)

### Episode-Based Measure Attribution (Continued)

For **chronic condition episode-based measures**:

- Episodes are attributed to the clinician group that renders services that make up a “trigger event.” A trigger event for chronic condition episode-based measures is identified by the occurrence of two claims billed in close proximity by the same clinician group. Both claims must have a diagnosis code indicating the chronic disease captured by the measure. The first claim must have an E&M code for outpatient services (identified in the measure’s codes list file (ZIP)) and the second claim must have either another E&M code for outpatient services OR a condition-related HCPCS/CPT code for procedure codes related to the treatment or management of the chronic condition. We apply two checks to ensure clinician groups are involved in the patient’s care:
  - A clinician within the group has provided care to a patient prior to or on the episode start date.
  - At least one clinician within the group has written at least 2 condition-related prescriptions on different days to 2 different patients during the performance period plus a one-year lookback period in measures where the use of prescriptions is informative about the nature of care that the clinician provides.
- The trigger event opens an attribution window from the date of the initial E&M outpatient service, during which time the same clinician group could reasonably be considered responsible for managing the patient’s chronic disease.
- The initial attribution window is extended each time we see additional E&M codes for outpatient services or condition-related HCPCS/CPT codes related to the treatment or management of the chronic condition, indicating an ongoing clinician-patient relationship. As a result, the total attribution window could span multiple years and vary in length for different patients.
- Because the total attribution window could span multiple performance periods, we divide the attribution window into segments of episodes which we assess in the performance period in which they conclude.

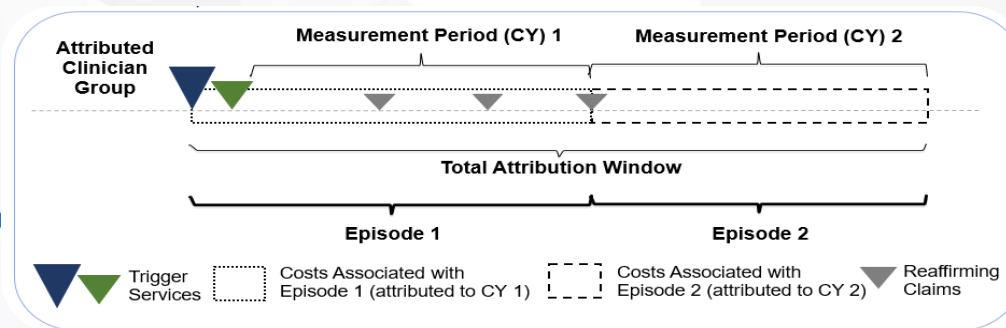


## Step 2. Understand How Cost Measures are Attributed (Continued)

### Episode-Based Measure Attribution (Continued)

For **chronic condition episode-based measures** (Continued):

- To attribute episodes to individual clinicians, we attribute episodes to each MIPS eligible clinician within an attributed clinician group that renders at least 30% of qualifying services during the episode. Two checks are conducted to confirm an individual clinician's role in the ongoing management of a patient's chronic condition:
  - First, we check to ensure the qualifying clinician(s) have rendered at least one E&M service code for outpatient services or a condition-related HCPCS/CPT code with a relevant diagnosis in connection with the same patient triggering the episode within 1 year prior to or on the episode start date.
  - Second, we check whether the clinician(s) have written at least 2 condition-related prescriptions on different days to 2 different patients during the performance period plus a one-year lookback period.
  - MIPS eligible clinicians in an attributed clinician group that render at least 30% of qualifying services and meet the 2 additional checks are considered for attribution.
- An individual clinician's performance on a chronic condition episode-based measure is based on all episodes attributed to the individual clinician, while the clinician group's performance is based on all the episodes attributed to the clinician group.
- If a single episode is attributed to multiple clinicians in a single clinician group, the episode is counted only once toward the clinician group's performance.



## Step 2. Understand How Cost Measures are Attributed (Continued)

For the **Emergency Medicine** measure, the steps for attributing an Emergency Medicine episode are as follows:

- Identify claim lines with positive standardized payment for any trigger codes that occur on the episode trigger day.
- Attribute an episode to any Tax Identification Number (TIN)-National Provider Identifier (NPI) billing the trigger codes.
- Attribute episodes to the TIN by aggregating all episodes attributed to NPIs that bill to that TIN. If the same episode is attributed to more than one NPI within a TIN, the episode is attributed only once to that TIN



## Step 3. Understand How Cost Measures are Calculated (Continued)

### TPCC Measure Calculation

| Step                                                     | Description/Additional Information                                                                                                                                                                                                                             |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Identify candidate events                             | This is the start of a primary care relationship between a clinician and Medicare patient.                                                                                                                                                                     |
| 2. Apply service category and specialty exclusions       | This excludes candidate events for certain clinicians. For example, clinicians whose candidate events meet thresholds for certain service categories (e.g., global surgery) or practice under certain specialties (e.g., dermatology).                         |
| 3. Construct risk windows                                | For remaining candidate events, this opens a year-long risk window beginning with the initial E&M primary care service of the candidate event.                                                                                                                 |
| 4. Attribute beneficiary months to TINs and TIN-NPIs     | Months in the risk window that occur during the performance period are attributed to the remaining eligible TIN-NPIs within the TIN responsible for the majority share, or plurality, of candidate events for a patient.                                       |
| 5. Calculate payment-standardized monthly observed costs | This sums the cost of all services billed for the Medicare patient during a given month. Costs are standardized to account for differences in Medicare payments unrelated to care provided.                                                                    |
| 6. Calculate risk-adjusted monthly costs                 | This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.                                                                                                                                          |
| 7. Apply specialty adjustment to risk-adjusted costs     | This accounts for the fact that costs vary across specialties and across TINs with varying specialty compositions.                                                                                                                                             |
| 8. Calculate the measure score                           | This is done by dividing each TIN and TIN-NPI's risk-adjusted monthly cost by the specialty-adjustment factor and multiplying by the observed cost across the total population of beneficiary-months where the risk window overlaps with the performance year. |

## Step 3. Understand How Cost Measures are Calculated (Continued)

### MSPB Clinician Measure Calculation

| Step                                                                                  | Description/Additional Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. Define the population of index admissions</b>                                   | An episode is opened by an inpatient hospital admission (“index admission”). Medicare Part A and Part B claims billed 3 days prior to and during the index admission and 30 days after hospital discharge are considered for inclusion.                                                                                                                                                                                                                                                                                                                                         |
| <b>2. Attribute MSPB Clinician episodes</b>                                           | <p>The MSPB Clinician attribution methodology distinguishes between medical episodes and surgical episodes. Episodes with medical MS-DRGs are attributed to:</p> <ul style="list-style-type: none"> <li>1) the TIN that billed at least 30% of inpatient E&amp;M services during the index admission, and</li> <li>2) any TIN-NPI who billed at least one E&amp;M service that was used to meet the 30% threshold for the TIN.</li> </ul> <p>Episodes with surgical MS-DRGs are attributed to the TIN and TIN-NPI that provided the main procedure for the index admission.</p> |
| <b>3. Exclude unrelated services and calculate episode standardized observed cost</b> | We exclude unrelated services specific to groups of MS-DRGs aggregated by Major Diagnostic Categories (MDCs), such as orthopedic procedures. This removes services clinically unrelated to the index admission and sums the cost of the remaining services. Costs are standardized to account for differences in Medicare payments unrelated to care provided.                                                                                                                                                                                                                  |
| <b>4. Risk-adjust MSPB Clinician episode costs to calculate expected cost</b>         | This accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>5. Exclude outliers and winsorize costs</b>                                        | This mitigates the effect of outlier high- and low-cost episodes on each TIN-NPI or TIN’s MSPB Clinician measure score.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>6. Calculate MSPB Clinician Measure score</b>                                      | This is done by calculating the ratio of standardized observed episode costs to winsorized expected episode costs and multiplying the average of this cost ratio across episodes for each TIN-NPI or TIN by the national average observed episode cost.                                                                                                                                                                                                                                                                                                                         |



## Step 3. Understand How Cost Measures are Calculated (Continued)

### Procedural and Acute Inpatient Medical Condition Episode-Based Measure Calculation

| Step                                                                                                                                                                                               | Description/Additional Information                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Trigger and define an episode (for the Emergency Medicine measure: Trigger an Episode and Define an ED Visit)                                                                                   | This relies on billing codes that open, or “trigger,” an episode. The pre- and post-trigger period length of the episode varies by measure.                                                                                                                      |
| 2. Attribute the episode to a clinician                                                                                                                                                            | For acute inpatient condition episodes, this is a clinician billing E&M services under a TIN that bills 30% of inpatient E&M services during the inpatient stay.<br><br>For procedural episodes, this can be any clinician who bills the trigger procedure code. |
| 3. Assign costs to the episode and calculate the standardized episode observed cost (for the Emergency Medicine measure: Exclude Clinically Unrelated Services to Calculate Episode Observed Cost) | The cost of the assigned services is summed to determine each episode’s standardized observed cost. Costs are standardized to account for differences in Medicare payments unrelated to care provided.                                                           |
| 4. Exclude episodes                                                                                                                                                                                | This removes unique groups of patients in cases where it may be impractical and unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.                                                                         |
| 5. Estimate Expected Costs through Risk Adjustment                                                                                                                                                 | This step accounts for Medicare patient-level risk factors that can affect medical costs, regardless of the care provided.                                                                                                                                       |
| 6. Calculate the measure score                                                                                                                                                                     | This is done by calculating the ratio of standardized observed episode costs to expected episode costs and multiplying the average cost ratio across episodes for each TIN-NPI or TIN by the national average episode cost.                                      |



## Step 3. Understand How Cost Measures are Calculated (Continued)

### Chronic Condition Episode-Based Measure Calculation

| Step                                                                                | Description/Additional Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. Identify patients receiving care</b>                                          | A trigger event identifies the start or continuation of a clinician group's management of a patient's chronic disease. A trigger event is identified by the occurrence of 2 Part B Physician/Supplier (Carrier) claims billed by the same clinician group practice within a specified time. The pair of services must include a trigger claim and a confirming claim. The trigger claim is an initial E&M code for outpatient services along with a relevant chronic condition diagnosis. The confirming claim can be either another outpatient services E&M code with a relevant chronic condition diagnosis, or a condition-related CPT/HCPCS code with a relevant chronic condition diagnosis. Once a trigger event is identified, this opens an attribution window from the point of the trigger claim, in which the patient's chronic disease care will be monitored by a clinician group. |
| <b>2. Identify the total length of care between a patient and a clinician group</b> | Once an attribution window is opened, it continues for a determined number of days, unless there's a service that demonstrates a continuing care relationship, also known as a reaffirming claim. After a reaffirming claim is identified, the attribution window is extended by the length of the initial attribution window from the point of each reaffirming claim billed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>3. Define an episode</b>                                                         | Episodes are segments of the total attribution window that are counted in a particular measurement period. Episodes are assigned to a clinician group (identified by TIN) or individual clinicians (identified by TIN-NPI) and can vary in length. Episodes are assessed in the measurement period in which they conclude and only attribute days not previously measured in preceding measurement periods, so there's no double counting of episode costs. After episodes are constructed, they're placed into more granular, mutually exclusive and exhaustive subgroups based on clinical criteria to enable meaningful clinical comparisons.                                                                                                                                                                                                                                                |

## Step 3. Understand How Cost Measures are Calculated (Continued)

### Chronic Condition Episode-Based Measure Calculation (Continued)

| Step                                                                                     | Description/Additional Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>4. Attribute the episode to the clinician group and clinician(s)</b>                  | The episode is attributed to the clinician group that bills the trigger and confirming claims for the total attribution window. To attribute the episode to an individual clinician, we identify any clinician within the attributed clinician group who plays a substantial role in the care for the patient. This is identified as a clinician billing at least 30% of outpatient services E&M codes with a relevant chronic condition diagnosis and/or condition-related CPT/HCPCS codes with a relevant chronic condition diagnosis on Part B Physician/Supplier claim lines during the episode. There are also additional checks to ensure that clinicians aren't attributed to an episode before they have their first encounter with the patient and that we capture appropriate specialties through prescription billing patterns. |
| <b>5. Assign costs to the episode and calculate the episode annualized observed cost</b> | Services that are clinically related to the care and management of a patient's chronic disease that occur during the episode are included in the measure. The standardized cost of the assigned services is summed and averaged across the number of days in an episode. This average daily cost is then multiplied by 365 to determine each episode's annualized standardized observed cost.                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>6. Exclude episodes</b>                                                               | Exclusions remove unique groups of patients or episodes from cost measure calculation in cases where it may be impractical or unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

## Step 3. Understand How Cost Measures are Calculated (Continued)

### Chronic Condition Episode-Based Measure Calculation (Continued)

| Step                                                          | Description/Additional Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 7. Calculate the annualized expected cost for risk adjustment | Risk adjustment predicts the expected costs by adjusting for factors outside of the clinician's or clinician group's reasonable influence (e.g., patient age, comorbidities, dual Medicare and Medicaid eligibility status, and other factors). The episode group's annualized observed costs are winsorized at the 98 <sup>th</sup> percentile for each model to handle extreme observations. A regression is then run using the risk adjustment variables as covariates to estimate the expected cost of each episode. Further statistical techniques are applied to reduce the effects of extreme outliers on measure scores. |
| 8. Calculate the measure score                                | For each episode, the ratio of winsorized annualized standardized observed cost to annualized expected cost (both of which are from Step 7) is calculated. The measure is calculated as a weighted average of these ratios across all of a clinician's or clinician group's attributed episodes, where the weighting is each episode's number of assigned days. The weighted average episode cost ratio is then multiplied by the national average winsorized annualized observed episode cost to generate a dollar figure for the cost measure score.                                                                           |

## Step 4. Understand What Cost Performance Feedback Will Be Available

MIPS eligible clinicians, groups, and virtual groups who meet the case minimum for any of the cost measures will receive category-and measure-level scoring information in their performance feedback. Each cost measure is scored out of 10 possible points, based on comparison to a performance period benchmark. (There are no historical benchmarks for cost measures.)

In addition to measure- and category-level scores, we provide patient-level reports and a companion patient-level reports supplement to help users understand the information contained in the report. Cost performance feedback won't be available until Summer 2025 when you sign in to the [QPP website](#).



## Help, Acronyms, and Version History

## Where Can You Go for Help?

Contact the Quality Payment Program Service Center by email at [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov), by creating a [QPP Service Center ticket](#), or by phone at 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

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

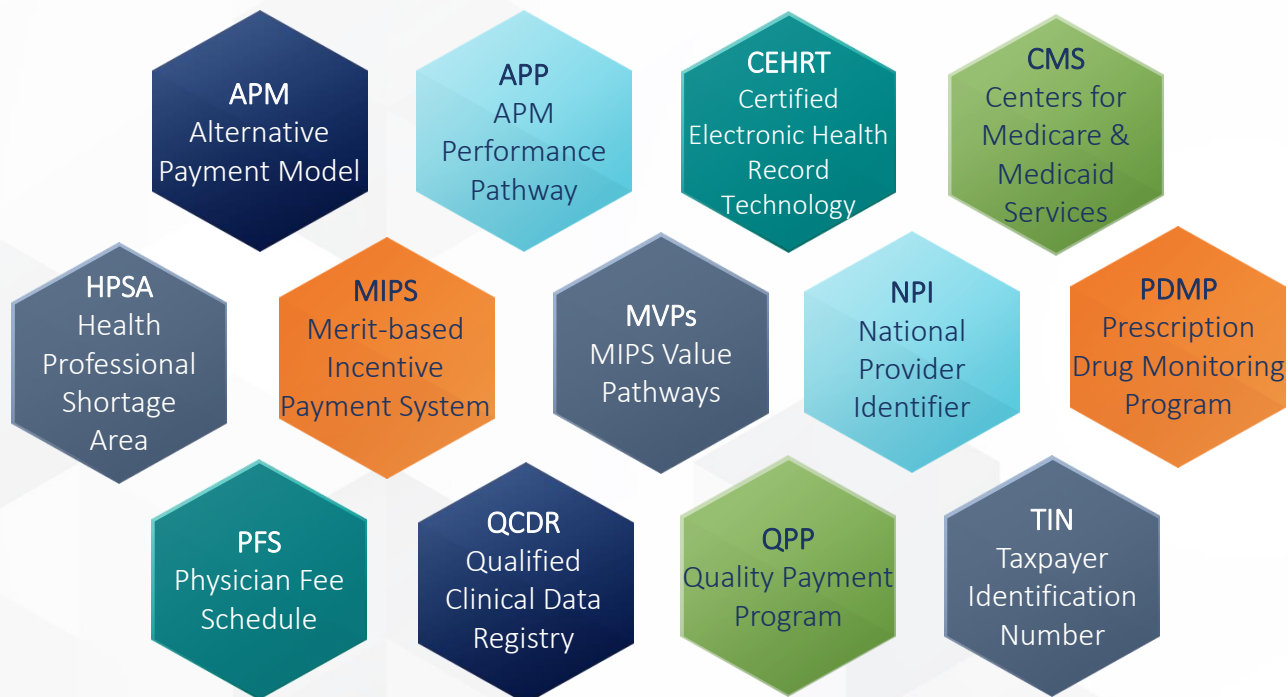
Visit the [Quality Payment Program website](#) for other [help and support information](#), to learn more about [MIPS](#), and to check out the resources available in the [Quality Payment Program Resource Library](#).

Visit the [Small Practices page](#) of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

CMS collaborates with clinicians and other interested parties to develop cost measures for potential implementation. This webpage contains information about this process, including how to participate: [QPP Cost Measure Information page](#).



## Acronyms



## Version History

If we need to update this document, changes will be identified here.

| DATE       | DESCRIPTION                                                                                          |
|------------|------------------------------------------------------------------------------------------------------|
| 01/04/2024 | Original Posting.                                                                                    |
| 04/29/2024 | Updated slide 39 to include information on how to develop cost measures for potential implementation |