HealthCare
Kentucky Regional Extension Center

Patient Attribution: Understanding Cost Measures 1 & 2

What cost measures are used to calculate the Cost Composite Score?

Six cost measures are used to calculate your TIN's Cost Composite Score:
1. Per Capita Costs for All Attributed Beneficiaries
2. Medicare Spending per Beneficiary
3. Per Capita Costs for Beneficiaries with Diabetes
4. Per Capita Costs for Beneficiaries with Coronary Artery Disease (CAD)
5. Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease (COPD)
6. Per Capita Costs for Beneficiaries with Heart Failure

Measure 1: For the Per Capita Costs for All Attributed Beneficiaries measure, costs reflect payments for all Medicare Part A and Part B claims submitted by all providers who treated the beneficiaries attributed to your TIN for the performance year, including providers who did not bill under your TIN.

Measure 2: For Medicare Spending per Beneficiary, costs are based on payments for all Medicare Part A and Part B claims submitted by all providers for care surrounding specified inpatient hospital stays (3 days prior to a hospital admission through 30 days post-discharge). This includes payments to providers who do not bill under your TIN.

A score for each cost domain is calculated as the equally-weighted average of measure scores within the domain, for all measures that have the required minimum number of eligible cases or episodes. Performance is then summarized across the cost domains for which scores could be calculated. This summary score is standardized relative to the mean of summary scores within the TIN's peer group to create a TIN's Cost Composite Score.

All cost measures are risk-adjusted based on the mix of beneficiaries attributed to your TIN; payment-standardized to account for differences in Medicare payments across geographic regions due to variations in local input prices; and specialty-adjusted to reflect the mix of specialties among eligible professionals within a TIN.

Measure 1 Attribution Process:

For Per Capita Cost for All Attributed Beneficiaries (one measure), Medicare attributes each beneficiary to the single TIN that provided more **PRIMARY CARE SERVICES** to that beneficiary (as measured by Medicare-allowed charges in 2015) than did any other TIN, through a two-step attribution process:

Step 1: A beneficiary is assigned to a TIN in the first step if the beneficiary received more primary care services from primary care PHYSICIANS, nurse practitioners, physician assistants, and clinical nurse specialists in that TIN than in any other TIN.

Step 2: If a beneficiary did not receive a primary care service from any primary care physician, nurse practitioner, physician assistant, or clinical nurse specialist in 2015, the beneficiary is assigned to a TIN in the second step if the beneficiary received more primary care services from specialist physicians in that TIN than in any other TIN

For additional details on the two-step attribution methodology, please see the Fact Sheet for Attribution in the 2017 VALUE MODIFIER, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html