Emergency Medicine Post-Field Test Refinement (PFTR) Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
PFTR Webinar, April 15, 2022
June 2022

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Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC to develop episode-based cost measures for potential use in the Merit-based Incentive Payment System (MIPS) to meet the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Acumen's measure development approach involves convening clinician expert panels to provide input in cycles of development ("Waves").[1] In Wave 4, instead of the typical Clinical Subcommittee (CS) process for episode group prioritization and selection, we obtained stakeholder input on candidate clinical areas and episode groups through a public comment period from December 16, 2020, to February 5, 2021.[2] This approach provided flexibility for a wider range of stakeholders to participate around their schedule. The prioritization criteria used to identify strong candidate episode groups and concepts were developed based on input from our technical expert panel (TEP), Person and Family Engagement (PFE), CS, and Clinician Expert Workgroups ("workgroups"). The following Wave 4 episode groups were finalized based on the prioritization criteria, public comments received, and discussions with CMS: (i) Emergency Medicine, (ii) Heart Failure, (iii) Low Back Pain, and (iv) Depression.

We held a nomination period for workgroup members between April 26, 2021, and May 21, 2021. The workgroups are composed of clinicians with expertise directly relevant to the selected episode groups. Workgroups (of about 15-20 members) were finalized in June 2021, and they provided detailed input on the development of the selected episode groups during their first workgroup webinars from June 21 to June 24, 2021. Acumen convened the workgroups again for a Service Assignment and Refinement (SAR) Webinar to revisit the specifications recommended during the workgroup webinar and refine the measures prior to national field testing. After the national field test from January 10, 2022 to March 25, 2022, Acumen convened

[1] For information on measure development in Waves 4, refer to the 2022 Episode-Based Cost Measures Field Testing Wave 4 Measure Development Process document (https://www.cms.gov/files/document/wave-4-measure-development-process-macra.pdf).
[2] For a summary of comments we received during the public comment period, refer to the MACRA Episode-Based Cost Measures: Wave 4 Measure Development Public Comment Summary Report document (https://www.cms.gov/files/document/wave-4-public-comment-summary.pdf).

the workgroups for a third meeting to continue measure specification and refinement discussions in April 2022. For Wave 4, all workgroup meetings were held virtually.

Emergency Medicine PFTR Webinar, April 15, 2022

This meeting summary document outlines the purpose, discussion, and recommendations from the Emergency Medicine PFTR Webinar. Section 1 provides an overview of the webinar goals and process. Section 2 summarizes the discussion and recommendations from the workgroup.

1. Overview

The goals of the Emergency Medicine PFTR Webinar on April 15, 2022, were the following:

(i) Discuss field testing feedback
(ii) Review empirical analyses
(iii) Confirm refinements to finalize the measure prior to submitting for potential consideration in MIPS

The meeting was held online via webinar and attended by 12 of the 18 workgroup members. The webinar was facilitated by an Acumen moderator, Suzann Pershing. The Emergency Medicine workgroup chair was Susan Nedza, who also facilitated meeting discussions. Libby Hoy from PFCCpartners presented findings from Person and Family Partners (PFPs). The MACRA Episode-Based Cost Measure Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties.[3]

Stakeholders beyond the workgroup members had access to a public dial-in number to observe the meeting as part of Acumen's continued effort to increase the transparency of the measure development process.

Prior to the webinar, workgroup members were provided with information and materials to inform their meeting discussions. After the webinar, workgroup members were sent a recording of the webinar and were polled on their preferences to ensure the measures are developed based on well-documented stakeholder input. Based on National Quality Forum practices, the threshold for support was greater than 60% consensus among poll responses. This document summarizes the workgroup members' input from both the discussion as well as the polls.

This meeting was convened by Acumen as part of the measure development process to gather expert clinical input; as such, these are preliminary discussions and materials, which don't represent any final decisions about the measure specifications or MIPS.

2. Summary of Sessions and Discussion

This section describes workgroup member discussions and recommendations. The first sub-section summarizes the PFP findings discussed in the webinar (Section 2.1). The remaining sub-sections describe workgroup member discussions and recommendations on constructing emergency department (ED) visit types and sub-populations (Section 2.2), services to exclude and their associated timeframe (Section 2.3), and addressing various types of ED dispositions (Section 2.4), respectively. Section 2.5 describes the next steps.

[3] CMS, "MACRA Episode-Based Cost Measures: Wave 4 Clinician Expert Workgroup Composition (Membership) List" (https://www.cms.gov/files/document/wave-4-measure-specific-workgroup-composition-list.pdf).

2.1 PFP Findings and Discussion

Libby Hoy presented findings from the field testing survey in which 8 patients and caregivers provided input prior to the meeting. A majority of patients and caregivers received an accurate diagnosis at ED admission, with some patients being diagnosed with a related chronic condition after an inpatient admission. Trauma was one common reported reason for admission, and trauma surgeons were the only ED care team members to follow up after discharge. Person and family commenters involved with trauma visits shared that ED physicians, nurses, clergy/social workers were integral to their ED care. About half of these commenters reported being included in the decision about admission to the hospital, and one commenter consulted with their primary care physician about this.

In general, COVID-19 has presented new challenges to patients and caregivers in EDs. Person and family commenters reported a reduced focus on diagnostics, and for one patient with dementia, challenges to accessing much needed caregivers.

2.2 Sub-Populations for Meaningful Clinical Comparison

Workgroup members discussed constructing ED Visit Types (Section 2.2.1) and accounting for admission versus discharge for ED visits (Section 2.2.2).

2.2.1 Constructing ED Visit Types

Workgroup members reviewed the methodology and summary statistics around the construction of ED Visit Types, discussing stakeholder feedback from the national field test on the mapping of International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes to visit types, as well as potential updates to the algorithm.[4] In previous meetings, members settled on classifying visit types based on body part and patient presentation. The following paragraphs summarize workgroup discussion from the webinar on the following items. Discussion topics were based on measure field testing feedback and public comments.

- Combining the neurological Visit Types: Altered Mental State, Stroke, and Neurologic
- Creating Ear/Nose/Throat (ENT) and Eye Disorders visit types using diagnosis codes from the Oral/Nasal/and Skin and Eye/Ear Visit Types
- Creating Visit Types for headache and fever, respectively
- Creating Visit Types for COVID-19 and COVID-19 exposure (or otherwise addressing the condition)

Overall, discussion centered on ensuring that this mapping supports accountability in the Emergency Medicine cost measure in a clinically appropriate way.

The workgroup generally opposed combining Altered Mental Status or Neurologic visit types with Stroke because of the significant differences in care team and patient risk that stroke patients experience. Also, due to their undifferentiated diagnosis, Altered Mental Status visits would likely come with more downstream costs associated with workup, diagnosis and, treatment of a complex condition. There may be higher mortality for such visits as well. Workgroup members noted that it may improve the Visit Type algorithm's accuracy to use

[4] The draft measure specifications that were used and circulated in the national field test are posted on the MACRA Feedback Page: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback.

Medicare Severity Diagnosis-Related Group (DRG) information from inpatient admissions to classify ED visits.

Members suggested separating ENT and Eye-related Visit Types, expressing strong support for reworking the existing diagnosis code to Visit Type mapping. For example, diagnosis codes for conditions such as sinusitis, dental caries, and stomatitis may be more clinically valid in an ENT Visit Type than in Oral/Nasal/Skin. Other codes such as those for pruritus, pressure ulcer, and urticaria were suggested for retention in Oral/Nasal/Skin because of the differences they present with ENT care. The code L02 (Cutaneous abscess, furuncle and carbuncle), which the draft measure includes in Oral/Nasal/Skin, was singled out as a strong reason to separate ENT codes from the rest of Oral/Nasal/Skin due to its different care team and applicability to many parts of the body. Similarly, eye-related codes were recommended to be categories in a separate Visit Type.

With regards to COVID-19, there was strong verbal agreement on the pandemic's impact on all types of ED care, due to factors including the capacity and resource triage considerations introduced by staffing limitations and the need to reduce SARS-CoV-2 spread. For example, during times with a high COVID prevalence, ED physicians likely sent many more patients home for monitoring who may have otherwise been admitted or placed in observation care. Some members agreed with excluding ED visits with COVID-19 infections or with exposure as a primary diagnosis; they mentioned the potential to revisit the specifications in future years once the virus becomes endemic.

Finally, workgroup members briefly discussed the suggestions to create Visit Types for non-diabetic endocrine issues, headache, and fever. There was general support for creating a non-diabetic endocrine Visit Type; a small number of related codes were included in the field testing draft specifications under other Visit Types, and no non-diabetic endocrine codes were included in the Diabetes Visit Type. With regard to headache/fever, the workgroup noted that ED clinicians will infrequently use codes with such limited granularity; while they might be included as diagnoses on the claim, there would very likely be more specific codes that would classify the ED visit into an existing, clinically specific Visit Type. The Acumen team supported this claim, reminding workgroup members that the hierarchy of ED Visit Types (which classifies visits into the most severe category for which they have a qualifying diagnosis) would render a Visit Type for headache/fever mostly obsolete.

2.2.2 Accounting for Admission versus Discharge

The workgroup reviewed previous webinar discussions and stakeholder input regarding sub-grouping episodes between those that end in discharge versus inpatient admission. Previously during the SAR Webinar, members had voted in favor of risk adjusting for the MS-DRG of the inpatient admission. Creating sub-groups for this distinction would maintain this methodology but would double the number of stratifications in the Emergency Medicine measure (i.e., from 28 to 56, where each visit type would have a separate risk adjustment model for those episodes that end in ED discharge versus inpatient admission). Workgroup members strongly supported this update because of the increased specificity that sub-grouping would afford and because of the limited influence of ED clinicians on inpatient and post-inpatient discharge care.

<u>Key Takeaways from Discussion and/or Polls for Sub-Populations for Meaningful Clinical Comparison</u>:

- Workgroup members voted in favor of the following updates to the Visit Type construction:
    - Sub-group all Visit Types by whether the ED visit terminates in ED discharge or inpatient admission

    - Continue using the MS-DRG on inpatient claims to contribute to Visit Type mapping
    - Recategorize the 2 Visit Types Skin/Eye and Oral/Nasal/Skin into Skin Conditions/Rashes/Abscesses and ENT/Eye Disorders, respectively
    - Rename Female Disorders to Gynecological Disorders
    - Create a Non-Diabetic Endocrine Visit Type
- Workgroup members voted against creating a Headache/Fever Visit Type
- Workgroup members voted to include episodes with COVID-19 into an existing Visit Type (e.g., General Infection or Respiratory)

2.3 Assigning Services to the Episode Group

Workgroup members discussed the episode window (Section2.3.1) and service exclusions (Section 2.3.2).

2.3.1 Episode Window

Acumen summarized previous workgroup discussion in support of a 30-day window and its rationale (e.g., alignment with many quality measures' window). After reiterating the strong stakeholder preference in public comments to shorten the episode window, Acumen shared analytic results summarizing the timing that claims in different service categories (e.g., inpatient surgical claims, outpatient office visits, ED visits, or post-acute care [PAC] claims) appear during Emergency Medicine episodes. Workgroup members remarked that PAC costs are more evenly distributed across the episode window, suggesting that most of post-ED PAC care lasts 30 days or longer.

Members strongly expressed support for a reduced episode window. They noted that much of the appropriate variation in cost (i.e., cost within the reasonable influence of the attributed clinician) that the Emergency Medicine measure should aim to capture occurs due to care coordination by ED clinicians. In these cases, ED re-visits shortly after the index visit are common. Such costs are generally attributable to poor care coordination, which Medicare allows ED clinicians to bill to help avoid complications. On the other hand, outpatient follow-up care with specialists or primary care doctors, which the workgroup considered appropriate care, is more distributed across the episode window.

The workgroup noted a potential challenge with attribution in including outpatient visits since there is inconsistency in the ED clinicians' role in directing care after discharge from the ED. In some cases, the patient may go directly to a referred specialty for follow-up care, while in other cases, follow-up care decisions fall entirely to the patient's primary care provider (if they are seen first).

2.3.2 Service Exclusions

Acumen reminded members that services can be excluded across different timeframes and across Visit Types. For example, a given service category (e.g., inpatient admissions) could be included within 7 days but not within the 7- to 30-day window, or it could be excluded only from some Visit Types. Acumen shared specific exclusions suggested by stakeholders (i.e., hemodialysis, chemotherapy, and PAC).

Stakeholders expressed support for existing exclusion rules that were implemented in the nationally field tested draft measure (e.g., admissions for multiple trauma, unrelated physical therapy, allergy shots, transplant admissions, post-discharge drug costs).

Workgroup members agreed with many of the suggestions. Of particular concern were Part B drugs, especially those used in ophthalmological care and chemotherapy, which are very

expensive and do not vary much in cost due to the clinician's discretion. Members were also concerned about ambulance services, which while costly, are often not within the reasonable influence of the ED clinician or inpatient clinician; also, these services are limited by local availability. Members noted that appropriate use measures for ambulance services may capture low-value care through means other than a cost measure. Finally, the workgroup raised the existence of appropriate use measures for different forms of imaging, but they supported including imaging in the Emergency Medicine cost measure despite some stakeholder comments in support of excluding these services.

Key Takeaways from Discussion and/or Polls for Assigning Services to the Episode Group:

- Members voted in support of reducing the episode window from 30 days to 14 days
- Members recommended to exclude the following services:
    - Radiation oncology
    - Ambulance services
    - Part B drugs provided after the ED visit

2.4 Addressing Various ED Dispositions and Risk Adjustment Variables

The final session focused on addressing the various ED clinical pathways (e.g., observation care or PAC) as well as updates to the risk adjustment model. Stakeholder feedback on observation care emphasized its importance to quality ED care, urging that the Emergency Medicine cost measure appropriately identify the clinician responsible for observation care and that observation stays aren't confused with inpatient stays. In the past, the workgroup voted to risk adjust for the presence of observation care for ED visits that end in discharge and not to risk adjust for such visits that end in inpatient admission (due to the use of inpatient MS-DRG risk adjustors). During this webinar, the workgroup expressed support for using Part B claims to denote episodes with observation care, and they reacted positively to testing results showing minimal differences in risk-adjusted cost for these cohorts.

With respect to transfers from PAC settings, Acumen recapped the previous consensus to risk adjust for transfers from inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), and long-term care hospitals (LTCH). Acumen also showed data on the cost distributions of these episodes and provider performance based on their frequency of PAC transfer episodes. The workgroup remarked on the effectiveness of risk adjustment in reducing disparities in observed cost. They noted that the risk adjustors for each transfer would ameliorate differences based on variation in patient severity due to comorbidities. The workgroup expressed support for including PAC transfers and continuing to risk adjust for them.

Finally, the workgroup discussed other risk adjustors suggested by stakeholders, including social determinants of health, hospital type and size, and ED volume. There was mixed feedback on each of these topics during discussion. Workgroup members raised academic hospitals as potentially having systematically more vulnerable patients, but they noted the difficulty of such a classification using claims data. Critical access hospitals (CAHs) were shown to have only a mild impact on provider-level cost scores, but members strongly supported risk adjusting on a conceptual basis; CAHs serve rural patients and likely have to transfer patients to other facilities on a routine basis due to capacity constraints. ED volume was raised as an important predictor of cost because overrun EDs have to triage resources and are likely to provide more expensive care. However, this is not easily observable using claims; the workgroup agreed that number of episodes is a poor proxy for ED volume. Dual eligibility in Medicare/Medicaid, the strongest predictor of ED cost differences across all social risk factors, was the final topic discussed for potential risk adjustment, and workgroup members strongly agreed that it should be addressed.

Key Takeaways from Discussion and/or Polls for Addressing Various ED Dispositions:

- Members voted to do the following:
  - Include and risk adjust PAC to ED transfer episodes
  - Risk adjust for episodes that occur in a CAH
  - Risk adjust for patients' dual eligibility in Medicare/Medicaid
- Workgroup members didn't reach consensus on the following, so the Emergency Medicine measure will not implement these changes:
  - Differentiate between ED observation care and non-ED observation care
  - Compare patients with observation care and ED discharge to inpatient-admitted patients

2.5 Next Steps

In the last session, Acumen provided a wrap-up of the discussion and an overview of the next steps. After the meeting, Acumen distributed the PFTR Webinar Poll to gather input from members on the discussions held during the webinar about potential refinements. The poll also included a section for other general comments. Acumen will operationalize input for the measure specifications based on PFTR Webinar Poll results.

Please contact **Acumen MACRA Clinical Committee Support** at macra-clinical-committee-support@acumenllc.com if you have any questions. If you are interested in receiving updates about MACRA Episode-Based Cost Measures, please complete this Mailing List Sign-Up Form to be added to our mailing list.