Quality Payment
PROGRAM

Questions for Field Testing Measure Specifications

Summer 2020 Field Testing

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1.0 Introduction

We are gathering input on the draft measure specifications for the 5 episode-based cost measures undergoing field testing. This document includes questions on each of the measures, and accompanies the draft specifications for each measure, comprising a Draft Measure Methodology document and Draft Measure Codes List file.[1]

Stakeholders may submit feedback in response to the questions included in this document as well as on other aspects of the measures through this online survey[2] between August 17 and September 18, 2020. When submitting feedback through the survey, stakeholders can also attach a PDF or Word document with their comment. Stakeholders may submit comments anonymously.

Field testing is taking place from August 17 to September 18, 2020. It is part of the measure development process and is an opportunity for clinicians and other stakeholders to learn about episode-based cost measures and provide input on the draft specifications. During field testing, we will:

- distribute Field Test Reports on the Quality Payment Program website[3] for group practices and solo practitioners who meet the minimum number of cases for each measure;
- post draft measure specifications (i.e., measure methodology and codes lists), and supplemental documentation, such as testing results, on the MACRA Feedback Page; and
- collect stakeholder feedback on the draft specifications for each measure.

The feedback from field testing helps inform refinements to the measures before consideration of their potential use in the Cost performance category of the Merit-based Incentive Payment System (MIPS). Feedback on other aspects of field testing, such as the Field Test Report format, will be considered for future testing periods. Table 1 outlines the measures undergoing field testing.

Table 1. Cost Measures Undergoing Field Testing

Episode Group Type	Episode-Based Cost Measure
Procedural	Colon and Rectal Resection
Procedural	Melanoma Resection
Acute Inpatient Medical Condition	Sepsis
Chronic Condition	Asthma/Chronic Obstructive Pulmonary Disease (COPD)
Chronic Condition	Diabetes

The cost measures were developed with extensive input from Clinical Subcommittees and Clinician Expert Workgroups, comprising clinician experts with experience in the clinical area of the measures under development. The Clinical Subcommittees recommended an episode group for development, defined its intended scope, and provided input on the composition of the smaller, measure-specific Clinician Expert Workgroups. These workgroups provided detailed input on each component of the measure at an in-person meeting in August 2019. They then met at a Service Assignment and Refinement webinar in January 2020 for follow-up discussions on service assignment and risk adjustment. After field testing, the workgroups will refine the draft measure specifications based on the stakeholder feedback. The Measure Development Process document provides more information on the development process of these measures.

[1] The specifications are available on the MACRA Feedback Page: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback
[2] The field testing online survey is available here: https://www.surveymonkey.com/r/2020-cost-measures-field-testing
[3] CMS, "Quality Payment Program Account," *Quality Payment Program,* https://qpp.cms.gov/login.

2.0 Questions on Draft Measure Specifications

This section includes specific questions on components of each episode-based cost measure that we are interested in gathering stakeholder feedback on. In addition to the questions in this section, the online survey also includes a general question for each measure, where stakeholders can submit comments on other aspects of the measure specifications not directly covered in the targeted questions below.

2.1 Colon and Rectal Resection Episode-Based Cost Measure

Defining an Episode Group

1. The measure scope was expanded from solely colon resections to also include rectal procedures. This change was informed by expert opinion that the types of services and the care trajectory were common across the types of procedures. Broadening the scope of the measure also improved the technical integrity of the measure and increased the coverage, which helps ensure the measure is impactful.

   Do you agree with the draft list of rectal trigger Current Procedural Terminology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes for rectal procedures and relevant rectal Medicare Severity-Diagnosis Related Groups (MS-DRGs) (since procedures which occur during an inpatient stay must have a relevant MS-DRG) that were added to expand the scope of the measure? If not, which rectal trigger codes should be added, removed, or otherwise modified?

Sub-Grouping the Episode Group

2. Additional rectal procedure trigger codes were added to the episode group when the measure scope was expanded to include rectal procedures. Therefore, the measure has been stratified into 2 mutually exclusive and exhaustive patient cohorts, called sub-groups, for Rectal Resection and Colon Resection. These sub-groups ensure clinical comparability so that the episodes for patients undergoing each procedure are compared only with episodes for patients undergoing the same procedure.

   The Rectal Resection sub-group includes episodes that: (i) are triggered by a rectal procedure code, (ii) have a trigger that is accompanied by a rectal or anal cancer diagnosis code, or (iii) are triggered by a lower anterior resection (LAR) (i.e., CPT/HCPCS codes 44145, 44146, 44207, and 44208) provided the episode is accompanied by an International Classification of Diseases, 10th revision (ICD-10) rectal cancer diagnosis code (i.e., C20).

   We classify rectopexies (i.e., CPT/HCPCS code 45400, and 45402) into the Colon Resection sub-group to ensure that the rectal procedures captured in the Rectal Resection sub-group are of similar complexity and entail comparable risks within the patient cohort. The Colon Resection sub-group captures all other cases triggered by the trigger codes not included in the definition for the Rectal Resection sub-group.

   Do the sub-group specifications for Colon Resection and Rectal Resection capture the distinction between these 2 patient cohorts? If not, how might the sub-group specifications be refined?

Assigning Costs to the Episode Group

3. For cost measures to assess clinician resource use as part of an overall evaluation of the value of care, service assignment should include services that are clinically related to the care for the triggering procedure and for which the attributed clinician can reasonably influence a large share of the services, either in their incidence or severity. Including a range of services helps the measure capture meaningful variation between clinicians.

   The measure includes pre-trigger services that are related to the procedure. Currently, assigned services in the 15 days prior to the trigger include cardiac diagnostic procedures (e.g., Diagnostic Cardiac Catheterization, Coronary Arteriography, Echocardiogram, Cardiac Stress Test, Electrocardiogram, Electrographic Cardiac Monitoring). Including these cardiac diagnostic procedures are important to follow for anesthesia protocols and to encourage care coordination as an area for improved patient outcomes and cost efficiency. This would also align with other surgical procedure measures. On the other hand, these pre-trigger services could be viewed as further removed from the trigger procedure.

   To balance these considerations and in light of the purpose of service assignment, should the following cardiac diagnostic procedures continue to be assigned to the pre-trigger period?

   a. Diagnostic cardiac catheterization, coronary arteriography
   b. Echocardiogram
   c. Cardiac stress test
   d. Electrocardiogram
   e. Electrographic cardiac monitoring

4. Episode-based cost measures are intended to capture clinician resource use so that they can be used within MIPS to reward clinicians on the value of care. The Colon and Rectal Resection measure currently captures costs that fall within the following broad categories or "clinical themes" (categorizations which are intended to present metrics in a coherent way for the Field Test Reports):
   - Trigger procedure and procedures during trigger stay or day
   - Pre-operative evaluation services
   - Routine post-operative care
   - Post-operative complications
   - Post-acute care and post-operative rehabilitation

   The complete list of services that are assigned to this measure are provided in the Draft Colon and Rectal Resection Measure Codes List file, which is available on the MACRA Feedback Page. Are there any types of services not currently included in the measure that should be considered for assignment that would reflect clinician resource use related to this procedure?

2.2 Melanoma Resection Episode-Based Cost Measure

Assigning Costs to the Episode Group

1. For cost measures to assess clinician resource use as part of an overall evaluation of the value of care, service assignment should include services that are clinically related to the care for the triggering procedure and for which the attributed clinician can reasonably

influence a large share of the services, either in their incidence or severity. Including a range of services helps the measure capture meaningful variation between clinicians.

The Melanoma Resection measure currently captures costs that fall within the following broad categories or "clinical themes" (categorizations which are intended to present metrics in a coherent way for the Field Test Reports):

- Primary resection; secondary excision; secondary reconstruction; lymph node services; infection; wound care
- Other surgical complications; other inpatient hospitalizations; other imaging; other emergency department visits; other post-acute care; other home health services; other pre-operative outpatient services; other post-operative outpatient services

The complete list of services that are assigned to this measure are provided in the Draft Melanoma Resection Measure Codes List file, which is available on the MACRA Feedback Page. The service assignment rules should also be considered in the context of the other components of the measure, such as risk adjustors.

Currently, costs related to anesthesia, pathology, anemia, aftercare, and systemic cancer treatment are not assigned to Melanoma Resection episodes. Considering this and the role of service assignment in measure construction, should these or other additional types of services be added to the measure?

Risk Adjusting the Episode Group

2. Risk adjustment serves to account for patient characteristics that are not under the influence of the attributed clinician. Currently, the Melanoma Resection risk adjustment variables include items like excision/reconstructive size, location of the trigger procedure, and presence of prior systemic therapy. Are there any additional patient characteristics that should be accounted for in the risk adjustment model to estimate the expected costs for treating patients receiving a melanoma resection?

   A complete list of risk adjustors is available in the Draft Melanoma Resection Measure Codes List file available on the MACRA Feedback Page.

Exclusions for the Episode Group

3. Exclusions serve to remove unique and often small groups of patients with certain characteristics from the cost measure, as they represent a patient cohort that differs substantially from the rest of the episode group in terms of clinical characteristics and cost. These exclusions may represent a disease state or process outside the intended scope of the measure. Exclusions are often applied when risk adjustment alone would not be sufficient to account for the patients' differences in cost.

   As an example, Mohs surgery procedures (defined by CPT/HCPCS 17311 or 17313) accompanied by a melanoma diagnosis code (either C43 or D03) are currently excluded from the measure. The rationale is that Mohs surgery is not part of standard clinical procedure for resecting melanomas, and as such, episodes where a Mohs surgery procedure occurs accompanied by a melanoma diagnosis should be excluded.

   Are there other services or conditions (e.g., that would be indicative of a patient population that would fall outside the scope of the measure or that is very different from the cohort at large) found prior to an episode that would warrant excluding an episode? These might include services outside of standard melanoma resection protocol, or that

are unrelated to the melanoma resection and that would indicate sufficiently different patient characteristics compared to the general cohort of patients undergoing melanoma resection.

2.3 Sepsis Episode-Based Cost Measure

Defining the Episode Group

1. The Sepsis measure focuses on the medical treatment of sepsis. This is defined as: (i) a sepsis MS-DRG (i.e., 870-2), or (ii) an MS-DRG indicating a hospitalization for a common source of infection where there is a diagnosis of sepsis. These sources of infection include non-hepatobiliary gastrointestinal infection, respiratory infection, skin and soft tissue infection, and kidney and urinary tract infection. These are common sources of infection representing a relatively homogenous patient cohort for medical treatment of sepsis; they are also included as risk adjustment variables to ensure comparability.

   Should this measure be expanded to include more severe infections or surgical treatment of infections? While this would bring more types of sepsis cases under the cost measure which may otherwise remain unassessed, it would also introduce greater heterogeneity in the measure's patient cohort. If so, what other sources of infection should be included?

Assigning Costs to the Episode Group

2. The measure currently captures costs that fall within the following categories of services, or "clinical themes" (categorizations which are intended to present metrics in a coherent way for the Field Test Reports):
   - Initial sepsis admission; recurrent sepsis
   - Recurrent respiratory infection, complication, or subsequent care; recurrent non-hepatobiliary gastrointestinal infection, complication, or subsequent care; recurrent skin and soft tissue infection, complication, or subsequent care; recurrent kidney and urinary tract infection, complication, or subsequent care
   - Cardiac and central nervous system complications (e.g., arrhythmia, syncope, encephalopathy); acute renal failure and medication complications
   - Outpatient follow-up and lab work; Part B antibiotics and infusion supplies; follow-up imaging; home health, physical therapy, occupational therapy, and speech language pathology; other post-acute care; Part D oral antibiotics; and Part D intravenous antibiotics

   The complete list of services that are assigned to the measure are provided in the Draft Sepsis Measure Codes List file on the MACRA Feedback Page.

   Are there any additional types of services that are clinically related to an episode of care for sepsis that would help capture clinician resource use? Examples of services not currently assigned include myocardial infarction following a hospitalization for sepsis and non-specific symptoms such as muscle weakness.

3. For the Sepsis measure, Part D prescription drugs considered clinically related to the treatment of sepsis were included in services assigned to episodes for feedback during field testing. The draft list of Part D services included in the measure is available in the Draft Sepsis Measure Codes List file.

Are there adjustments you would make to this list to group additional, clinically relevant drug costs to the episodes, or to exclude costs currently grouped to episodes?

Risk Adjusting the Episode Group

4. The measure currently includes cases of "Sepsis Present on Admission" and "Hospital-Acquired Sepsis," though we may want to handle these cases differently. This is because our analyses indicate that hospital-acquired cases, while a very small minority of episodes (approximately 4% of all episodes), tend to have higher episode costs than where sepsis is present on admission. To account for this, we could risk adjust or exclude these episodes, or consider stratifying the measure into sub-groups for this patient cohort or addressing hospital-acquired sepsis in a separate measure. We could also include in the measure as-is without handling the two types of cases separately.

   Adding a **risk adjustor** for hospital-acquired sepsis would retain these episodes in the cost measure and account for their higher expected cost. One consideration is that risk adjustment aims to account for factors outside the clinician's influence (e.g., patient comorbidities); however, there may be circumstances where a clinician's care could influence whether a patient develops sepsis during the hospitalization.

   Hospital-acquired sepsis cases could be **excluded** from this measure, meaning clinician resource use for these cases would not be assessed, leaving a gap in coverage that may represent an area for improved cost performance.

   For the **sub-grouping** option, there may be some technical limitations as there needs to be sufficient episodes to allow a risk adjustment model to be run separately for each sub-group. The small share of hospital-acquired sepsis episodes may mean that this distinction would yield too few episodes per provider for meaningful comparison.

   Given these considerations, how should hospital-acquired sepsis cases be accounted for: risk adjust, exclude, address in a separate measure, consider sub-grouping, or leave as is (i.e., include both in this measure without sub-grouping or risk adjustment)?

5. The Sepsis measure already risk adjusts for a variety of patient factors from the CMS-HCC risk adjustment model (e.g., human immunodeficiency virus/acquired immunodeficiency syndrome, end-stage renal disease) and other factors (e.g., source of infection, transfer from inpatient rehabilitation facility/ skilled nursing facility/ long-term care hospital, hospice care). Are there other patient factors prior to or during the hospitalization that are likely to impact the severity of the sepsis and the consequent outcomes and downstream costs?

2.4 Asthma/Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure

Assigning Costs to the Episode Group

1. The goal of the cost measure is to include services and costs where appropriate care for asthma or COPD can decrease the occurrence or severity of another service. The measure currently captures costs that fall within the following "clinical themes" (categorizations which are intended to present metrics in a coherent way for the Field Test Reports):

- Asthma/COPD exacerbation; asthma/COPD chronic care; lung surgery; nebulizers and home oxygen; arrhythmias; sepsis; non-specific symptoms
- Pulmonary imaging; home health, physical therapy, occupational therapy, and pulmonary rehabilitation
- Other respiratory complications; other post-acute care
- Outpatient medications for chronic care of asthma/COPD; outpatient medications for asthma/COPD exacerbations; outpatient medications for tobacco cessation

The complete list of services that are assigned to the measure are provided in the Draft Asthma/COPD Measure Codes List file, available on the MACRA Feedback Page.

Are there any additional types of services that are clinically related to an episode of care for asthma or COPD that should be included in the measure to meaningfully assess clinician resource use?

2. Thoracic surgeries and allergen treatment are high-cost services that are currently assigned, but may be outside of the scope of chronic care for patients with asthma or COPD. Should these costs be considered clinically related and included in the episode?

3. The nature of care for chronic conditions means that effective management can reduce the risk and/or severity of other patient outcomes. For example, well-managed chronic asthma or COPD can mean that non-specific symptoms are less frequent and severe than where these underlying chronic conditions have not been appropriately treated. Non-specific symptoms include malaise, syncope, and chest pain; should these complications be included as costs to help differentiate good care of asthma or COPD from poor care?

   Similarly, appropriate treatment of asthma or COPD can decrease the risk and severity of heart attacks. Note that the measure uses a risk adjustment model that includes covariates for a number of comorbidities that would also affect the severity of heart attack such as diabetes, coronary artery disease, and previous heart attacks. This means that by including services for heart attacks in the Asthma/COPD cost measure – and risk adjusting for other patient comorbidities – the measure is better able to both capture this source of variation and opportunity for improvement in chronic care and account for other factors that affect resource use. As such, should services for heart attacks be included in the cost measure as a marker to differentiate care for asthma or COPD?

4. Including post-acute care (PAC) services related to the chronic care of asthma and COPD can help distinguish effective PAC use between clinicians and retain incentives for appropriate PAC utilization. However, PAC services can become costly when utilized for a long period of time, and a single patient with high PAC utilization can potentially result in a disproportionately large impact on a clinician's or clinician group's final measure score, despite good management of most of their other patients. We use the following methods to address this concern, while still capturing PAC service utilization:

   - For Skilled Nursing Facility (SNF), only assign SNF stays if the clinically related inpatient stay is assigned, and restrict the attributed SNF costs to 30 days. Is this

an appropriate approach or is there another appropriate timeframe to distinguish over- or under-utilization between clinicians?

- For Long-Term Care Hospital and Inpatient Rehabilitation Facility, only assign stays when there is a preceding inpatient stay considered clinically related to the episode group. Is this an appropriate approach? What would be an appropriate timeframe to cap costs?

5. For the Asthma/COPD measure, Part D prescription drugs considered clinically related to the treatment of asthma/COPD were included in services assigned to episodes. The draft list of Part D services included in the measure is available in the Draft Asthma/COPD Measure Codes List file.

   Are there adjustments you would make to this list to group additional, clinically relevant drug costs to the episodes, or to exclude costs currently grouped to episodes?

Attributing the Episode Group to Clinicians

6. Currently, the Asthma/COPD cost measure is attributed to any clinician group, identified by Taxpayer Identification Number (TIN), billing the trigger event claims, and to any individual clinician, identified by a TIN and National Provider Identification (NPI) pair (TIN-NPI), within that TIN that bills at least 30% of *"primary care" evaluation and management (E&M)* codes with an asthma or COPD diagnosis and/or *chronic condition-related CPT/HCPCS* codes for relevant services accompanied by an asthma or COPD diagnosis on Part B Physician/Supplier (Carrier) claim lines during the episode. Under the TIN-NPI attribution methodology, the following 10 clinician specialties are most frequently attributed the measure: Internal Medicine, Family Practice, Pulmonary Disease, Nurse Practitioner, Allergy/Immunology, Cardiology, Physician Assistant, Critical Care (Intensivists), General Practice, and Geriatric Medicine.

   The scope of the measure is intended for both primary care physicians as well as specialists who manage the chronic disease. Are these appropriate specialties for the measure to capture? Are there any specialties that provide ancillary care to these patients that should be attributed the measure?

Sub-Grouping the Episode Group

7. Currently, the Asthma/COPD measure is stratified into 3 mutually exclusive and exhaustive sub-groups representing different patient cohorts: Asthma, COPD, and both Asthma and COPD. These sub-groups ensure comparability between patients as episodes within each stratified cohort are compared only with each other. To assign episodes to these sub-groups, we examine all ICD-10 diagnosis claims for an episode and assign the episode to a sub-group if the claims for one diagnosis or the other reach an 85% threshold. Should neither diagnosis reach this threshold, then the episode is placed in the sub-group of having both asthma and COPD.

   Is this methodology appropriate to delineate the disease processes? Is there other information within claims data that we should consider to delineate these sub-groups?

Risk Adjusting the Episode Group

8. While the cost measure includes a robust risk adjustment model, there may be other factors that affect the spending for patients with asthma or COPD, such as through higher patient severity and greater incidence of downstream outcomes. Besides the variables in the current risk adjustment model, are there other factors outside the influence of the clinician that should be accounted for in estimating the expected cost for treating asthma or COPD? The detailed list of risk adjustors used in the risk adjustment model is in the Draft Asthma/COPD Measure Codes List file, available on the MACRA Feedback Page.

2.5 Diabetes Episode-Based Cost Measure

Assigning Costs to the Episode Group

1. The Diabetes cost measure assigns services where appropriate care for the disease process can decrease the risk and severity of complications. The measure currently captures costs that fall within the following "clinical themes" (categorizations which are intended to present metrics in a coherent way for the Field Test Reports):
    - Diabetes care management
    - Metabolic dysfunction; neuropathy and peripheral vascular disease; nephropathy and renal disease; retinopathy/diabetic eye disease; heart disease; cerebrovascular disease; ulcers and cellulitis; other infection
    - Diabetes medications; other medications; diabetes treatment supplies; other durable medical equipment
    - Other inpatient hospitalization; other emergency department visits; other outpatient services; home health care; post-acute care

    The complete list of assigned services are provided in the Draft Measure Codes List file, available on the MACRA Feedback Page.

    Are there any changes to the assigned services that would help the measure capture meaningful variation in resource use between clinicians?

2. Including post-acute care (PAC) services related to the chronic care of diabetes can help distinguish effective PAC use between clinicians and retain incentives for appropriate PAC utilization. However, PAC services can become costly when utilized for a long period of time, and a single patient with high PAC utilization can potentially result in a disproportionately large impact on a clinician's or clinician group's final measure score, despite good management of most of their other patients. We use the following methods to address this concern, while still capturing PAC service utilization:

    - For Skilled Nursing Facility (SNF), only assign SNF stays if the clinically related inpatient stay is assigned, and restrict the attributed SNF costs to 30 days. Is this an appropriate approach or is there another appropriate timeframe to distinguish over- or under-utilization between clinicians?
    - For Long-Term Care Hospital and Inpatient Rehabilitation Facility, only assign stays when there is a preceding inpatient stay considered clinically related to the episode group. Is this an appropriate approach? What would be an appropriate timeframe to cap costs?

3. For the Diabetes measure, Part D prescription drugs considered clinically related to the treatment of diabetes were included in services assigned to episodes. The draft list of Part D services included in the measure is available in the Draft Diabetes Measure Codes List file.

   Are there adjustments you would make to this list to group additional, clinically relevant drug costs to the episodes, or to exclude costs currently grouped to episodes?

Attributing the Episode Group to Clinicians

4. Currently, the Diabetes cost measure is attributed to any TIN billing the trigger event claims, and to any TIN-NPI within that TIN that bills at least 30% of *"primary care" E&M* codes with a diabetes diagnosis and/or *chronic condition-related CPT/HCPCS codes* for relevant services accompanied by a diabetes diagnosis on Part B Physician/Supplier (Carrier) claim lines during the episode. Under the TIN-NPI attribution methodology, the following 10 clinician specialties are most frequently attributed the measure: Internal Medicine, Family Practice, Nurse Practitioner, Podiatry, Cardiology, Endocrinology, Nephrology, Physician Assistant, Ophthalmology, and General Practice.

   The scope of the measure is intended for both primary care physicians as well as specialists expected to manage the chronic disease. Are these specialties appropriate for the measure to assess? Are there any specialties that provide ancillary care to these patients that should be attributed the measure?

Sub-Grouping the Episode Group

5. Currently, the Diabetes episode group is stratified into 2 patient cohorts or sub-groups: Type 1 Diabetes and Type 2 Diabetes. These sub-groups ensure comparability between patients as episodes within each stratified cohort are compared only with each other. We assign episodes to sub-groups by combining results from 3 independent methods that focus on different claims-based markers of type 1 and type 2 diabetes (including all-claim diagnoses, E&M claim diagnoses, and endocrinologist-billed diagnoses) to reduce the chance of misclassification from limitations in claims data in individual methods alone. Please refer to the Draft Diabetes Measure Methodology available on the MACRA Feedback Page for a detailed illustration of this sub-grouping methodology.

   Is this methodology appropriate to classify episodes into Type 1 Diabetes and Type 2 Diabetes? Is there other information within claims data that we should consider to delineate these sub-groups?

Risk Adjusting the Episode Group

6. While the cost measure includes a robust risk adjustment model, there may be other factors that affect the severity and downstream outcomes of patients with diabetes. The detailed list of risk adjustors used in the risk adjustment model is in the Diabetes Draft Measure Codes List file on the MACRA Feedback Page. Outside of variables in the current risk adjustment model, are there factors outside of the influence of the clinician that should be accounted for in estimating the expected cost for an episode?