Quality Payment
PROGRAM

National Summary Data Report on 5 Episode-Based Cost Measures

- Emergency Medicine
- Heart Failure
- Low Back Pain
- Major Depressive Disorder
- Psychoses/Related Conditions

Winter 2022 Field Testing

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1.0 Introduction

This National Summary Data Report provides the results of empirical analyses for 5 episode-based cost measures under development. This report presents national-level summary statistics, calculated using data from January 1 to December 31, 2019, that stakeholders may use to understand the performance of clinicians and clinician groups relative to the performance of others nationally. The information provided is for field testing purposes only. Specifically, this report provides summary statistics on patient demographics, as well as clinicians and clinician groups that are attributed cost measures, based on the draft specifications.

This document serves as a supplemental resource to other documents being shared with stakeholders for the winter 2022 field testing period. More detailed testing results for each measure can be found in the measure-specific Measure Testing Forms, available on the MACRA Feedback Page.[1]

The rest of this section gives an overview of field testing and the cost measures undergoing field testing, and Section 2 provides national summary statistics for each measure.

1.1 Overview of 2022 Cost Measures Field Testing

Field Testing is taking place from January 10 to February 25, 2022. As a part of the measure development process, field testing is an opportunity for clinicians and other stakeholders to learn about episode-based cost measures and provide input on the draft specifications.[2] During field testing, we are:

- distributing 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;
- posting draft measure specifications (i.e., measure methodology and codes list) and supplemental documentation, such as testing results, on the MACRA Feedback page; and
- collecting stakeholder feedback on the draft specifications for each measure.

We are collecting stakeholder feedback on the draft specifications for each measure from **January 10 to February 25, 2022.** To provide feedback, please navigate to the 2022 Cost Measures Field Testing Feedback Survey

Field Test Reports are available at the clinician group practice and solo practitioner (or clinician) levels. Clinicians are identified by a unique Taxpayer Identification Number (TIN) and National Provider Identifier (NPI) combination (TIN-NPI), while clinician groups are identified by their TIN.

[1] CMS, "Cost Measure Field Testing," MACRA Feedback Page, https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback.
[2] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the Secretary, as determined appropriate, to conduct an analysis of cost with respect to care episode and patient condition groups (referred to as "episode groups") and use the methodology developed for purposes of the cost performance category of the Merit-based Incentive Payment System (MIPS). CMS has contracted with Acumen to develop and re-evaluate cost measures for potential use in the MIPS cost performance category of the Quality Payment Program.
[3] CMS, "QPP Account," Quality Payment Program, https://qpp.cms.gov/login.

To receive a Field Test Report, Clinicians and clinician groups must have at least 20 episodes for a measure.

Table 1 lists the episode-based cost measures undergoing field testing and their clinical focus.

Table 1. Cost Measures Undergoing Field Testing in 2022

No.	Episode-Based Cost Measure	Description
1	Emergency Medicine	This measure focuses on the care provided by clinicians in the emergency department and includes visits leading to both discharge and hospital admission.
2	Heart Failure	This measure focuses on the outpatient treatment and management of heart failure.
3	Low Back Pain	This measure focuses on the outpatient treatment and management of low back pain.
4	Major Depressive Disorder	This measure focuses on the outpatient treatment and management of major depressive disorder.
5	Psychoses/Related Conditions	This measure focuses on the inpatient treatment and care for psychoses or related conditions.

All stakeholders are encouraged to review and provide feedback on the draft measure specifications of these measures, even if they did not receive a Field Test Report. Stakeholders can review publicly available materials, including the draft measure specifications, mock reports, and supplemental documentation, including a Frequently Asked Questions (FAQ) and development process overview, on the MACRA Feedback Page.

1.2 Episode-Based Cost Measure Development

Stakeholder input is critical to the development of robust, meaningful, and actionable episode-based cost measures. Throughout the measure development process, Acumen sought input from clinicians and other stakeholders to inform the development of the cost measures. Acumen developed the episode-based cost measures with input from a public comment period, Clinician Expert Workgroups, a technical expert panel (TEP), and Patient and Family Partners (PFPs).

Episode-based cost measures represent the cost to Medicare for the items and services furnished to patients during an episode of care. These measures are designed to inform clinicians on the costs related to the management of a certain condition or procedure that occurred during a defined period. The measures focus on costs that are clinically related to the care provided by clinicians to whom the episodes are attributed. In conjunction with quality of care assessment, cost measures aim to incentivize high-value, patient-centered care across a patient's care trajectory.

1.3 Methodology

All empirical analyses presented in this document were conducted using the following data sources:

- Medicare Enrollment Database (EDB)
- Common Working File (CWF) Claims Data
    - Durable Medical Equipment (DME) Claims Data

    - Home Health (HH) Claims Data
    - Hospice (HS) Claims Data
    - Inpatient (IP) Claims Data
    - Outpatient (OP) Claims Data
    - Part B Physician/Supplier (Carrier) Claims Data
    - Skilled Nursing (SN) Claims Data
- Minimum Data Set (MDS)
- Medicare Prescription Drug Event Tap Data (PDT)

In field testing documentation, the term "cost" refers to allowed amounts on traditional, fee-for-service Medicare claims data, which include the Medicare-allowed charge for a given service and both the amount of the Medicare trust fund payments and any applicable patient deductible and coinsurance amounts. Medicare Parts A and B claims are used for all measures, and Part D claims are used for the 3 chronic condition measures (Major Depressive Disorder, Heart Failure, and Low Back Pain). Additionally, cost figures are standardized to remove the effect of differences in Medicare payment among healthcare providers that are the result of differences in regional healthcare provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments, such as those for teaching hospitals. This standardization is intended to isolate cost differences that result from healthcare delivery choices, allowing for more accurate resource use comparisons between healthcare providers.[4]

The cost measures were developed and the cost measure scores were calculated based on the methodology documented in the Draft Cost Measure Methodology and the Draft Measure Codes List files corresponding to each of the 5 cost measures.[5] All analyses were calculated on episodes ending during the measurement period of January 1, 2019 through December 31, 2019.

[4] CMS, "CMS Price (Payment) Standardization Overview" *ResDAC page*, https://resdac.org/articles/cms-price-payment-standardization-overview

[5] CMS, Draft Cost Measure Methodology and Draft Measure Codes List files, *MACRA Feedback Page* (January 2022), https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback

2.0 National Summary Statistics

This section provides national summary statistics and high-level trends for the 5 cost measures undergoing field testing. Section 2.1 presents summary statistics on patient demographics. Section 2.2 provides details on the number and specialties of clinicians and clinician groups that are attributed cost measures. Finally, Section 2.3 presents summary statistics of Medicare Part D prescription drug costs for the cost measures that include those costs.

Note: Unless otherwise noted in the table description, only clinicians and clinician groups attributed at least 20 episodes for a measure during the measurement period are included in the tables below.

2.1 Summary of Patient Demographics

The table below provides a summary of demographic information for patients with at least one episode for the cost measures being field tested during the measurement period. There may be more episodes than patients since the same patient can have more than one episode in the period.

Table 2. Patient Demographics

Cost Measure	Number of Episodes	Number of Patients	Average Age (Years)	Sex (% Female)
Emergency Medicine	15,551,631	8,233,348	71.66	57.2%
Heart Failure	1,752,647	1,396,704	76.89	49.4%
Low Back Pain	6,022,102	4,402,357	71.94	61.0%
Major Depressive Disorder	2,193,909	1,876,080	71.13	70.6%
Psychoses/Related Conditions	148,583	92,555	51.89	47.1%

2.2 Summary Information for Clinicians and Clinician Groups that are Attributed Cost Measures

Episodes are attributed to a clinician(s) based on the claims information available at the time of the trigger. The principal clinician(s) is (are) held responsible for the services that are assigned to the episode based on their clinical relevance to the role of the clinician(s) in managing patient care.

The rules for attributing episodes vary depending on the type of episode group. For detailed information on the attribution methodologies for each of the cost measures, please refer to the corresponding measure methodology available on the MACRA Feedback page.

Table 3 presents the number of clinicians (TIN-NPIs) and clinician groups (TINs) by the number of cost measures for which they received a Field Test Report.

Table 3. Number of TINs and TIN-NPIs with a Field Test Report for At Least One Episode-Based Cost Measure

Number of Episode-Based Cost Measures	Number of TINs	Number of TIN-NPIs
1	56,396	179,500
2	5,325	6,683
3	3,978	1,745
4	740	17
5	405	0

Table 4 summarizes the 3 most attributed specialties for each cost measure, based on the number of episodes attributed to clinicians from each specialty. Specialty information is based on the reported Health Care Finance Administration (HCFA) specialty designations found on the Medicare Part B Physician/Supplier claims included in the episode.

Table 4. Most Attributed Specialties by Number of Episodes

Cost Measure	Most Attributed Specialty			Second Most Attributed Specialty			Third Most Attributed Specialty		
	Specialty	# of TIN-NPIs	# Episodes	Specialty	# of TIN-NPIs	# Episodes	Specialty	# of TIN-NPIs	# Episodes
Emergency Medicine	Emergency Medicine	52,314	11,708,890	Physician Assistant	12,798	1,499,163	Nurse Practitioner	7,288	838,253
Heart Failure	Cardiology	10,232	461,908	Internal Medicine	3,868	126,485	Cardiac Electrophysiology	1,227	67,761
Low Back Pain	Chiropractic	24,200	1,411,472	Physical Therapist in Private Practice	11,046	381,408	Physical Medicine and Rehabilitation	3,524	318,259
Major Depressive Disorder	Internal Medicine	6,322	228,907	Psychiatry	4,588	218,339	Family Practice	5,460	179,691
Psychoses/Related Conditions	Psychiatry	3,327	107,055	Nurse Practitioner	925	31,164	Internal Medicine	358	17,626

The following tables provide a distribution of the number of episodes attributed to TINs and TIN-NPIs for each of the cost measures being field tested.

Table 5-A. Distribution of Episode Counts per TIN

Cost Measure	# of TINs	Mean # of Episodes	Episode Count Percentile						
			1st	10th	25th	50th	75th	90th	99th
Emergency Medicine	4,071	3,800	20	28	67	1,033	4,422	9,413	35,044
Heart Failure	10,667	143	20	22	28	46	106	311	1,589
Low Back Pain	49,949	110	20	23	31	50	94	188	1,185
Major Depressive Disorder	17,237	104	20	22	27	42	83	195	1,107
Psychoses/Related Conditions	2,041	78	20	24	32	53	92	163	398

Table 5-B. Distribution of Episode Counts per TIN-NPI

Cost Measure	# TIN-NPIs	Mean # of Episodes	Episode Count Percentile						
			1st	10th	25th	50th	75th	90th	99th
Emergency Medicine	79,540	194	20	31	57	139	280	439	777
Heart Failure	19,829	44	20	21	25	33	51	77	178
Low Back Pain	69,742	57	20	22	26	38	66	114	276
Major Depressive Disorder	23,927	38	20	21	23	30	43	64	147
Psychoses/Related Conditions	5,131	47	20	22	26	35	53	85	200

2.3 Summary of Standardized Part D Drug Costs

Part D drugs have been identified by stakeholders as an important clinical component of costs for the episode-based cost measures. 3 of the 5 cost measures undergoing field testing include Part D drug costs in the measure: Major Depressive Disorder, Heart Failure, and Low Back Pain. Part D drug costs likely account for a large share of the overall episode cost for these measures. An adjustment to account for post-point-of-sale rebates within Part D standardized amounts (which only reflect point-of-sale drug costs) is included in the Part D payment standardization methodology[6,7] to ensure that the cost of Part D branded drugs do not appear disproportionately costly relative to generic and/or Part B drug substitutes.

The rules for including Part D drugs vary depending on the cost measure and were informed with careful considerations by clinical expert workgroups. For detailed information on the

[6] CMS Part D Payment Standardization Methodology is available at https://resdac.org/articles/cms-price-payment-standardization-overview

[7] Methodology for incorporating rebates in Part D standardized amounts is available at https://www.cms.gov/files/document/methodology-incorporation-rebates-part-d-standardized-amounts.pdf

inclusion of Part D drug costs for each of the 3 cost measures, please refer to the corresponding measure methodology available on the MACRA Feedback page.

Table 6 provides summary statistics for the cost measures that include Part D drug costs.

Table 6. Part D Enrollment by Measure

Cost Measure	Total # of Episodes	# of Beneficiaries	% of Beneficiaries with Part D Enrollment
Heart Failure	1,752,647	1,752,647	74.39%
Low Back Pain	6,022,102	6,022,102	75.94%
Major Depressive Disorder	2,193,909	2,193,909	77.98%