

Summary of Person and Family Engagement (PFE) and Input for Wave 3 Episode-Based Cost Measure Development

MACRA Episode-Based Cost Measures

March 2021

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, to develop episode-based cost measures for use in the Merit-based Incentive Payment System (MIPS) to meet the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As part of this work, Acumen, Westat, and PFCCpartners gathered the input of persons with lived experiences with a range of medical conditions relevant to 5 episode-based measures developed in 2019-20.

This document provides an overview of the measure development process and how patient and family engagement (PFE) has been incorporated. The rest of the document summarizes the person and family partner (PFP) input received, noting how it's considered and reflected in the chronic condition measure framework and the 5 measures:

- Asthma/Chronic Obstructive Pulmonary Disorder (COPD)
- Colon and Rectal Resection
- Diabetes
- Melanoma Resection
- Sepsis

1. Measure Development Process

Acumen develops cost measures in cycles, or waves, which involves convening expert panels to prioritize measures and build out detailed specifications in an iterative process.¹ In each Wave, we gather iterative input from experts and stakeholders for ongoing testing of measure specifications.² In Waves 1 and 2, we developed 19 episode-based cost measures. Throughout Wave 3 of measure development, Acumen continued to build on this stakeholder engagement; we solicited and considered PFE input on (i) selection of episode groups for development, and (ii) a broad set of questions around constructing measures that will provide meaningful feedback on clinicians' resource use via service assignment, provider attribution, episode length, and more. Acumen shares this input with Clinical Subcommittees (CS) and measure-specific Clinician Expert Workgroups (hereafter "Workgroups"), composed of around 15 clinicians. Workgroup members considered this input, along with empirical analyses, environmental scans and the literature, and clinical judgment, in building out each component of the episode-based cost measures. CS and Workgroup members also had the opportunity in each meeting to identify questions for person and family representatives to provide guidance to their input. To

¹ 2020 Episode-Based Cost Measures Field Testing: Wave 3 Measure Development Process (2020) <https://www.cms.gov/files/document/macra-cmft-ebcm-process-2020.pdf>

² Summary of Person and Family Committee (PFC) Input for Wave 2 Episode-Based Cost Measure Development (2018) <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-pfc-findings-all-measures.pdf>

provide overarching guidance across measures and the project in general, Acumen has a standing Technical Expert Panel (TEP) which includes person and family members.

Wave 3 of measure development involved person and family input at multiple stages of the development process. As the CS were providing input on prioritizing episode groups to develop for Wave 3, we shared for their consideration a guiding principles document that was developed through structured interviews with a Person and Family Committee (PFC) convened in 2017. These guiding principles have provided consistency across Waves of development.

After the 5 episode-based measures were confirmed for development, we conducted 16 in-depth interviews with persons who have lived experience with the 5 conditions in July 2019. In these discussions, individuals provided input on the following topics:

- The attributable clinician(s) and other clinicians involved in the episode
- Healthcare services provided by various clinicians and costs incurred therein
- Patient-related factors (e.g., adherence to treatment plan, co-pays) that may influence the costs of healthcare services included in the episode
- Indicators of quality that should be considered alongside cost measures

These findings were shared with Workgroups at in-person meetings in August 2019 and a follow-up webinar in January 2020 to assist in their construction and refinement of the specifications.

In August and September 2020, Acumen conducted a period of national field testing when we produced feedback reports for all attributed clinicians and posted draft specifications and testing results for public comment.^{3,4} We received 22 comments from individuals through a Cost Measures Questionnaire for Person and Family Input. This survey included questions on the specifications of the Wave 3 measures, as well as general questions on cost measure development. The measure-specific comments received were summarized and shared with the Workgroups after field testing to inform measure refinements during the Post-Field Test Refinement (PFTR) webinars in October 2020.

2. Chronic Condition Framework

In developing the new framework of chronic condition cost measures, Acumen considered input on general patterns of care:

- PFPs reported that the frequency of appointments ranged from monthly to annually.
- Persons with lived experience with asthma/COPD described visits with their primary manager of COPD care as routine, including receiving a standard set of services during each visit.
- Representatives noted that the primary manager of their care occasionally referred them to additional services, typically to support lifestyle changes and self-management.

³ Cost Measure Specifications for Field Testing (2020) <https://www.cms.gov/files/zip/macra-2020-wave-3-ft-specs.zip>

⁴ 2020 Field Testing Feedback Summary Report (2020) <https://www.cms.gov/files/document/macra-2020-ft-feedback-summary-report.pdf>

This input is reflected in the trigger logic for the chronic condition measure framework. The measure looks for a pair of services between the same TIN and patient within 180 days, ensuring that healthier patients with routine care aren't left out of the measure as could occur if the measure required the 2 visits to occur within closer proximity. The trigger logic also uses Current Procedure Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for services related to the care and management of a condition, reflecting the input that there are standard services.

3. Asthma/COPD Cost Measure

PFPs who have experience with asthma and/or COPD provided input on this measure during development. The following sections summarize this input for each measure component, noting how it was considered and reflected in the specifications.

3.1 Attribution

Person and family representatives identified a range of specialties involved in the care of the condition:

- PFPs identified pulmonologists, general practitioners, and primary care clinicians as being part of their care team.
- During field testing, person and family respondents also identified the following specialties: nurse practitioners, allergists and immunologists, cardiologists, physician assistants, intensivists, general practitioners, and geriatric medicine specialists.

The attribution methodology is based on billing patterns in claims data. The Workgroup provided input on trigger codes and methodology to ensure that both specialists and primary care clinicians are attributed, which person and family representatives had identified as both being part of their care team. We also considered the patient and family input to help validate the results of our analyses into frequently attributed specialties which show that the measure captures the range of clinician types that individuals identified as being part of their care team.

3.2 Service Assignment

PFPs provided input on the types of care services that they received:

- Person and family representatives specified that almost all services occurred in ambulatory care settings.
- During field testing, some representatives suggested including additional services such as spirometers and other breathing accessory aids.
- Some respondents identified services that address other symptoms, such as malaise, syncope, chest pain, weight loss, or acute respiratory distress syndrome.

The measure includes services provided in ambulatory care settings related to the care and management of asthma and COPD. It also includes spirometers and other breathing accessory aids. The Workgroup members discussed services related to non-specific symptoms and eventually recommended not assigning these services as they may be clinically unrelated to asthma or COPD.

3.3 Alignment with Quality

Persons who have lived experience with asthma and COPD provided input on indicators of quality:

- Some PFPs noted that an indication of high-quality care includes the ability of clinicians to listen to patients' concerns and be responsive.
- Person and family representatives also cited avoidance of the emergency room as another indication of high-quality care.
- Some representatives highlighted opportunities to improve care, including coordination across practices, and the use of prescribed inhalers.

The measure includes emergency room visits as assigned services, reflecting the patient and family perspective that this is related to the management of asthma/COPD. Additional points highlighted by PFPs will also be used in future documentation to support the measure rationale, performance gap, and opportunities for improvement.

4. Colon and Rectal Resection Cost Measure

PFPs with lived experience with colon or rectal resection provided input on the based cost measure. The following sections describe PFE input that was considered and reflected in the specifications.

4.1 Attribution

Person and family representatives identified the following types of clinicians as part of their care team:

- Colorectal surgeons
- Anesthesiologists

The attribution methodology is based on the clinician billing a trigger code for a procedure for colon or rectal resection, removal or partial removal of small/large bowel, proctectomy, or excision of rectal procidentia with anastomosis. As such, the measure captures surgeons, including colorectal surgeons, per an analysis of the most frequently attributed specialties. While anesthesiologists aren't attributed under this methodology, the measure includes the costs of anesthesia services, reflecting the role that anesthesia plays in the costs of care for surgeries.

4.2 Service Assignment

PFPs provided several suggestions for services to include in the cost measure:

- Representatives identified anesthesia, pre-operative testing and evaluations (such as lab work or imaging), and wound care and ostomy supplies following surgery for inclusion in the cost measure.
- Some input suggested that cardiac procedures should only be performed if medically necessary.
- People with experience with this surgery shared their perspective that while follow-up visits may be intended to occur within 2 weeks, this may be delayed as patients juggle other responsibilities in everyday life.

The measure includes the services identified by PFPs. The Workgroup discussed cardiac services at length, and ultimately voted to exclude diagnostic cardiac catheterization and

coronary arteriography services, but to include electrographic cardiac monitoring, electrocardiograms, echocardiograms, and cardiac stress tests in the pre-trigger period of the cost measure. In light of the input from people with lived experiences, the measure was adjusted to expand the episode window post-trigger period for certain follow-up care from 15 to 30 days.

5. Diabetes Cost Measure

Person and family representatives provided input on provider attribution and service assignment; the following sections detail input that was considered by the Workgroup and implemented in the cost measure.

5.1 Attribution

PFPs identified the following types of clinicians on their care team:

- Endocrinologists
- Primary care clinicians

Similar to the Asthma/COPD measure (section 3.1), we used this input to validate the attribution methodology; these specialties are among the most frequently attributed for this cost measure. The Workgroup for this measure agreed on the importance of capturing both specialists and generalists to meaningfully assess the costs of care.

5.2 Service Assignment

Person and family representatives who had experience with diabetes treatment provided input on the types of care services received:

- A common set of screening and lab tests
- Culturally relevant education

The measure includes clinically related tests and screens, such as blood glucose and hemoglobin A1C tests, or diabetic foot/eye exams. The Diabetes Workgroup agreed on the importance of education services being culturally relevant. While the specific nature of the services wouldn't be distinguishable in claims data, the measure does include education and self-management services. The need for culturally relevant education will be included in future documentation as a consideration for care improvement. The measure also includes all telehealth services accompanied by a diagnosis code for diabetes or related condition (e.g., chronic kidney disease) to ensure that care visits delivered virtually are captured.

6. Melanoma Resection Cost Measure

PFPs with experience with the melanoma resection procedure provided input on provider attribution and service assignment; the sections below describe the input that was considered by the Workgroup and implemented in the cost measure.

6.1 Attribution

Person and family representatives identified the following types of clinicians in their care team; all individuals who shared input noted that the procedure was performed in the outpatient hospital setting:

- Surgeons

- Oncologists
- Anesthesiologists

The attribution methodology is based on the clinician who bills a CPT/HCPCS code for melanoma resection of malignant growth and tissue rearrangements when accompanied by a diagnosis code for malignant melanoma of skin or melanoma in situ. As such, dermatologists and surgeons are the most frequently attributed clinicians. A small number of surgical oncologists are attributed. The measure focuses on the role of the clinician performing the procedure and the care that's clinically related to that role, so oncologists and anesthesiologists tend not to be attributed by this measure. The measure is only triggered in the outpatient or office settings, supported by clinical input and empirical analyses that show only a very small number of cases in the inpatient hospital setting representing a substantially different patient cohort.

6.2 Service Assignment

Person and family representatives identified the types of care services that were relevant to their experience:

- Individuals received either general or “twilight” anesthesia.
- PFPs noted that they received follow-up care, such as visits to the surgeon for surgical wound care and services from a nurse or discharge coordinator to avoid or identify complications.

The Workgroup for this measure voted to include anesthesia costs in the measure. The measure also includes services for follow-up care and complications.

7. Sepsis Cost Measure

PFPs provided input on the Sepsis acute inpatient hospitalization episode-based cost measure. The following sections detail PFE input on the types of providers that typically treat sepsis patients, and the services typically rendered, that was considered by the Workgroup and implemented in the measure.

7.1 Attribution

During in-depth interviews, person and family representatives mentioned the following specialties as being part of their care team with different roles:

- Internists often oversaw treatment
- Patients received specialty referrals depending on the source of infection

This input is reflected in testing that shows internal medicine clinicians as the most frequently attributed specialty for the Sepsis cost measure. Other specialties, such as pulmonary, nephrology, and gastroenterology, were all commonly attributed in the measure, in line with appropriate referrals for lung, kidney, or gastrointestinal infections.

7.2 Service Assignment

Person and family representatives provided the following input on the types and timing of care services:

- People with experience with sepsis noted that care began upon admission to the hospital, so it wouldn't make sense to include costs in a pre-trigger period.
- PFPs believed that the cost of treatments ordered by the attributed clinician should be included. They also identified antibiotics, diagnostic testing and procedures (e.g., blood and urine tests, chest imaging) as part of the care for sepsis.
- Patient and family representatives noted that the cost of services for the surgical removal of catheters due to infection should be included.
- PFPs noted the importance of including patient education and prevention training in the measure.

The Workgroup considered this input in providing recommendations on the measure specifications. The measure has no pre-trigger period; sepsis treatment is often urgent and unplanned, so the attributed clinician would play no role in the patient's care prior to the trigger inpatient stay. The measure includes the costs of all services during the inpatient hospitalization, as well as antibiotics and diagnostic testing. During the PFTR webinar, the Workgroup voted not to assign services for the surgical removal of catheters for 2 reasons:

- If a patient is hospitalized for the surgical removal of an implanted catheter, then they're likely going to be receiving antibiotics and other services that would be captured by a readmission hospitalization.
- Outpatient removals of catheters are unlikely to be surgical and don't occur often. The Sepsis Workgroup agreed with the rationale for including education and prevention services; however, these are currently not identifiable in claims data as there are no applicable codes.