

# Asthma/COPD Cost Measure Field Test Report

Name of Clinician Group  
Taxpayer Identification Number (TIN): #####  
Measurement Period: January 1, 2019 – December 31, 2019

## 1 OVERVIEW AND RESULTS

This report details your performance on the Asthma/Chronic Obstructive Pulmonary Disease (COPD) measure for field testing. Field testing is a voluntary opportunity for clinicians and other stakeholders to provide feedback on the draft specifications for cost measures currently under development. For more information about field testing, reference materials are available on the [MACRA Feedback Page](#).<sup>1</sup>

We are collecting stakeholder feedback from **August 17 to September 18, 2020**. To provide feedback on the draft measure specifications and field test report content and format, please navigate to the [2020 Cost Measures Field Testing Survey](#):  
<https://www.surveymonkey.com/r/2020-cost-measures-field-testing>.

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**The measure score, and the information contained in this report are for field testing only. The information in this report does not affect any scoring or payment adjustments in the Merit-based Incentive Payment System (MIPS).** The information in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicare Services (CMS), including but not limited to circumstances in which an error is discovered. Only clinicians (identified by their unique Taxpayer Identification Number [TIN] and National Provider Identifier [NPI] combination, or TIN-NPI) and clinician groups (identified by their TIN) with at least 20 episodes during the measurement period have received a field test report.

<sup>1</sup> CMS, MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

## What is the Asthma/COPD Measure?

Episode-based cost measures represent the cost to Medicare for the items and services provided to a patient during an episode of care (“episode”). In this report, “cost” generally means the Medicare allowed amount.<sup>2</sup> All episode-based cost measures are payment standardized to account for payment factors that are unrelated to the care provided (such as add-on payments for medical education and geographic variation in Medicare payment amounts).<sup>3</sup>

The Asthma/COPD cost measure evaluates a clinician group’s risk-adjusted cost to Medicare for patients receiving medical care to manage asthma or COPD. The measure score is a clinician group’s weighted average of risk-adjusted cost for each episode attributed to the clinician group, where each episode is weighted by the number of assigned days during the episode. This chronic condition measure includes services that are clinically related and under the reasonable influence of the attributed clinician group. Services are assigned during an Asthma/COPD episode, which is a portion of the overall time period of a clinician group’s responsibility for managing a patient’s asthma or COPD. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure. More information about the specifications for this measure is included in the “[What Are the Specifications for the Measure?](#)” section below.<sup>4</sup>

## Your Cost Measure Performance

Table 1 provides high-level results for your cost measure performance for field testing. **Your TIN’s Cost Measure Score** is the weighted average of annualized risk-adjusted cost to Medicare for the Asthma/COPD measure (calculated as the weighted average ratio of the winsorized annualized standardized observed cost to annualized expected cost across all episodes attributed to the clinician group, multiplied by the national average winsorized annualized observed episode cost, where weighting is each episode’s number of assigned days). The **national average cost measure score** is the average annualized risk-adjusted cost across all clinician groups nationally. **Your TIN’s cost measure score percentile** provides the percentile for your performance on the score among all clinician groups nationally; higher percentile values indicate that your episodes are relatively more expensive than episodes attributed to other clinician groups.

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<sup>2</sup> The Medicare allowed amount on Medicare claims data includes both Medicare and trust fund payments and any applicable patient deductible and coinsurance amounts. Medicare Parts A, B, and D claims data are used to construct the episode-based cost measures used in the Field Test Reports. More detailed information on the Part D payment standardization methodology and the Part D rebate adjustment methodology is available on the MACRA Feedback Page.

<sup>3</sup> For more information, please refer to the “CMS Part A and Part B Price (Payment) Standardization - Basics (05/2020)” and “CMS Part A and Part B Price (Payment) Standardization - Detailed Methods (05/2020)” documents posted on ResDAC: <https://www.resdac.org/articles/cms-price-payment-standardization-overview>.

<sup>4</sup> Additionally, more detailed information on the measure can be found in the Draft Measure Methodology document and the Draft Measure Codes List, which are both available on the MACRA Feedback Page.

**Table 1: Your Cost Measure Score Performance (Glossary: [Table 8](#))**

	Asthma/COPD Measure
Number of Episodes	170
Your TIN's Cost Measure Score	\$5,249
National Average Cost Measure Score	\$5,454
Your TIN's Cost Measure Score Percentile	57

**Note:** All metric descriptions are provided in the [Glossary](#). For quick navigation between a table in the report and its corresponding table in the glossary, click on the table number provided in parentheses in the table title.

This report provides various breakdowns of the costs and episodes counted toward your measure score, and Table 2 below lists certain clinical themes, if any, where your TIN's average clinical theme cost was higher than the national average. Clinical themes are clinical categorizations that organize all assigned services into broader categories. They are mutually exclusive and exhaustive of all service assignment rules, which were developed with input from the Asthma/COPD Clinician Expert Workgroup. To see which items fall within each clinical theme, please see the Draft Measure Codes List file.

**Table 2: Clinical Themes with Higher Than Average Clinical Theme Costs**

Clinical Themes with Higher Than Average Clinical Theme Costs
Sepsis; Lung Surgery; Outpatient Medications for Chronic Care of Asthma/COPD

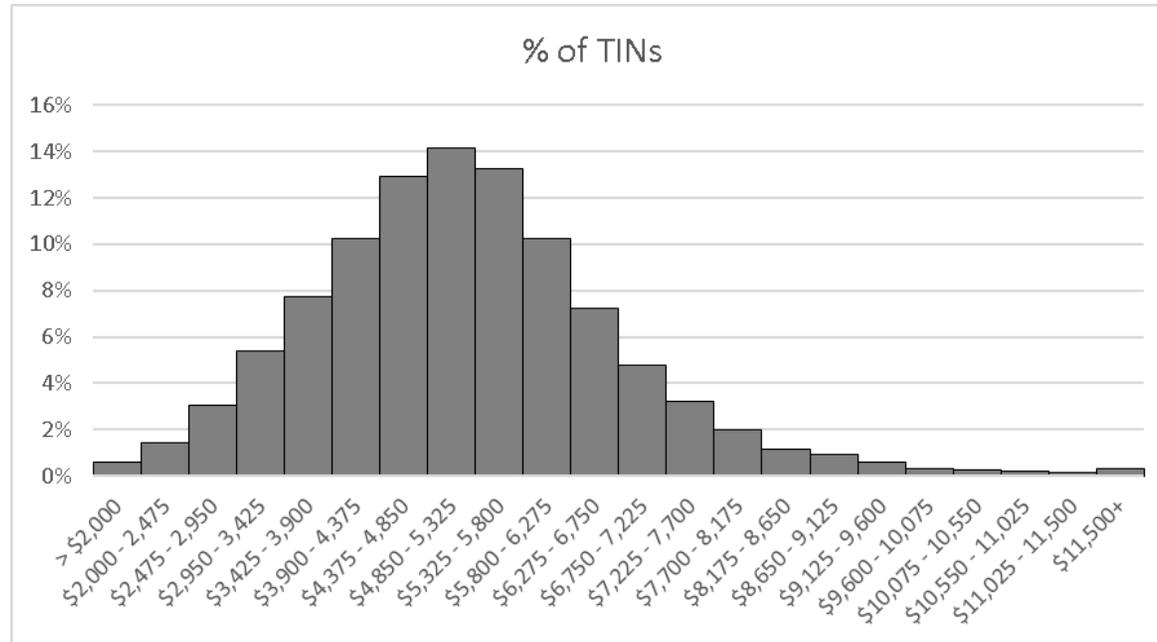
### Supplemental CSV File with Episode-Level Data

In addition to this report, you have received an episode-level data file in Comma Separated Value (CSV) format for this measure. This file provides detailed information on every episode used to calculate your measure score, which includes winsorized observed cost, risk-adjusted cost, facilities and clinicians rendering care, the share of cost by service setting, the patient relationship code (PRC) on the trigger/reaffirming claim line, and more. In addition, there is a data dictionary CSV file that provides definitions for each metric used in your episode-level data CSV file (i.e., "2020-08-episode-level-data-dictionary-chronic.csv") that was attached within the same ZIP file as this report.

## 2 COMPARISON OF YOUR SCORE TO THE NATIONAL DISTRIBUTION

This section provides information on the distribution of cost measure scores for the Asthma/COPD measure. Figure 1 below displays a histogram of the national distribution across all clinician groups. Table 3 below includes the distribution of risk-adjusted cost of your episodes along with the distribution for all episodes across all clinician groups.

**Figure 1: National Distribution of Measure Scores**



**Table 3: Cost Distribution for Your Clinician Group's (TIN) Episodes and Episodes across All Clinician Groups**

	Annualized Risk-Adjusted Cost					
	Mean	Cost Percentiles				
		5 <sup>th</sup> (Least Expensive)	25 <sup>th</sup>	50 <sup>th</sup> (Median)	75 <sup>th</sup>	95 <sup>th</sup> (Most Expensive)
Your TIN's Episodes	\$5,211	\$507	\$1,281	\$2,753	\$5,760	\$18,803
Episodes across all Clinician Groups	\$5,339	\$475	\$1,315	\$2,826	\$6,093	\$18,752

### 3 BREAKDOWN OF COST MEASURE PERFORMANCE

This section provides breakdowns of your cost measure performance based on the current measure specifications.

#### Episode Sub-Groups

Episode sub-groups are mutually exclusive and exhaustive stratifications of a cost measure, and they enable meaningful clinical comparisons. The sub-groups for this measure were developed based on clinical input from members of the Asthma/COPD Clinician Expert Workgroup.<sup>5</sup> Table 4 presents your count and share of episodes as well as your performance on the mean ratio of winsorized annualized observed to annualized expected cost by episode sub-group alongside the national average (i.e., across all clinician groups nationally).

**Table 4: Cost Measure Performance by Episode Sub-Group (Glossary: [Table 9](#))**

Episode Sub-Group	Your Episode Count	Share of Episodes		Mean Ratio of Winsorized Annualized Observed to Expected Cost	
		Your TIN	National Average	Your TIN	National Average
<b>Asthma/COPD</b>	170	100.0%	100.0%	0.98	1.01
Asthma	42	24.7%	20.6%	0.91	0.96
COPD	92	54.1%	61.5%	1.02	1.02
Both Asthma and COPD	36	21.2%	17.9%	0.95	1.01

#### Other Sources of Cost

This section provides additional breakdowns of your cost measure performance by various sources of cost. For the tables in this section, your performance is presented alongside the national average and for clinician groups (i.e., TINs) in your risk bracket. Risk brackets were constructed to provide a more informative comparison for clinician groups, as clinician groups within the same risk bracket are likely to have a similar patient case-mix. The risk score of each episode is the ratio of annualized expected cost (as predicted through a risk adjustment model) to the national average winsorized annualized observed episode cost. A clinician group's risk bracket is determined by assigning the TIN to a decile based on where their average episode risk score falls in the national distribution of average episode risk scores.

<sup>5</sup> More detailed information on episode sub-groups can be found in the Draft Measure Methodology document and the Draft Measure Codes List, which are both available on the MACRA Feedback Page.

Table 5 provides a breakdown of cost and use by Medicare setting and service category (Berenson-Eggers Type of Service); the definitions of the various categories of services presented in this table can be found on page 48, Table C.2 of the [Detailed Methods of the 2015 Supplemental Quality and Resource Use Reports \(QRURs\)](#) document. You may compare your average cost of services per episode and share of episodes with certain services for the settings and service categories to identify sources that are contributing to your cost measure performance. The share of episodes with a certain service shows the percentage of episodes with at least 1 service from the given setting/category.

**Table 5: Cost and Use by Medicare Setting and Service Category (Glossary: [Table 10](#))**

Medicare Setting and Service Category	Average Annualized Cost of Services Per Episode <i>(Conditional)</i>			Share of Episodes with Certain Service		
	Your TIN	National Average	TINs in Your Risk Bracket	Your TIN	National Average	TINs in Your Risk Bracket
All Services	\$4,732	\$5,494	\$4,741	100.0%	100.0%	100.0%
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding Emergency Department)	\$702	\$844	\$795	100.0%	100.0%	100.0%
Outpatient Evaluation & Management Services	\$679	\$811	\$767	100.0%	99.9%	99.8%
Major Procedures	\$0	\$198	\$236	0.0%	1.9%	1.4%
Ambulatory/Minor Procedures	\$57	\$105	\$96	19.4%	28.0%	26.1%
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	\$180	\$740	\$648	2.9%	8.0%	5.6%
Ancillary Services	\$311	\$352	\$319	97.1%	94.8%	94.7%
Laboratory, Pathology, and Other Tests	\$34	\$64	\$61	95.3%	88.7%	89.6%
Imaging Services	\$165	\$184	\$181	60.6%	63.7%	59.9%
Durable Medical Equipment and Supplies	\$622	\$579	\$560	29.4%	34.5%	28.9%
Hospital Inpatient Services	\$7,752	\$7,726	\$7,125	22.4%	31.0%	24.7%
Inpatient Hospital	\$10,822	\$10,758	\$10,185	10.6%	22.5%	16.8%
Physician Services During Hospitalization	\$730	\$887	\$831	23.5%	31.0%	24.6%
Emergency Room Services	\$1,196	\$1,221	\$1,158	35.3%	43.6%	38.0%
Emergency Evaluation & Management Services	\$1,277	\$1,319	\$1,256	32.9%	37.6%	32.3%
Procedures	\$235	\$262	\$254	8.8%	17.3%	13.6%
Laboratory, Pathology, and Other Tests	\$15	\$13	\$12	20.0%	21.3%	17.6%
Imaging Services	\$60	\$61	\$59	30.6%	38.3%	32.8%
Post-Acute Services	\$5,137	\$6,439	\$6,122	8.8%	22.1%	12.4%
Home Health	\$2,887	\$3,805	\$3,479	7.6%	15.3%	10.1%
Skilled Nursing Facility	\$8,091	\$7,055	\$7,507	3.5%	16.4%	6.9%
Inpatient Rehabilitation or Long-Term Care Hospital	\$18,371	\$20,789	\$19,153	0.6%	4.7%	2.7%

Medicare Setting and Service Category	Average Annualized Cost of Services Per Episode (Conditional)			Share of Episodes with Certain Service		
	Your TIN	National Average	TINs in Your Risk Bracket	Your TIN	National Average	TINs in Your Risk Bracket
Part D Services	\$1,735	\$1,628	\$1,595	71.2%	72.4%	70.1%
All Other Services	\$1,615	\$1,622	\$1,506	91.2%	88.7%	88.5%
Ambulance Services	\$0	\$0	\$0	0.0%	0.0%	0.0%
Anesthesia Services	\$27	\$45	\$40	0.6%	2.1%	1.1%
Chemotherapy and Other Part B-Covered Drugs	\$779	\$1,270	\$1,132	26.5%	30.1%	25.8%
Dialysis	\$76	\$88	\$87	0.6%	5.2%	3.7%
All Other Services Not Otherwise Classified	\$92	\$87	\$86	69.4%	64.9%	65.6%

Note: Asterisk (\*): Values for which you were more than one standard deviation above the average for clinician groups in your risk bracket. Caret (^): Values for which you were more than 2 standard deviations above the average for clinician groups in your risk bracket.

Table 6 provides a breakdown of cost and use by clinical themes. Clinical themes are clinical categorizations that organize all assigned services into broader categories. They are mutually exclusive and exhaustive of all service assignment rules, which were developed with input from the Asthma/COPD Clinician Expert Workgroup. To see which service assignment rules fall within each clinical theme, you may review the Draft Measure Codes List file for the measure.

**Table 6: Cost and Use by Clinical Theme (Glossary: [Table 11](#))**

Clinical Theme	Average Annualized Cost Per Episode (Conditional)			Share of Episodes with Any Cost From Given Clinical Theme		
	Your TIN	National Average	TINs in Your Risk Bracket	Your TIN	National Average	TINs in Your Risk Bracket
(1) Asthma/COPD Chronic Care	\$702	\$835	\$778	100.0%	100.0%	100.0%
(2) Asthma/COPD Exacerbation	\$2,475	\$3,211	\$3,013	18.8%	28.4%	23.2%
(3) Home Health, Physical Therapy, Occupational Therapy, and Pulmonary Rehabilitation	\$907	\$1,770	\$1,318	24.7%	30.0%	23.7%
(4) Other Post-Acute Care	\$9,722	\$12,404	\$11,406	2.4%	10.3%	5.8%
(5) Non-Specific Symptoms	\$354	\$402	\$391	20.0%	25.7%	23.2%
(6) Sepsis	\$13,121	\$12,660	\$12,273	5.3%	11.0%	7.4%
(7) Pulmonary Imaging	\$174	\$195	\$190	63.5%	68.6%	64.8%
(8) Lung Surgery	\$21,049	\$19,113	\$18,703	0.6%	3.4%	2.2%
(9) Other Respiratory Complications	\$1,253	\$1,738	\$1,448	44.1%	50.0%	46.8%
(10) Arrhythmias	\$981	\$1,127	\$1,080	23.5%	30.0%	26.7%
(11) Nebulizers and Home Oxygen	\$948	\$1,020	\$938	32.4%	39.2%	34.1%

Clinical Theme	Average Annualized Cost Per Episode (Conditional)			Share of Episodes with Any Cost From Given Clinical Theme		
	Your TIN	National Average	TINs in Your Risk Bracket	Your TIN	National Average	TINs in Your Risk Bracket
(12) Outpatient Medications for Chronic Care of Asthma/COPD	\$1,849	\$1,832	\$1,801	63.5%	64.2%	61.0%
(13) Outpatient Medications for Asthma/COPD Exacerbations	\$25	\$29	\$28	46.5%	54.7%	51.4%
(14) Outpatient Medications for Tobacco Cessation	\$724	\$730	\$749	1.8%	6.7%	5.5%

Note: Asterisk (\*): Values for which you were more than one standard deviation above the average for clinician groups in your risk bracket. Caret (^): Values for which you were more than 2 standard deviations above the average for clinician groups in your risk bracket.

Table 7 provides a list of clinicians that contributed the most to your Part B Physician/Supplier episode costs for the Asthma/COPD measure. Specifically, this table lists the top 5 clinicians (identified by their NPI) from within and outside your clinician group (i.e., TIN) that represented the most cost for your episodes.

**Table 7: Top 5 Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs (Glossary: [Table 12](#))**

NPIs Within Your TIN	NPIs Outside Your TIN
(1) Name of Clinician - #####	(1) Name of Clinician - #####
(2) Name of Clinician - #####	(2) Name of Clinician - #####
(3) Name of Clinician - #####	(3) Name of Clinician - #####
(4) Name of Clinician - #####	(4) Name of Clinician - #####
(5) Name of Clinician - #####	(5) Name of Clinician - #####

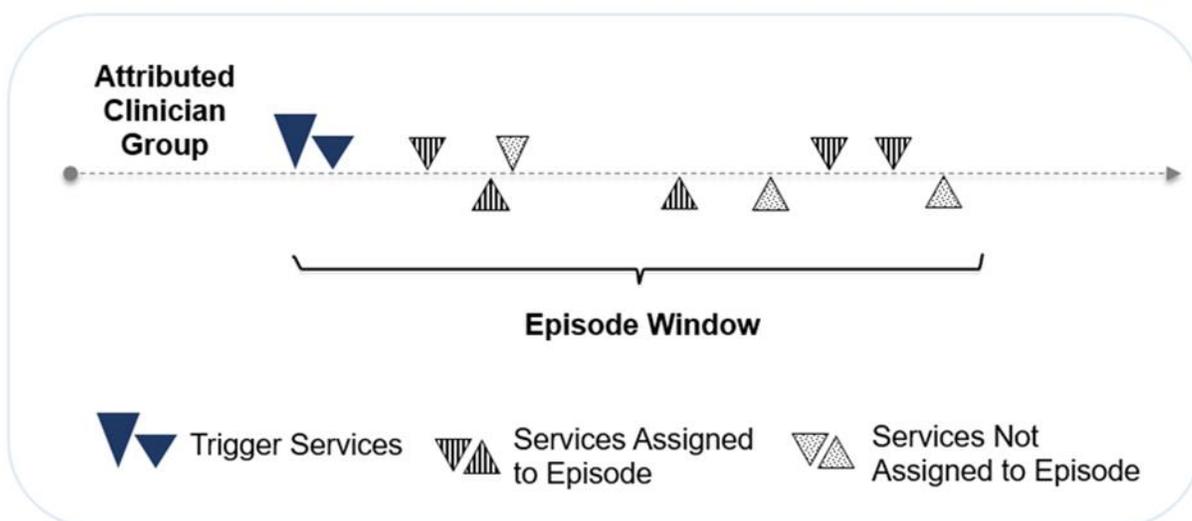
## 4 ADDITIONAL INFORMATION

### What is the Methodology for Calculating Cost Measure Scores?

A chronic cost measure score is calculated through the following steps:

- 1. Identify patients receiving care:** A trigger event identifies the start or continuation of a clinician group's management of a patient's chronic disease. A trigger event is identified by the occurrence of two Part B Physician/Supplier (Carrier) claims billed by the same clinician group practice within 180 days of one another. The pair of services must include a trigger claim and a confirming claim. The trigger claim is an initial "primary care" E&M (evaluation and management) code with a relevant chronic condition diagnosis. The confirming claim can be either another "primary care" E&M code with a relevant chronic condition diagnosis, or a *chronic condition-related Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS)* code for related services with a relevant chronic condition diagnosis. Once a trigger event is identified, this opens a one-year attribution window from the point of the trigger claim, in which the patient's chronic disease care will be monitored by a clinician group.
- 2. Identify the total length of care between a patient and a clinician group:** A reaffirming claim is a service billed during an open attribution window (from Step 1) by the same clinician group that billed the trigger event, which reaffirms and extends a clinician group's responsibility for managing a patient's chronic disease. A reaffirming claim is either a "primary care" E&M code with a relevant chronic condition diagnosis, or a *chronic condition-related CPT/HCPCS* code for related services with a relevant chronic condition diagnosis. After all reaffirming claims are identified, each attribution window is extended by one year from the point of any reaffirming claim billed during an open attribution window. The total attribution window begins with the trigger claim and concludes one year after the final reaffirming claim. Therefore, the total attribution window can span multiple years and vary in length for different patients. This requires that the total attribution window is measured incrementally and periodically across multiple measurement periods.
- 3. Define an episode:** Episodes are, at a minimum, one-year segments of the total attribution window that are measured in a respective measurement period. Under this definition, clinician groups are measured on a patient each time one year of the total attribution window elapses and/or when the total attribution window ultimately concludes. Episodes are assessed in the measurement period in which they conclude and will only attribute days not previously measured in preceding measurement periods. After episodes are constructed, they are placed into more granular, mutually exclusive and exhaustive sub-groups based on clinical criteria to enable meaningful clinical comparisons. Figure 2 below depicts how an episode is constructed.

**Figure 2: Diagram Showing an Example of a Constructed Episode**



4. **Attribute the episode to the clinician group and clinician(s):** For this chronic measure, an attributed clinician group is the clinician group that bills the trigger and confirming claims for the total attribution window. An attributed clinician is any clinician within the attributed clinician group that bills at least 30% of “*primary care*” E&M codes with a relevant chronic condition diagnosis and/or *chronic condition-related CPT/HCPCS* codes for related services with a relevant chronic condition diagnosis on Part B Physician/Supplier (Carrier) claim lines during the episode.
5. **Assign costs to the episode and calculate the episode annualized observed cost:** Clinically-related services that occur during the episode are assigned. The standardized cost of the assigned services is summed and averaged across the number of days in an episode. This average daily cost is then multiplied by 365 to determine each episode’s annualized standardized observed cost.
6. **Exclude episodes:** Exclusions remove unique groups of patients or episodes from cost measure calculation in cases where it may be impractical or unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.
7. **Calculate the annualized expected cost through risk adjustment:** Risk adjustment predicts the expected costs by adjusting for factors outside of the clinician’s or clinician group’s reasonable influence (e.g., accounting for patient age, comorbidities, and other factors). The episode group’s annualized observed costs are winsorized at the 1<sup>st</sup> and 99<sup>th</sup> percentiles for each model to handle extreme observations. A regression is then run using the risk adjustment variables as covariates to estimate the expected cost of each episode. Statistical techniques are applied to reduce the effects of extreme outliers on measure scores.
8. **Calculate the measure score:** For each episode, the ratio of winsorized annualized standardized observed cost to annualized expected cost (both of which are from step 7) is calculated. The measure is calculated as a weighted average of these ratios across all of a clinician’s or clinician group’s attributed episodes, where the weighting is each

episode's number of assigned days. The weighted average episode cost ratio is then multiplied by the national average winsorized annualized observed episode cost to generate a dollar figure for the cost measure score.

A more detailed description of the methodology is in the Draft Cost Measure Methodology, which is available on the MACRA Feedback Page.

### What Are the Specifications for the Measure?

This section provides a quick, at-a-glance reference for the Asthma/COPD episode-based cost measure specifications. More details on each component can be found in the Draft Cost Measure Methodology, and the full list of codes and logic used to define each component can be found in the Draft Measure Codes List file; these documents are available on the MACRA Feedback Page.

**Episode Window:** During what time period are costs measured?

The episode window is the portion of the overall time period of a clinician group's responsibility for managing a patient that is assigned to a measurement period.

- The episode window length for the Asthma/COPD measure is between 1 year (365 days) and 2 years minus 1 day (729 days), and varies in length between clinician groups.

**Triggers:** Patients receiving what medical care are included in the measure?

- Patients receiving medical care for treatment of their asthma or COPD are included in the measure.
- The start or continuation of a clinician group's management of a patient's asthma or COPD is identified by the appearance of a pair of services within 180 days.
- This pair of services includes (i) an initial "primary care" E&M code with a relevant asthma or COPD diagnosis, and (ii) either:
  - Another "primary care" E&M code with a relevant asthma or COPD diagnosis, or
  - A chronic condition-related CPT/HCPCS code for relevant services accompanied by a relevant asthma or COPD diagnosis.

**Sub-Groups:** What are the mutually exclusive types of episodes?

- Asthma
- COPD
- Both Asthma and COPD

**Service Assignment:** Which clinically related costs are included in the measure?

Assigned services fall within the following 14 clinical themes:

- 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

**Risk Adjustment:** Which risk factors are accounted for in the risk adjustment model?

- Standard risk adjustors, including comorbidities captured by 79 Hierarchical Condition Category (HCC) codes that map with over 9,500 International Statistical Classification of Diseases and Related Health Problems Clinical Modification (ICD-10-CM) codes, interaction variables accounting for a range of comorbidities, patient age category, patient disability status, patient end-stage renal disease status, and recent use of institutional long-term care.
- Measure-specific risk adjustors including but not limited to smoking, obstructive sleep apnea, home oxygen, or prior intubation for respiratory issue.
- For the full list of standard and measure-specific risk adjustment variables, please reference the “RA” and “RA\_Details” tabs of the Draft Measure Codes List file.
- A separate linear regression is run for each sub-group and Medicare Part D enrollment status combination to ensure fair comparison. The episode group’s annualized observed costs are winsorized at the 1<sup>st</sup> and 99<sup>th</sup> percentiles prior to the regression for each model to handle extreme observations.

**Exclusions:** Which populations are excluded from measure calculation?

- Standard exclusions to ensure data completeness:
  - The patient has a primary payer other than Medicare for any time overlapping the episode window or 120-day lookback period prior to the episode window.
  - The patient was not enrolled in Medicare Parts A and B for the entirety of the lookback period plus episode window, or was enrolled in Part C for any part of the lookback plus episode window.
  - The patient was not found in the Medicare Enrollment Database (EDB).
  - The patient was covered by the Railroad Retirement Board.
  - The patient resided outside the United States or its territories during the episode window.
  - The patient has an episode window shorter than one year.
- Measure-specific exclusions including patients with sickle cell disease, cystic fibrosis, interstitial pulmonary fibrosis, or prior lung cancer, surgery, or transplant. For the full list of measure-specific exclusions, please reference the “Exclusions” and “Exclusions\_Details” tabs of the Draft Measure Codes List file.

### Where Can I Find More Information?

For more information on the Asthma/COPD measure or field testing, please visit the [MACRA Feedback Page](#),<sup>6</sup> which contains field testing resources such as a Fact Sheet, a Frequently Asked Questions (FAQ) document, an overview of the measure development process, and measure-specific resources such as the Draft Measure Methodology and Draft Measure Codes List file.

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<sup>6</sup> CMS, MACRA Feedback Page, <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>.

If you have further questions, please call 1-866-288-8292 (TTY 1-877-715-6222), Monday through Friday, 8:00 a.m. - 8:00 p.m. Eastern Time or email [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov).

## Appendix A – Glossary

**Table 8: Definitions for Your Cost Measure Score Performance (Report: [Table 1](#))**

Term	Description
Number of Episodes	The number of episodes attributed to your TIN within the measurement period.
Your TIN's Cost Measure Score	Your TIN's weighted average of annualized risk-adjusted cost for the measure. <u>Method of calculation:</u> The weighted average ratio of winsorized annualized standardized observed cost to annualized expected cost across all your episodes, multiplied by the national average winsorized annualized observed episode cost. The weighting is each episode's number of assigned days.
National Average Cost Measure Score	Average annualized risk-adjusted cost across all clinician groups nationally for this episode-based cost measure. <u>Method of calculation:</u> The mean ratio of winsorized annualized standardized observed cost to annualized expected cost (as predicted through a risk adjustment model) across all clinician groups nationally, multiplied by the national average winsorized observed episode cost. The mean ratio is calculated by taking the weighted average of the observed to expected ratio for each clinician group (the weighting is each episode's number of assigned days) and then calculating the average of these ratios across all clinician groups.
Your TIN's Cost Measure Score Percentile	The percentile for your TIN's cost measure score among all cost measure scores for all clinician groups nationally. <u>Interpretation:</u> Higher values indicate that your episodes are relatively more expensive than episodes attributed to other clinician groups (and the inverse for lower values). <u>Example:</u> If your cost measure score percentile is in the 40 <sup>th</sup> percentile, then that means your cost measure score was higher than the scores for 40% of all clinician groups nationally and lower than the scores for 60% of all clinician groups.

**Table 9: Definitions for Cost Measure Performance by Episode Sub-Group (Report: [Table 4](#))**

Term	Description
Episode Sub-Group	The name of the measure or the episode sub-group. Episode sub-groups are divisions, or stratifications, for a measure that define more homogenous patient cohorts to ensure clinical comparability (i.e., the cost measure fairly compares like patients).
Your Episode Count	The number of episodes attributed to your TIN within the measurement period for each sub-group (or the measure as a whole).
Share of Episodes	<u>Your TIN:</u> Share of episodes (across all episodes for your TIN) by sub-group. <u>National Average:</u> Average share of episodes (for all clinician groups nationally) by sub-group.

Term	Description
Mean Ratio of Winsorized Annualized Observed to Expected Cost	<p><u>Your TIN:</u> Your weighted average ratio of winsorized annualized standardized observed to annualized expected cost across your episodes for each sub-group (and for the measure as a whole). As a note, your cost measure score is the product of the weighted average ratio for the measure as a whole and the national average winsorized annualized observed episode cost, where the weighting is each episode's number of assigned days.</p> <p><u>National Average:</u> The mean ratio of winsorized annualized standardized observed to annualized expected cost across all clinician groups nationally for each sub-group (and for the measure as a whole). This is calculated by taking the weighted average of the observed to expected ratio for each clinician group (the weighting is each episode's number of assigned days) and then calculating the average of these ratios across all clinician groups for each sub-group.</p>

**Table 10: Definitions for Cost and Use by Medicare Setting and Service Category (Report: Table 5)**

Term	Description
Medicare Setting and Service Category	The settings and service categories available from the claims data based on the Berenson-Eggers Type of Service Codes. <sup>7</sup>
Average Annualized Cost of Services Per Episode ( <i>Conditional</i> )	<p><u>Your TIN:</u> The average annualized cost of services from a setting/category across all episodes for your TIN. Note that this average is calculated out of all your TIN's episodes that include at least one service from the given setting/category (i.e., it is conditional).</p> <p><u>National Average:</u> The average annualized cost of services for a setting/category across all episodes for all clinician groups nationally. Note that this average is calculated out of all episodes that include at least one service from the given setting/category (i.e., it is conditional).</p> <p><u>TINs in Your Risk Bracket:</u> The average annualized cost of services for a setting/category across all episodes for clinician groups in your risk bracket. Note that this average is calculated out of all episodes that include at least one service from the given setting/category (i.e., it is conditional).</p>
Share of Episodes with Certain Service	<p><u>Your TIN:</u> The share of episodes with a certain service from a setting/category across all episodes for your TIN.</p> <p><u>National Average:</u> The average share of episodes with a certain service from a setting/category across all clinician groups nationally.</p> <p><u>TINs in Your Risk Bracket:</u> The average share of episodes with a certain service from a setting/category across all clinician groups in your risk bracket.</p>

<sup>7</sup> Definitions of the various categories of services presented in this table can be found on page 48, Table C.2 of the [Detailed Methods of the 2015 Supplemental Quality and Resource Use Reports \(QRURs\)](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-SQRUR-Detailed-Methods.pdf) document (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-SQRUR-Detailed-Methods.pdf>)

**Table 11: Definitions for Cost and Use by Clinical Theme (Report: [Table 6](#))**

Term	Description
Clinical Theme	Clinical themes are clinical categorizations that organize all assigned services into broader categories. They are mutually exclusive and exhaustive of all service assignment rules, which were developed with input from the Asthma/COPD Clinician Expert Workgroup. To see which service assignment rules fall within each clinical theme, you may review the Draft Measure Codes List file for the measure.
Average Annualized Cost Per Episode <i>(Conditional)</i>	<p><u>Your TIN</u>: The average annualized cost calculated per episode for the clinical theme (i.e., for all billed items within that clinical theme). Note that this average is calculated out of all your episodes that include at least one service from the given clinical theme, meaning it is conditional.</p> <p><u>National Average</u>: The average annualized cost calculated per episode for the clinical theme out of all episodes for all clinician groups nationally (calculated only for episodes that include at least one service from the given clinical theme).</p> <p><u>TINs in Your Risk Bracket</u>: The average annualized cost calculated per episode for the clinical theme out of all episodes for TINs in your risk bracket (calculated only for episodes that include at least one service from the given clinical theme).</p>
Share of Episodes with Any Cost From Given Clinical Theme	<p><u>Your TIN</u>: The share of episodes with any cost from a given clinical theme across all episodes for your TIN.</p> <p><u>National Average</u>: The average share of episodes with any cost from a given clinical theme across all clinician groups nationally.</p> <p><u>TINs in Your Risk Bracket</u>: The average share of episodes with any cost from a given clinical theme across all clinician groups in your risk bracket.</p>

**Table 12: Definitions for Top 5 Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs (Report: [Table 7](#))**

Term	Description
NPIs Within Your TIN	List of the top 5 clinicians (i.e., NPIs) within your TIN that contributed the most Part B Physician/Supplier costs to your episodes.
NPIs Outside Your TIN	List of the top 5 clinicians (i.e., NPIs) outside your TIN that contributed the most Part B Physician/Supplier costs to your episodes.