Rheumatoid Arthritis Workgroup Webinar Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, July 26, 2022
September 2022

Contents

Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC to develop episode-based cost measures for potential use in the Merit-based Incentive Payment System (MIPS) to meet the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Acumen's measure development approach involves convening clinician expert panels to provide input in cycles of development ("Waves").[1] In Wave 5, we obtained input on candidate clinical areas and episode groups through a public comment period from February 18, 2022, to April 1, 2022.[2] This approach provided flexibility for a wider range of interested parties to participate around their schedule. The prioritization criteria used to identify strong candidate episode groups and concepts were developed based on input from our technical expert panel (TEP), Person and Family Engagement (PFE), Clinical Subcommittees (CS), and Clinician Expert Workgroups ("workgroups"). The following Wave 5 episode groups were finalized based on the prioritization criteria, public comments received, and discussions with CMS: (i) Kidney Transplant Management, (ii) Prostate Cancer, and (iii) Rheumatoid Arthritis.

We held a nomination period for workgroup members between June 3, 2022, and July 1, 2022. The workgroups are composed of clinicians with expertise directly relevant to the selected episode groups. Workgroups (of about 15-20 members) were finalized in July 2022, and they provided detailed input on the development of the selected episode groups during their first workgroup webinars from July 26 to 28, 2022. For Wave 5, all workgroup meetings will be held

[1] For information on measure development in Wave 4, refer to the Wave 4 Measure Development Process document (https://www.cms.gov/files/document/wave-4-measure-development-process-macra.pdf).
[2] For a summary of comments we received during the public comment period, refer to the Wave 5 Measure Development Public Comment Summary Report (https://www.cms.gov/files/document/wave-5-public-comment-summary-report.pdf).

virtually. The workgroups will convene for a second and third meeting to continue measure specification and refinement discussions before and after a national field test, which is currently slated for early 2023.

Rheumatoid Arthritis Workgroup Webinar, July 26, 2022

This meeting summary document outlines the purpose, discussion, and recommendations from the Rheumatoid Arthritis workgroup webinar. Section 1 provides an overview of the webinar goals and process. Section 2 summarizes the discussion and recommendations from the workgroup. Section 3 is an appendix that describes the materials and information provided to workgroup members prior to and at the beginning of the webinar as preparation for discussion on detailed measure specifications.

1. Overview

The goals of the Rheumatoid Arthritis workgroup webinar on July 26, 2022, were the following:

(i) Provide input to specify a cost measure for potential use in MIPS that can accurately distinguish between good and poor performance among clinicians in terms of cost efficiency
(ii) Consider results of empirical analyses and the Person and Family Partner (PFP) findings
(iii) Provide input on how to define the patient cohort, account for sub-populations to ensure that the measure allows for meaningful clinical comparisons, and identify clinically related services

The meeting was held online via webinar and attended by 12 of the 14 workgroup members. The webinar was facilitated by Acumen moderator, Heather Litvinoff. The Rheumatoid Arthritis workgroup chair was Alex Limanni, who also facilitated meeting discussions. Two PFPs, Rosie Bartel and Connie Montgomery, attended the webinar to discuss and address questions regarding the PFP findings. The MACRA Episode-Based Cost Measure Workgroup Composition List will contain the full list of members, including names, professional roles, employers, and clinical specialties; it will be posted on the MACRA Feedback Page.[3]

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

Prior to the webinar, workgroup members were provided with information and materials to inform their meeting discussions (see Section 3). After the webinar, workgroup members were sent a recording of the webinar and were polled on their preferences to ensure the measures are developed based on well-documented input. Based on National Quality Forum practices, the threshold for support was >60% consensus among poll responses. This document summarizes the workgroup members' input from both the discussion as well as the polls.

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

[3] The composition list will be posted on the MACRA Feedback Page (https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback).

2. Summary of Sessions and Discussion

This section is organized based on meeting sessions and describes workgroup member discussions and recommendations. The first sub-section summarizes the PFP findings discussed during the webinar. The remaining sub-sections describe workgroup member discussions and recommendations on defining the patient cohort, accounting for patient heterogeneity, and identifying clinically related services, respectively. The final sub-section provides an overview of next steps for the measure development process.

2.1 Person and Family Partner (PFP) Findings and Discussion

We conducted focus groups and interviews with 4 PFPs to gather input that would inform cost measure development for rheumatoid arthritis. During the webinar, 2 PFPs shared these findings and fielded questions from the workgroup members.

PFPs reported their care journey started with seeking care due to pain, though each PFP noted being diagnosed at different stages of their lives with varying experiences and difficulties during the diagnosis process. Generally, primary care physicians (PCPs) were the first point of contact and then PFPs were referred to rheumatologists. PFPs noted both rheumatologists and PCPs were responsible for their rheumatoid arthritis care. Other members of the care team included physical and occupational therapists, social workers, care coordinators, behavioral health clinicians, and occasionally surgeons or other specialists to treat complications and comorbid conditions.

PFPs described routine care as including pharmacological treatments to reduce inflammation and pain, physical and occupational therapy to maintain function and mobility, and routine lab work and imaging to monitor their condition. Pharmacological treatments included biologics, biosimilars, methotrexate, non-steroidal anti-inflammatory drugs (NSAIDs), and steroids. While one PFP noted that biologic medications were important to their care, other PFPs reported that these were either not offered to them or not accessible to them due to high out-of-pocket costs. PFPs reported that the frequency of services increased when their symptoms worsened. PFPs also noted that as their condition progressed, they required additional services, such as joint replacement surgeries.

PFPs also provided input on factors that differentiated good and poor care. PFPs valued services that help maintain physical function and limit joint deterioration. PFPs also noted the importance of good communication and expressed that poor communication and relationship-management with certain clinicians led to worse care and delayed diagnoses. PFPs reported challenges with accessing timely care due to geographic limitations, lack of availability, cultural stigmas, and poor care coordination. PFPs also reported difficulties in being referred to ancillary services, such as physical and occupational therapy and behavioral services. PFPs identified care coordinators as helpful in overcoming barriers to care.

2.2 Defining the Patient Cohort

Acumen reviewed the methodology for constructing an episode-based cost measure, with a focus on “triggering an episode.” Cost measures for chronic conditions aim to identify a longitudinal patient-clinician relationship (i.e., trigger an episode of care for that condition) using the presence of related service and diagnosis codes on claims billed by the same provider (as identified by their Tax Identification Number [TIN]). The workgroup discussed these categories of service and diagnosis codes in the context of what patient and clinician populations they would capture, and to what degree they would reliably indicate an ongoing care relationship. The following sub-sections summarize discussion of the draft measure specifications,

appropriate target scope of the measure, and what service and diagnosis codes should be used to identify the target population.

In the draft Rheumatoid Arthritis measure, episodes are triggered when the same TIN bills Medicare one trigger claim (outpatient evaluation & management [E&M] code) and one confirming claim (any trigger service, or condition-specific Current Procedural Terminology / Healthcare Common Procedure Coding System [CPT/HCPCS] code) within 180 days. Both of these claims must have at least one qualifying International Classification of Diseases, 10th Revision (ICD-10) diagnosis code to indicate that the patient is receiving rheumatoid arthritis-related care. Medication-related confirming services are identified using Part B Physician/Supplier claims. Part D prescription drugs aren't included in the trigger logic, as not all beneficiaries are enrolled in Part D. Acumen asked the workgroup to review the triggering methodology, as well as these services and diagnoses, to discuss how the draft specifications may be improved.

2.2.1 Trigger Window

Workgroup members asked for clarification about the trigger window, noting clinical guidelines recommend patients are seen more frequently than every 180 days, particularly at the start of care. Acumen clarified the trigger window doesn't suggest the frequency at which care should occur. Rather, the trigger window is the upper bound of elapsed time for a trigger and confirming service to be linked as a trigger event. During the discussion, PFPs and workgroup members noted scenarios in which clinicians and patients either can't or don't follow clinically-recommended timelines, as there can be clinical, economic, geographic, psychological, and logistical barriers to receiving timely care. Members verbally agreed that 180 days is an appropriate trigger window.

2.2.2 Confirming Services

The workgroup generally agreed with including medication-related services as confirming claims. The workgroup supported continuing to use injection of biologic medications as confirming claims and recommended adding biosimilar medications and methotrexate. Several members questioned the inclusion of measurement of leflunomide (CPT/HCPCS 80193), but the workgroup didn't indicate strong preferences for whether to remove this code. The workgroup noted measurement of leflunomide is relevant but infrequently used and may not add much value to the measure. However, if the code is clinically relevant, and there are no concerns other than the low volume of use, it may be appropriate to continue to include the code.

The workgroup also suggested additional confirming services, such as laboratory services (e.g., blood counts, comprehensive metabolic panel, sedimentation rate, C-reactive protein), joint and tendon injections, and screening tests for hepatitis and tuberculosis. The workgroup noted some lab tests can be done for a number of reasons besides rheumatoid arthritis, and cautioned that the services should only be included if done as part of rheumatoid arthritis care. Several members also mentioned that tests for hepatitis and tuberculosis are necessary before starting biologic medications, and these screenings could be used as confirming services.

2.2.3 Trigger Diagnoses

The workgroup discussed which diagnosis codes indicate a trigger or confirming service was provided as part of treatment and management of rheumatoid arthritis. The preliminary Rheumatoid Arthritis measure specifications include diagnoses within the following ICD-10-CM diagnosis categories:

- M05: Rheumatoid arthritis with rheumatoid factor
- M06: Other rheumatoid arthritis
- M07: Enteropathic arthropathies
- M08: Juvenile arthritis

The workgroup generally agreed with including rheumatoid arthritis with rheumatoid factor (M05) and other rheumatoid arthritis (M06). However, several workgroup members recommended removing Adult-onset Still's Disease (M061) and inflammatory polyarthropathy (M064). For inflammatory polyarthropathy, workgroup members elaborated the diagnosis code is used for other conditions (e.g., lupus).

The workgroup also discussed removing enteropathic arthropathies (M07) and juvenile arthritis (M08) from the list of trigger diagnoses, as management of these conditions differs from management of rheumatoid arthritis. For example, enteropathic arthropathies are often co-treated with gastroenterologists, and juvenile arthritis may or may not become rheumatoid arthritis. Additionally, this approach would align with MIPS quality measures, which only include diagnoses within the rheumatoid arthritis with rheumatoid factor (M05) and other rheumatoid arthritis (M06) categories.

Key Takeaways from Discussion and/or Polls for Defining the Patient Cohort:

- Members recommended continuing to include biologic medications and measurement of leflunomide as confirming services
- Members recommended adding the following categories of confirming services: biosimilars, methotrexate, joint and tendon injections, laboratory tests for monitoring, and screening tests
- Members recommended continuing to include most diagnoses under rheumatoid arthritis with rheumatoid factor (M05) and other rheumatoid arthritis (M06)
- Members recommended removing enteropathic arthropathies (M07), juvenile arthritis (M08), Adult-onset Still's Disease (M061), and inflammatory polyarthropathy (M064) from the trigger diagnoses

2.3 Accounting for Patient Heterogeneity

Acumen presented their approach to address variation in cost performance due to patient features such as comorbidities, enrollment, or social determinants of health. All episode-based cost measures use risk adjustment to account for clinical complexity. The default model is the CMS-Hierarchical Condition Category (CMS-HCC) model version 22 (V22), although future measures may update the model to V24. This model has 79 variables for comorbidities based on the beneficiary's claims history, as well as indicators for age and Medicare enrollment status; cost measures also include additional measure-specific risk adjustors as recommended by the workgroup. During the webinar, the workgroup and moderators reviewed the 3 options for addressing heterogeneity:

- Stratifying the patient population into mutually exclusive and exhaustive sub-groups to define more homogenous patient cohorts[4]

[4] Sub-grouping is a method that's intended for when we would want to compare episodes only with other similar episodes within the same sub-group. This approach is used when sub-groups are very different from one another, and each sub-group requires its own risk adjustment model. Since each sub-group will have its own risk adjustment model, the size of each sub-group should be sufficiently large.

- Defining covariates in the risk adjustment model[5]
- Identifying measure exclusions[6]

The workgroup is also able to recommend monitoring sub-populations for future testing and consideration.

2.3.1 Newly and Previously Diagnosed Rheumatoid Arthritis

Workgroup members generally agreed that both newly diagnosed and previously diagnosed patients should be included in the patient cohort, though treatment guidelines and costs can differ based on whether a patient is newly diagnosed or previously diagnosed. Including both new and existing rheumatoid arthritis patients captures opportunities for improvement around slowing disease progression and breaking the cycle of relapse and remission. Acumen also noted previously diagnosed patients also make up a significant portion of the patient cohort included in the preliminary measure (>80%), and they're included in MIPS quality measure patient cohorts.

Workgroup members also noted challenges with using claims data to identify whether a patient was previously diagnosed with rheumatoid arthritis. The standard risk adjustment model already includes a variable for HCC40 (Rheumatoid Arthritis and Inflammatory Connective Tissue Disease). During the workgroup meeting, Acumen demonstrated that HCC40 captures a similar share of episodes compared to constructing a separate risk adjustment variable for rheumatoid arthritis diagnoses during the 120-day lookback period, suggesting there isn't a need to add a separate measure-specific risk adjustor.

2.3.2 Comorbid Conditions and Risk Factors

Acumen presented an initial list of measure-specific comorbid conditions and risk factors to consider when discussing how to account for patient heterogeneity. These included cognitive status/dementia, depression, fibromyalgia, frailty, interstitial lung disease, osteoarthritis, smoking, vasculitis, and prior joint replacement/revision surgery. Workgroup members generally agreed that these characteristics present at the start of an episode could influence costs of care.

The workgroup also suggested additional sub-populations. The workgroup discussed that disease activity can affect costs of care, and noted limitations with using claims data to determine disease activity (e.g., inflammatory marker levels aren't included in claims). The workgroup also recommended accounting for differences due to regional musculoskeletal syndromes, transplants, malignancies, fractures, history of falls, and rural versus urban. The workgroup noted that treatment for transplant patients and patients with malignancies may overlap with and alter the care they receive for rheumatoid arthritis. Acumen noted several of the suggested sub-populations are already captured through the standard risk adjustment model (e.g., age, number of comorbid conditions).

---

[5] Risk adjusting is a method to account for the case-mix of patients and other non-clinical characteristics that influence complexity. It's meant to be used for sub-populations that make a large share of patients who have a characteristic that's outside of the attributed clinician's reasonable influence. Risk-adjusted cost measures compare observed episode spending to an expected episode spending (predicted by a risk adjustment model).

[6] Excluding is a method in which we exclude certain patients or episodes to address issues with patient heterogeneity. This approach should be used when the sub-population affects a small, unique set of patients in which risk adjustment wouldn't be sufficient to account for their differences in expected cost.

Key Takeaways from Discussion and/or Polls for Accounting for Patient Heterogeneity:

- Members recommended to risk adjust for the following sub-populations:
  - Cognitive status/dementia
  - Depression
  - Frailty (e.g., durable medical equipment [DME], home oxygen use)
  - Interstitial lung disease
  - Smoking
  - Vasculitis
  - Fractures
  - History of Falls
- Members didn't reach consensus on an approach for the following sub-populations, which will continue to be monitored for future testing and consideration:
  - Fibromyalgia
  - Osteoarthritis
  - Regional musculoskeletal syndromes
  - Transplants
  - Malignancies
  - Rural versus urban

2.4 Identifying Clinically Related Services

Acumen described the purpose of service assignment so that members could discuss which services associated with the attributed clinician's role in managing the patient's care should be included in the cost measure. These assigned services should be inclusive enough to identify a measurable performance difference between clinicians but also not introduce excessive noise. Episode-based cost measures aim to only include clinically relevant costs whose occurrence, intensity, and/or frequency are within the reasonable influence of the attributed clinician. Service assignment can be an effective form of adjusting for patient risk by omitting unrelated costs not furnished for management of a kidney transplant.

Acumen asked for feedback on whether the following preliminary service assignment categories and examples to capture both standard treatment and services provided to treat complications or worsening symptoms:

- Part B pharmacological treatment (non-steroidal anti-inflammatory agents, corticosteroids, disease-modifying anti-rheumatic drugs [DMARDS])
- Part D pharmacological treatment (non-steroidal anti-inflammatory agents, corticosteroids, DMARDS, antidepressants, anti-anxiety)[7]
- Imaging (X-ray, magnetic resonance imaging [MRI])
- Lab work/monitoring (erythrocyte sedimentation rate, c-reactive protein, screening tests)
- Rehabilitation services (physical and occupational therapy services)
- Injections (joint injections, tendon injections)
- Joint surgery (joint replacement/revisions)
- Complications (infections, hospitalizations, emergency department visits, subsequent post-acute care use)
- Durable Medical Equipment (DME) (braces, wheelchair, walkers)
- Management of co-morbidities (fibromyalgia symptom management, weight management)

[7] If Part D medications are included, the measure will account for the fact that not all beneficiaries are enrolled in Part D (e.g., through sub-grouping).

- Psychological services (psychotherapy for conditions such as depression or anxiety)

Broadly, the workgroup recommended considering how to identify which services are provided as part of treatment for rheumatoid arthritis and which services are unrelated to the episode. The workgroup highlighted both Part B and Part D medications as major aspects of rheumatoid arthritis treatment, and encouraged additional discussions around how to assign costs of medications. For example, several members noted that clinicians may substitute Part B medications for Part D medications to lower patients' out-of-pocket costs and increase access to medications. The workgroup recommended considering how scenarios like this could affect measure performance.

Key Takeaways from Discussion and/or Polls for Identifying Clinically Related Services:

- Members suggested including both Part B and Part D clinically-related medications, and emphasized the need for additional discussions about assigning medication costs
- Members suggested considering additional specialty care that may be related to rheumatoid arthritis (e.g., cardiac, pulmonary)
- Members reiterated the importance of only assigning clinically related services under the influence of the attributed clinician, particularly for complications and comorbid conditions (e.g., emergency department/hospital stays, infections, joint surgeries, behavioral health services)

2.5 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the Workgroup Webinar Poll to gather input from members on the discussions held during the webinar. In this poll, we also asked workgroup members for their availability for the second webinar in either late September or early October 2022. Acumen will operationalize input for the measure specifications based on workgroup webinar discussion and poll results and will follow up with workgroup members with more information about the next steps in the measure development process.

3. Appendix: Overview of Workgroup Member Preparation and Shared Materials

3.1 Introduction

Section 3.2 provides an overview of materials shared with the workgroup members prior to the workgroup webinar, and Section 3.3 provides a recap of concepts of the measure development process presented by Acumen.

3.2 Overview of Meeting Materials

Prior to the meeting, workgroup members were provided with the following information to inform their discussions and votes:

- Agenda and Slide Deck, which was sent prior to the meeting and outlined the topics and process used for the webinar, including embedded empirical analysis results
- A Welcome Packet of materials providing an overview of Wave 5 of cost measure development and information on the measure frameworks
- A Chronic Condition Cost Measure Framework Overview, which provided an at-a-glance summary of the chronic condition measure framework and lists the initial set of draft codes used in triggering for the meeting analyses, as well as Hierarchical Condition Categories (HCCs) used in the base risk adjustment model
- Investigation workbooks sent prior to the meeting, which presented detailed findings from empirical analyses:
    - A Sub-Population Analysis, which provided data on the frequency and cost associated with a preliminary set of sub-populations informed by public comments received and deliberations among the Acumen clinical team
    - Service Utilization over Time Analysis, which lists the top 200 most frequent services for each claim setting across episodes for the draft version of the measure along with various metrics regarding those services (e.g., share of episodes with that service, average cost of the service per episode, share of attributed clinicians who furnished the service)

The materials shared were based on analyses run on draft measure specifications that the Acumen clinical team created based on input from the Wave 5 measure development public comments and discussions with CMS.

3.3 Overview of Cost Measure Development

At the beginning of the meeting, Acumen presented an introductory session on the following topics:

- The activities done to date for the development of episode-based cost measures, including the Wave 5 measure development public comment period
- The goals of the meeting and timeline of activities for Wave 5
- A recap of the Quality Payment Program and episode-based cost measures for MIPS
- A recap on the different sources of information for the workgroup to consider in addition to their clinical expertise, including analyses and data, a literature review, and findings from the PFPs