Movement Disorders Service Assignment and Refinement (SAR) Webinar Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, October 17, 2023
November 2023

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 6, we reviewed feedback from prior Waves; this includes input from public comment periods in which we sought input on candidate clinical areas and episode groups for potential development.[2] We developed prioritization criteria used to identify strong candidate episode groups and concepts 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 6 episode groups were selected for development based on the prioritization criteria, prior input received, and discussions with CMS: (i) Movement Disorders: Parkinson's Disease, Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), and (ii) Non-Pressure Ulcers.

We held a nomination period for workgroup members between May 15, 2023, and June 2, 2023. The workgroups are composed of clinicians with expertise directly relevant to the selected episode groups. We finalized workgroups of about 15-20 members in June 2023, and they provided detailed input on the development of the selected episode groups during their first workgroup webinars from June 27 to 28, 2023. Then, Acumen convened the workgroups again for a Service Assignment and Refinement (SAR) Webinar to revisit the specifications recommended during the initial meeting and refine the measures prior to national field testing. For Wave 6, all workgroup meetings were held virtually. The workgroups will convene for a third

[1] For information on measure development in Wave 5, refer to the Wave 5 Measure Development Process document (https://www.cms.gov/files/document/2023-cmft-ebcm-process.pdf).
[2] For a summary of comments we received during the Waves 4 and 5 public comment periods, refer to the Wave 4 Measure Development Public Comment Summary Report (https://www.cms.gov/files/document/wave-4-public-comment-summary.pdf) and the Wave 5 Measure Development Public Comment Summary Report (https://www.cms.gov/files/document/wave-5-public-comment-summary-report.pdf).

meeting to continue measure specification and refinement discussions after a national field test, which is currently slated for early 2024.

Movement Disorders SAR Webinar, October 17, 2023

This meeting summary document outlines the purpose, discussion, and recommendations from the Movement Disorders SAR Webinar. Section 1 provides an overview of the webinar goals and process. Section 2 summarizes the discussion and recommendations from the workgroup. Appendix A.1 provides an overview of the chronic condition cost measure framework.

1. Overview

The goals of the Movement Disorders SAR Webinar 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 14 of the 15 workgroup members. The webinar was facilitated by Acumen moderator, Heather Litvinoff. The Movement Disorders workgroup chair was Chloe Slocum, who also facilitated meeting discussions. Two PFPs, Danny van Leeuwen and Patricia Chavez, attended the webinar to discuss and address questions regarding the PFP findings. The Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties.[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, including the meeting agenda and slide deck. A reference document with background on chronic condition measures, their framework, draft trigger codes, and information about the base risk adjustment model was shared with workgroup members prior to the June 2023 Workgroup Webinars. Also, workgroup members received the investigations described in Table 1 below.

Table 1: Workgroup Webinar Investigations

Investigation	Description
Sub-Population Analysis	• Provides data on the frequency and cost associated with a set of sub-populations informed by public comments received, prior workgroup discussions, and deliberations among the Acumen clinical team • Useful for discussion regarding accounting for patient heterogeneity

[3] CMS, "MACRA Episode-Based Cost Measures Wave 6 Clinician Expert Workgroup Composition (Membership) List" (https://www.cms.gov/files/document/wave-6-measure-specific-workgroup-composition-list.pdf).

Investigation	Description
Service Utilization over Time Analysis	• Provides data on 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) • Useful for discussion regarding identifying clinically relevant services

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 similar meeting discussion 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.

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 5 PFPs to gather input to inform development for the Movement Disorders cost measure. During the webinar, 2 PFPs shared these findings and fielded questions from workgroup members.

PFPs highlighted treatment and management that prioritizes maintaining movement as the most important indicator of quality care for movement disorders. Coordination of services and treatment was also pointed out as an essential feature of care, though PFPs reported concerns with a decrease in interaction between medical and non-medical clinicians since the implementation of Electronic Medical Records (EMR). Patients relied on their caregivers to support them with the coordination of care.

While PFPs were aware of complementary interventions for MS, such as massage therapy or chiropractic care, not all of them were able to incur all travel and care costs to access them. Patients who did use complementary interventions used more than one. Additionally, PFPs didn't identify any communication between clinicians and complementary practitioners.

Most PFPs noted discontentment with Durable Medical Equipment (DME) covered by Medicare, which were reported to be lower quality and not tailored to condition-specific needs. PFPs also mentioned difficulties in dealing with DME vendors.

One PFP indicated a long period of time with symptoms until receiving a final Parkinson's diagnosis. She also reported feeling unsupported at the time of diagnosis, as the neurologist didn't offer many resources on Parkinson's care and resisted in referring the PFP to a specialist. The PFP was later able to engage with movement specialists, physical therapists, and other community activities (e.g. peer support, vocal exercise classes, and exercise and movement

classes). She noted her concerns with how non-English speakers may not be appropriately supported by similar programs, as she found few resources available in other languages.

2.2 Defining the Episode

Acumen reviewed the methodology for constructing an episode-based cost measure, including the steps for defining an episode of care. 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 clinician group (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 steps for defining the patient cohort are described in Steps 1-4 of Table A1 in Appendix A. Acumen asked the workgroup to review the triggering methodology and provided targeted discussion questions on how the draft measure specifications may be improved.

Following the first webinar, the workgroup voted to include rehabilitation and outpatient evaluation and management (E/M) services as triggering services (i.e., first service) to indicate a patient-clinician relationship. Acumen conducted subsequent analyses to determine the impact of adding rehabilitation services as trigger services in the coverage of new patients and TINs in the measure. The preliminary results showed that rehabilitation services would capture a nominal number of new patients but would add around 10,000 new TINs to the measure. The workgroup discussed whether it was appropriate to attribute the measure to physical therapists (PT), occupational therapists (OT), and/or speech-language pathologists (SLP) and the extent to which these clinicians can influence care within the episode, especially when it involves costly medications.

Acumen also revisited the concept of including a "medication attribution check" to the measure, which would ensure that clinicians are only attributed a Movement Disorders episode if they prescribe at least 2 condition-related medications to 2 different patients during the current plus prior performance period (see Step 4 in Table A1 of Appendix A). Including a medication attribution check would exclude some clinicians from the attribution logic (e.g., PT, OT, SLP) because they don't prescribe medications. One member asked for PFP input, who confirmed she was prescribed medications at the time of her Parkinson's diagnosis. Other panelists also noted that medications may be prescribed at different stages of Parkinson's and MS, which could also impact the decision of which specialties to include in the attribution logic.

The workgroup also reviewed a list of additional related conditions that were suggested in the first webinar, such as Parkinson Plus syndromes, dystonia, and other degenerative diseases. Some members noted that some degenerative diseases (e.g., other degenerative diseases) are more similar to neurodegenerative conditions and would activate similar services to Parkinson's. Alternatively, the workgroup pointed out that conditions such as dystonia or Tourette's have different care patterns from the conditions currently included in the measure. Some members were also concerned about difficulties in accounting for heterogeneity among Parkinsonism patients (e.g., medication-induced Parkinson's isn't degenerative or progressive) and recommended not including them.

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

- The workgroup recommended to include rehabilitation services as trigger claims.
- Members recommended adding a medication attribution check to limit attribution only to medication-prescribing clinicians.

- The workgroup recommended to include other degenerative diseases of basal ganglia in the measure, but did not reach a consensus on including multisystem atrophy. Given the lack of consensus and the rarity of diagnosis, multisystem atrophy will not be included in the measure.
- Members recommended not including secondary Parkinsonism, dystonia, and other degenerative diseases of nervous system as additional diagnoses.

2.3 Accounting for Patient Heterogeneity

Members engaged in a detailed discussion about how to account for patient heterogeneity among various sub-populations within the Movement Disorders episode group. Sub-populations refer to patient cohorts as defined by their pre-existing conditions and other patient characteristics. Acumen described the methods for accounting for patient heterogeneity, and those are described in Table 2 below.

Table 2: Methods for Accounting for Patient Heterogeneity

Method	Description
Sub-Group	• If applicable, we may stratify the patient population into mutually exclusive and exhaustive sub-groups to define more homogenous patient cohorts. • 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.
Risk-Adjust	• We may define covariates in the risk adjustment model for the measure. • 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 up a large share of patients who have a characteristic that's outside of the attributed clinician's reasonable influence. • Risk-adjusted cost measures adjust observed episode spending to an expected episode spending (predicted by a risk adjustment model).
Exclude	• We may identify certain measure exclusions. • 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.
Monitor for Further Testing	• We may monitor certain sub-populations for further testing. • Monitoring for further testing is an option for flagging certain sub-populations that the workgroup may revisit later during measure development upon review of further data. This approach is best used when the workgroup requests additional data or information on a sub-population to discuss the appropriate method for meaningful clinical comparison.

After Acumen provided a description of each method and presented analytic data on sub-populations, workgroup members discussed the patient sub-populations and their preferences for how to address them. Information about these methods are also described in Steps 3, 6, and 7 of Table A1 in Appendix A.

Following the first webinar, the workgroup didn't reach a consensus on whether to include ALS and Huntington's as sub-groups in the measure. During the SAR Webinar, members reviewed data on episode coverage for ALS and Huntington's, which presented significantly lower episode counts compared to Parkinson's and MS. The workgroup was generally in favor of including ALS in the measure but not Huntington's, as they noted that ALS showed a more similar care profile to Parkinson's and MS compared to Huntington's.

Members also reviewed the following list of risk adjustors they had voted on after the June 2023 Workgroup Webinar:

- Psychosis
- Dementia
- Wheelchair Dependence
- History of Falling
- Spasticity
- Bowel or Bladder Incontinence
- Difficulty Swallowing
- Cognitive Status
- Tracheostomy
- Living Setting
- Frailty
- Pressure Injuries
- Malnutrition
- Respiratory Failure
- Dysarthria
- Dysphonia
- Deep Brain Stimulators/Pumps
- Sleep Apnea

Members generally agreed with the list and were interested in also looking at social determinants of health (SDOHs), which will be analyzed further during field testing.

The workgroup also revisited the discussion introduced in the first webinar to rename the measure, as they considered "Movement Disorders" an inaccurate classification of the conditions currently included. They narrowed down the options to 2 potential names: "Neurodegenerative Disorders Affecting Movement" or "Progressive Neurological Disorders Affecting Movement." Members were interested in getting PFP input on how to appropriately name the measure, as the workgroup expressed concerns with potential negative connotations of the term "neurodegenerative."

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

- Members recommended including ALS in the measure and not including Huntington's.
- The workgroup recommended including sleep apnea as a risk adjustor.
- Members recommended renaming the measure to "Progressive Neurological Disorders Affecting Movement," and we can explore this further during field testing.

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 Movement Disorders. Information about identifying clinically related services is also described in Step 5 of Table A1 in Appendix A.

Using prior input from public comments, as well as internal literature reviews and workgroup feedback from June 2023, Acumen drafted the following categories of clinically related services:

- Routine Provider Visits (Physician office visits, telehealth)
- Rehab (PT/OT/SLP; chiropractic)
- Labs (Complete blood count, metabolic panel)
- Behavioral Health (Psychiatric care)
- Related Hospitalizations and Post-Acute Care (PAC) (Admissions for Parkinson's, MS)
- Imaging (magnetic resonance imaging [MRI], computed tomography [CT] scan)
- Home Health (Nursing, PT)
- Emergency Department (ED) Visits (Altered mental status, Parkinson's)
- Durable Medical Equipment (Wheelchair, cane)
- Pulmonary Services (Respiratory therapy)
- Sleep-Related Studies
- Contractures
- Nutrition Services
- Gastrostomy
- Tracheostomy
- Fall-Related Care
- Swallow Studies
- Infusions
- Part D Medications

The workgroup went over additional services that they considered sufficiently clinically related to the measure. Members listed services that capture adverse outcomes of movement disorders care such as urosepsis, pressure injuries, aspiration, pneumonia, falls with fractures, subdural hematomas, and medication toxicity syndromes.

The workgroup also discussed high-cost services (e.g., deep brain stimulation, drug-administration intrathecal pumps, G-tubes for medications) and questioned whether the measure would penalize clinicians for appropriate use of services. To address workgroup concerns, Acumen will conduct additional analyses on their impacts on clinician performance for the next webinar.

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

- Members recommended including the following as clinically related services: deep brain stimulation, drug-administration intrathecal pumps, G-tubes for medications (e.g., Duopa), hip fractures/joint replacements related to falls, hospitalizations for urinary tract infections, pressure injuries, pneumonia (including aspiration), and medication toxicity syndromes.
- Members didn't reach consensus on including sepsis, other fractures (e.g., wrist), subdural hematomas, and hospitalizations for metabolic nutritional status as clinically related services. Based on further input from the Acumen clinician team, subdural hematomas shall be included in the measure, while the remaining non-consensus services will not be included.

2.5 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the SAR Webinar Poll to gather input from members on the discussions held during the webinar. 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.

APPENDIX A: CHRONIC CONDITION COST MEASURE FRAMEWORK

The table below provides an overview of the chronic condition episode-based cost measure framework.

Table A1. Chronic Condition Cost Measure Framework

Step	Description

Step 1: Trigger – Identify a Clinician Patient Relationship	• Trigger logic looks for a pair of services billed by the same clinician group (identified by their TIN) to identify a clinician-patient relationship. The time period between the 2 services that constitute a trigger event is referred to as the 'trigger window' and reflects how often the clinician group sees the patient.
	• A **trigger event** consists of (i) a trigger claim, and (ii) a confirming claim.
	  ○ A **trigger claim** is an outpatient evaluation and management (E/M) code with a relevant diagnosis
	  ○ A **confirming claim** is either another outpatient E/M code with a relevant diagnosis, or a condition-related Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code with a relevant diagnosis

Step 2: Reaffirm – Identify the Total Length of Care	• Once a clinician-patient relationship is identified, this starts a period of time when the TIN is measured on related costs (i.e., 'attribution window'). • The attribution can be extended if we continue to see that the TIN is providing care for the patient for this condition (as identified by 'reaffirming claims'). The same trigger and confirming codes are typically used to reaffirm the clinician-patient relationship.

Step 3: Define an Episode During Which Cost will be Assessed	• An 'episode' is a segment of care that allows clinicians to be assessed in a measurement (or performance) period.
	• An episode window length is one year at a minimum. Episodes are assessed in the measurement period in which they end and only include days not previously measured in preceding measurement periods.
	  ○ The episode window length may vary depending on the length of the total relationship between a patient and clinician group ('total attribution window'), and the data that hasn't been assessed in preceding measurement periods.
	  ○ Clinicians or clinician groups are measured on a patient at the end of the calendar year if there are 365 days' worth of claims data that hasn't previously been assessed or when the total attribution window ends, ensuring costs are only assessed once.
	• Once an episode window is defined, if applicable, the episode is placed into one of the episode sub-groups to enable meaningful clinical comparisons.

Step 4: Attribute the Episode to the Clinician Group and Clinician(s)	• Attribute episode to the TIN that billed the trigger services (trigger claim and confirming claim) for the 'total attribution window.'
	• Attribute episode to the clinicians [identified by their TIN-National Provider Identifier (TIN-NPI)] within the attributed TIN that played a substantial role in the patient's care:
	  ○ Billed at least 30% of outpatient E/M codes with a relevant diagnosis and/or condition-related CPT/HCPCS codes with a relevant diagnosis
	• The TIN-NPI must also meet particular requirements to ensure that no costs are assigned to the attributed TIN-NPI prior to seeing the patient and that we're attributing episodes to clinicians who manage a patient's chronic care. The TIN-NPI must have:
	  ○ Check #1: Provided condition-related care to the patient prior to or on the episode start date (to ensure that clinicians are attributed episodes after they met the patient)
	  ○ Check #2: Prescribed at least 2 condition-related medications to 2 different patients during the current plus prior performance period (to ensure that attributed clinicians are actually involved in providing ongoing chronic care management)
	  ▪ This check is only used in measures where the use of prescriptions is informative about the nature of care that the clinician provides. When some of the types of clinicians that manage the condition don't always prescribe the relevant medication (e.g., clinicians that can't prescribe), a chronic condition cost measure wouldn't use this check.

Step	Description
Step 5: Assign the Cost of Clinically Related Services	• Measures include only the costs for clinically related services, rather than all costs within the episode. • Clinically related services include treatment, monitoring, complications, and other services where the attributed clinician has reasonable influence on occurrence, frequency, and/or intensity. • Costs are payment standardized to remove variation due to geographic region or provider-specific adjustments. • These are identified through medical service codes and diagnosis codes. The measure calculates the cost of these specific services observed during the episode window.
Step 6: Apply Measure Exclusions	• 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.
Step 7: Risk-Adjust Episode Cost	• Risk adjustment predicts the expected cost of an episode by adjusting for factors outside of the clinician's control. • The risk adjustment model includes many variables the workgroup will discuss throughout development. As a starting point, we assess the following: (i) Hierarchical Condition Categories (HCCs) from the CMS-HCC Version 24 (V24) Risk Adjustment Model, which includes 86 HCCs, (ii) age variables, (iii) indicator variables, and (iv) interaction variables. • In addition, each measure may have tailored risk adjustors for factors specific to the condition. • If the cost measure has episode sub-groups, the risk adjustment model is run separately for each sub-group.
Step 8: Calculate the Measure Score	• The measure is calculated as the ratio of the observed cost (standardized to remove geographic and other differences) to the expected cost, averaged across all episodes attributed to the provider. • Longer episodes are weighted more heavily than shorter ones to ensure fair comparisons; a scaled approach is used to calculate observed and expected costs. • The average ratio of observed to expected costs per provider is then translated into a dollar amount as the provider's measure score.

Please contact **Acumen MACRA Clinical Committee Support** at macra-clinical-committee-support@acumenllc.com if you have any questions. If you're interested in receiving updates about MACRA Episode-Based Cost Measures, please complete this Mailing List Sign-Up Form to be added to our mailing list.