Quality Payment
PROGRAM

2020 Field Testing Feedback Summary Report for 5 Episode-Based Cost Measures:

- Asthma/Chronic Obstructive Pulmonary Disease
- Colon and Rectal Resection
- Diabetes
- Melanoma Resection
- Sepsis

December 2020

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1.0 Introduction

1.1 Project Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program. Under the Quality Payment Program, clinicians are incentivized to provide high-quality and high-value care through Advanced Alternative Payment Models or the Merit-based Incentive Payment System (MIPS). MIPS eligible clinicians will receive a performance-based adjustment to their Medicare payments. This payment adjustment is based on a MIPS final score that assesses evidence-based and practice-specific data in 4 performance categories: (i) Quality, (ii) Cost, (iii) Improvement Activities, and (iv) Promoting Interoperability.

CMS has contracted with Acumen to develop new episode-based cost measures for potential use in the Cost performance category of MIPS. Acumen has implemented a measure development process that relies on input from a large number of stakeholders, including multiple groups of clinicians affiliated with a broad range of professional societies, to develop clinically appropriate and transparent measures that provide actionable information to clinicians.

1.2 Field Testing Overview

Field testing is part of the measure development process and is an opportunity for clinicians and other stakeholders to learn about episode-based cost measures and provide input on the draft specifications. CMS and Acumen conducted field testing for 5 newly developed episode-based cost measures from August 17 to September 18, 2020. The episode-based measures were developed with input from 4 Clinical Subcommittees and 5 measure-specific Clinician Expert Workgroups that selected episode groups to develop into cost measures and provided input on measure specifications from May 2019 to January 2020. The Clinical Subcommittees and the episode-based cost measures they developed are listed in Table 1 below.

Table 1. Wave 3 Clinical Subcommittees and Episode-Based Cost Measures

Wave 3 Clinical Subcommittee	Episode-Based Cost Measure
Chronic Condition and Disease Management	Asthma/Chronic Obstructive Pulmonary Disease (COPD)
General and Colorectal Surgery	Colon and Rectal Resection
Chronic Condition and Disease Management	Diabetes
Dermatologic Disease Management	Melanoma Resection
Hospital Medicine	Sepsis

During field testing, clinicians and clinician groups had the opportunity to view a Field Test Report on the Quality Payment Program website with information about their performance. Field Test Reports were available to clinicians and clinician groups who met the following criteria for different episode groups during the measurement period (1/1/2019-12/31/2019):

- **Procedural**: Clinicians who performed melanoma resection or colon and rectal resection procedures and had 10 or more episodes
- **Acute inpatient medical condition**: Clinicians who managed the acute inpatient hospitalization for the treatment of sepsis and had or more 10 episodes

- **Chronic condition**: Clinicians who managed the ongoing treatment of chronic COPD or diabetes and had 20 or more episodes

A total of 1,558 Field Test Reports were downloaded from the Quality Payment Program website during field testing. Of the reports downloaded, 1,013 reports were at the clinician group level (identified by Tax Identification Number or TIN) and 545 reports were at the individual clinician level (identified by a unique TIN and National Provider Identifier pair, or TIN-NPI).

For the duration of field testing, stakeholders were invited to provide feedback by completing an online survey or submitting a comment letter.[1] Clinicians or stakeholders that didn't receive a report were encouraged to provide feedback on publicly available field testing materials: (i) draft measure specifications, (ii) mock Field Test Reports, and (iii) supplemental documentation.[2] In total, Acumen received 24 complete survey responses, including 13 comment letters. The list of stakeholders who submitted a comment through the online field testing feedback survey is provided in Appendix C. Acumen additionally received 22 comments from person and family representatives through the Cost Measures Questionnaire for Person and Family Input distributed by project partner, PFCCpartners, to their Patient Family Advisory (PFA) network.[3] Measure-specific comments that were received are included in Section 3 and were used to inform measure refinements by the Clinician Expert Workgroups after field testing.

Acumen and CMS posted the MACRA Wave 3 Cost Measures Field Testing Webinar to the Quality Payment Program Webinar Library at the start of the field testing period.[4] The webinar recording, slides, and transcript were available for stakeholders to review throughout field testing. The webinar presentation outlined: (i) the cost measure field testing project (ii) the measure development and re-evaluation processes, and (iii) field testing activities. The webinar recording was viewed approximately 450 times during the field testing period.

[1] The survey was previously available online at this link: https://www.surveymonkey.com/r/2020-cost-measures-field-testing.
[2] Field testing materials are available for download on the MACRA Feedback Page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html.
[3] The questionnaire was previously available online at this link: https://www.surveymonkey.com/r/pf-ft-questionnaire
[4] MACRA Wave 3 Cost Measures Field Testing Webinar materials are available on the Quality Payment Program Webinar Library: https://qpp.cms.gov/about/webinars.

2.0 Feedback Summary

This section summarizes that feedback received on the measure specifications, the measure development process, the Field Test Report template, and the supplemental documentation. This section doesn't include a summary of the measure-specific feedback, which is presented in Section 3. Measure-specific feedback was presented to the Clinician Expert Workgroups following the completion of field testing to inform the refinement of the cost measures.

2.1 Components of Episode-Based Cost Measures

2.1.1 Inclusion of Part D Costs

Field testing feedback was generally not supportive of the inclusion of Part D drug costs in cost measures, with stakeholders expressing concern that clinicians could be held accountable for transactions that are out of their control or if patients require high-cost medications. Relatedly, stakeholders expressed concern about the lack of transparency for Part D costs. It was suggested that CMS should risk adjust Part D drug costs by specialty, condition, or patient demographics. The decision to incorporate Part D drug costs in this wave of measure development was based largely on positive stakeholder feedback received during prior field tests.

2.1.2 Introduction of Chronic Condition Cost Measures

Some stakeholders reported that chronic condition cost measures represent an opportunity to reduce healthcare costs without impeding patient access, choice, or quality of care while others reported it was difficult to evaluate the new measures without measure reliability testing results. Stakeholder feedback suggested that the ongoing COVID-19 and wildfire public health emergencies may impact the costs associated with treating chronic conditions such as asthma, COPD, and diabetes and that CMS should evaluate the potential effect.

2.1.3 Attribution of Cost

Stakeholders provided a variety of cost measure attribution suggestions for consideration including to compare specialists with other specialists, only attribute episodes at the group practice level, increase the threshold for attributing acute inpatient or chronic condition episodes to individual clinicians, and to not attribute costs to multiple clinicians. Stakeholder feedback suggested these revisions would support team-based care and build buy-in by measuring what is actionable and within a clinician's control.

2.1.4 Risk Adjustment

Stakeholders maintain that resource use and patient health outcomes are influenced by the social determinants of health and that the cost measures aren't adequately adjusted for these differences when calculating cost measures performance scores. One specialty society suggested that the cost measures' risk adjustment models be revised to independently consider all significant factors associated with the outcomes for the condition or patient population being measured.

2.1.5 Alignment of Cost and Quality

Stakeholders recognize the importance of linking cost and quality, including opportunities to do in the forthcoming MIPS Value Pathways (MVPs), to better evaluate clinician performance and improve patient health outcomes.

2.2 Measure Development Approach

2.2.1 Stakeholder Engagement

Stakeholders expressed appreciation for the opportunity to provide feedback during field testing and for the incorporation of previous suggestions in an effort to continually improve the measure development and field testing processes.

2.2.2 Impact of COVID-19

Stakeholders reported that the COVID-19 and wildfire public health emergencies presented challenges to participating in field testing. In anticipation of these challenges, CMS delayed the start of the field testing period until August and sought stakeholder input on their ability to participate. Due to these challenges, commenters suggested that stakeholder participation would be limited and recommended extensions to the field testing feedback period, additional measure testing, and reporting the measures initially for informational purposes only. Stakeholders recommended that CMS consider the impact of the current public health emergencies when making implementation decisions about the measures. A period of informational-only reporting to allow further testing and review was specifically recommended.

CMS's inclusion of telehealth services in the cost measures, partly in response to the COVID-19 pandemic, was seen as a positive step that should be continued going forward in an effort to expand access to vulnerable patient populations so long as CMS monitors for unintended consequences. Patient and family representatives reported that telehealth services during the COVID-19 pandemic reduced travel costs, offered greater convenience, reduced wait times often associated with in-person visits, and permitted ongoing care to continue.

2.2.3 Measure Testing Information

Feedback from stakeholders included requests for additional information about measure performance and testing, including specific requests to review measure reliability results during field testing.

2.2.4 Person and Family Input

Patient and family representatives expressed concern that episode groups may inadvertently lock patients into treatment options that don't reflect the subtleties of the individuals with the disease or condition. They suggested developing cost measures that are meaningful for patients, caregivers, and clinicians. Patient and family representatives also suggested that cost measures be reflective of diverse patient and family populations.

2.3 Field Test Report Template and Supplemental Documentation

2.3.1 Field Test Report Access, Format, and Content

Stakeholders didn't report any issues accessing Field Test Reports during the field testing period. All stakeholders that provided feedback on this topic reported that it was either "very easy" or "easy" to access their reports. Comments also suggested that sending Field Test Reports proactively to eligible clinicians could improve engagement among stakeholders.

Feedback generally was positive regarding the updated Field Test Report and the supplemental episode-level data file, though some stakeholders preferred the previous Excel format. Stakeholders reported that the episode-level file contained outdated Medicare patient identifiers, which made it challenging to evaluate clinician performance at a granular level and limited the usefulness of the report. Some stakeholders recommended adding more information and

specificity to the Field Test Reports and others indicated that they still found the reports complex and challenging to understand the performance metrics presented.

3.0 Measure-Specific Field Testing Feedback

This section includes the measure-specific feedback received on the 5 cost measures during the field testing period. These feedback were shared with the Clinician Expert Workgroups prior to the Post-Field Test Refinement (PFTR) webinars in October 2020 for their review as they considered potential refinements to the measures. The stakeholder feedback is categorized into the 5 components of cost measure development.

3.1 Asthma/Chronic Obstructive Pulmonary Disease (COPD)

3.1.1 Definition of an Episode Group

- A commenter found the sub-grouping methodology appropriate, but asked about how other underlying lung diseases are considered in the presentation of a patient.

3.1.2 Assignment of Costs to the Episode Group

- A few stakeholders suggested including the following in the list of Part D services/drugs:
    - New drugs/classifications, including combination medications to increase compliance
    - Biologics dupilumab
    - Biologics reslizumab
- Some commenters suggested assigning the following clinically related services:
    - Laboratory complete blood count with immunoglobulin level
    - Laboratory complete blood count with Eosinophil count*
    - Pneumococcal immunizations*
    - Pulmonary function tests*
    - Exhaled fractional nitric oxide (FeNO)*
    - Inhalation bronchial challenge*
    - Bronchodilation responsiveness spirometry*

    *indicates services that are already assigned

- One stakeholder noted that non-specific symptoms, including malaise, syncope, and chest pain, are a reflection of an advanced stage of the disease. Another stakeholder commented that these non-specific symptoms aren't common in asthma and shouldn't be assigned. However, some person and family representatives were supportive of including these non-specific symptoms and suggested other symptoms to include, such as dyspnea on exertion, decreased appetite, weight loss, and acute respiratory distress syndrome.
- One commenter suggested including services for heart attacks, as heart and lung issues tend to coincide; however, another commenter noted they aren't aware of data showing that asthma increases the risk of heart attacks.
- Some stakeholders recommended not assigning thoracic surgeries as they aren't clinically related to asthma care.
- Some stakeholders recommended not assigning allergen treatment or allergen immunotherapy, as allergy treatment is ongoing and would be difficult to assign to a

specific episode of care. It was also noted that assigning allergen immunotherapy costs to an asthma/COPD episode would penalize allergists who predominately provide services related to allergen immunotherapy. One person and family representative shared that they're currently receiving allergy shots and consider it an integral part of their asthma control/treatment plan.

- A commenter noted it's unlikely that an inpatient stay for only asthma or COPD would be longer than 30 days without other complications.
- One stakeholder commented that post-acute care (PAC) isn't generally required for asthma, and thus PAC costs shouldn't be assigned to the measure.
- A stakeholder agreed with the inclusion of occupational therapy services as a cost in the Asthma/COPD measure. This stakeholder highlighted the importance of occupational therapy in addressing different aspects of performance in a variety of contexts and environments to support the engagement in occupations that affect physical and mental health, well-being, and quality of life.
- One stakeholder highlighted the importance of considering the impact of the COVID-19 pandemic on the Asthma/COPD measure. Specifically, the pandemic has resulted in a decrease in pulmonary function tests due to the potential to aerosolize and spread COVID-19, making it difficult to properly manage asthma in the office setting.
- Some person and family representatives suggested including additional services such as spirometers and other breathing accessory aids.
- One patient and family representative reported managing costs by categorizing them into routine and emergency costs, and further explained that spending on emergent care is reduced if they receive routine quality chronic care.

3.1.3 Attribution of the Episode Group to Clinicians

- One stakeholder commented that the attribution methodology should account for patients that might be misdiagnosed as having asthma by non-specialists, but determined as not having asthma when referred to a specialist. They further raised the concern that the attribution methodology could assign costs of other physicians or acute care providers (who misdiagnose patients with asthma and start them on high-cost and inappropriate treatments) to specialists who receive these patients as referrals.
- A few commenters noted that Nurse Practitioners shouldn't be considered a clinical specialty, and commented that treating Nurse Practitioners as a specialty could result in inappropriate assignment of costs.
- Some person and family representatives noted that the following clinicians/specialties have helped them manage their asthma or COPD: Nurse Practitioners, Allergy/Immunology, Cardiology, Physician Assistant, Critical Care (Intensivists), General Practice, and Geriatric Medicine.

3.1.4 Risk Adjustment and Exclusions

- A commenter suggested considering social determinants of health as risk adjustment variables since they impact care.
- One stakeholder suggested that the risk adjustment methodology account for factors contributing to higher costs of asthma or COPD care in certain geographic areas,

particularly those affected by the wildfires throughout the west coast states, and avoid penalizing clinicians caring for individuals in these parts of the country.

3.1.5 Alignment of Cost with Quality

- One commenter suggested that the cost measure doesn't establish a connection between cost and quality.
- A few person and family representatives noted that an indication of high-quality care includes the ability for clinicians to listen to patients' concerns and be responsive in the context of clinical partnership, which can result in a reduction in symptoms and ability to participate in activities. Avoidance of emergency room use was another indication that their asthma or COPD was well controlled.
- Some patient and family representatives highlighted opportunities to improve care, which include specialists coordinating with other treating clinicians and the use of prescribed inhalers.
- One patient reported being tested annually for managing asthma, which improved their maintenance and reduced the symptoms they experience.
- A few person and family representatives reported that if their asthma or COPD is well maintained, clinician visits could be routine.
- Some person and family representatives explained that they typically manage the coordination between their primary care clinician and specialist, and make decisions about who to see based on the availability of the specialist and/or severity of symptoms.

3.2 Colon and Rectal Resection

3.2.1 Definition of an Episode Group

- One commenter agreed with the draft list of rectal Current Procedural Technology (CPT)/Healthcare Common Procedure Coding System (HCPCS) trigger codes for rectal procedures and relevant rectal Medicare Severity-Diagnosis Related Groups (MS-DRGs).
- One commenter suggested adding a few CPT/HCPCS codes that were frequently used by their colorectal surgery division because the codes weren't present in their respective Field Testing Report. However, some of these CPT/HCPCS codes had already been discussed in detail by the workgroup. For example:
    - The commenter agreed with a previous workgroup decision to include the following CPT/HCPCS codes as episode triggers: 44144, 44157, 44158, 44208, 44211, 45113, and 45402.
    - The commenter recommended adding 2 CPT/HCPCS codes (e.g., 44320 and 45116) as episode triggers, which the workgroup previously decided to remove because the procedures differed in scope from colon resections in the measure or were associated with a lower morbidity and/or pain.
- The same commenter also recommended adding 6 CPT/HCPCS codes as episode triggers that weren't previously discussed by the workgroup (e.g., 44620, 44625, 44626, 44188, 44227, and 45550).

Table 2. Summary of Feedback on Trigger Codes

Codes	No. of Commenters	Add, Remove, or Modify	Comments
44320, 45116, 44620, 44625, 44626, 44188, 44227, 45550	1	Add	• One stakeholder advocated for including these CPT/HCPCS codes as episode triggers because colorectal surgeons in their colorectal surgery division use them.

3.2.2 Assignment of Costs to the Episode Group

- One commenter agreed with the workgroup's previous decision to include occupational therapy services as downstream costs for the Colon and Rectal Resection measure.
- One commenter implied that the Field Testing Report didn't list out complications separately, and emphasized adequately and completely identifying services related to complications in reports, as these services can lead to increased episode costs.
- One commenter agreed with the workgroup's previous decision to continue to assign electrocardiograms and electrographic cardiac monitoring in the pre-trigger period. However, they also recommended no longer assigning some of the other cardiac diagnostic procedures from the pre-trigger period including: (i) diagnostic cardiac catheterization, coronary arteriography, (ii) echocardiogram, and (iii) cardiac stress test.
- One person and family representative suggested that the cardiac diagnostic procedures should only be performed if medical history or current need indicates that they're necessary.

3.2.3 Attribution of the Episode Group to Clinicians

- No feedback on this topic was received.

3.2.4 Risk Adjustment and Exclusions

- One commenter highlighted that emergent colectomies can be associated with heightened clinical risk and cost, which aligns with a previous workgroup decision to risk adjust for this patient characteristic that's outside of the attributed clinician's reasonable influence.

3.2.5 Alignment of Cost with Quality

- One commenter highlighted that it's unclear if the procedures as listed are done for the correct indications. Colorectal surgery uses the number of lymph nodes identified in the specimen as a quality indicator.
- A few person and family representatives indicated that pre-and post-follow-up care and a trusting relationship with the surgeon—to understand the procedure, potential risks, complications, and recovery expectations—are important quality indicators.

3.3 Diabetes

3.3.1 Definition of an Episode Group

- A few commenters noted that the sub-grouping methodology is appropriate. One of these commenters said that they feel that statistics on diabetes care are skewed

because type 2 diabetes patients who require insulin are included with type 1 diabetes patients. While some of these patients are ketosis-prone and deserve inclusion, many aren't.

- One commenter suggested that we include gestational diabetes as its own sub-group because it's not included in either the Type 1 Diabetes or Type 2 Diabetes sub-groups.

3.3.2 Assignment of Costs to the Episode Group

- Several commenters suggested no changes to the assigned services in the draft measure codes list.
- One commenter suggested that we include dietary education for diabetes patients. As a note, the measure already includes diabetes self-management education and support, and medical nutrition therapy as assigned services.
- One commenter asked whether the measure's service assignment includes "advanced treatment technology tools," such as continuous glucose monitoring devices. As a note, the measure includes continuous glucose monitoring devices, insulin pumps, and other technologies under the "Diabetes Treatment Supplies" clinical theme.
- Several commenters, including 2 stakeholders representing ophthalmology practices that were assigned Diabetes episodes, expressed concern that services outside of their TIN are being used to evaluate the total cost of their episodes, similar to the Total Per Capita Cost (TPCC) measure. As a note, the revised measure methodology will only attribute episodes to clinicians who provided at least 2 patients with at least 2 diabetes medication prescriptions.
- One commenter said that occupational therapy services should be included in the measure because occupational therapists engage in several interventions that could reduce the likelihood of readmissions for patients with diabetes. As a note, occupational therapists are already an eligible specialty that can be attributed the measure, and occupational therapy services are assigned.
- A few commenters agreed with our methods of capturing post-acute care service utilization. However, one of these commenters was unsure of whether routine 21-day inpatient rehabilitation stays in skilled nursing facilities (SNF) are included. As a note, SNF stays up to 30 days are included.
- One commenter said that it's very rare to have someone admitted into an acute care setting for only diabetes complications and have an extended stay of 30 days.
- One commenter agreed with the draft list of Part D services.
- A commenter said that as new medications come to market, adjustments should be made to the list of Part D services included in the measure. They went on to say that the "donut hole" may need to be considered in the measure. This is the coverage gap that occurs when Part D enrollees reach a certain cost limit, leading them to be responsible for a greater share of their prescription drug costs.
- One commenter said that new diabetes medications are typically brand name only and are quite expensive, so clinicians shouldn't be penalized for using newer drugs with improved mortality documentation.
- One commenter said that they would like sodium glucose transporter-2 inhibitors to be included in the draft list of Part D services. As a note, the draft list already includes

these drugs, including ertuglifozin (Steglatro), canagliflozin (Invokana), empagliflozin (Jardiance), and dapagliflozin (Farxiga).

- One person and family representative said that the health care system needs to get control over the cost of medications since people are experiencing several downstream consequences because they can't afford their medications.
- A patient and family representative agreed with the list of services included in the measure, but suggested that we add services that better inform and educate patients before they experience complications of diabetes. One way they suggested is through videos with testimonies from people of color, because the lack of trust makes it important to inform patients of color of the consequences of not following a prevention plan of action.
- Person and family representatives agreed that clinicians directly influence post-acute care services related to diabetes. They recognized the needs for these services, particularly when the patient can't care for their daily needs due to amputation or if they're in a weakened status.

3.3.3 Attribution of the Episode Group to Clinicians

- A few commenters agreed with the measure's attribution methodology and the specialties that can be attributed the measure.
- One commenter suggested that we include nutrition professionals and dieticians as specialties that can be attributed the measure. As a note, registered dieticians and nutrition professionals are already a specialty eligible for measure attribution.
- One commenter said that nurse practitioners are clinicians and not a specialty. As a note, nurse practitioners are listed on Medicare claims as a specialty that's eligible for measure attribution.
- One commenter said that interventional radiologists do vascular procedures and asked if vascular surgery falls under cardiology. As a note, both interventional radiology and cardiology are eligible specialties for measure attribution.
- Some commenters questioned whether ophthalmologists should be an eligible specialty because these practices are concerned that services outside of their TIN are being used to evaluate cost.
- One commenter was concerned about the share of clinicians who don't directly manage chronic diseases (i.e., hospitalists) that are being attributed Diabetes episodes. The number of patients allocated to endocrinologists and primary care clinicians within their TIN was lower than expected and the number of patients attributed to "non-diabetes" clinicians (i.e., cardiologists, oncologists, and hospitalists) was high.
- Some person and family representatives noted that the following clinicians/specialties have helped them manage their diabetes: internal medicine, family practice, nurse practitioners, cardiology, endocrinology, endocrinology, podiatry, physician assistants, and ophthalmology.

3.3.4 Risk Adjustment and Exclusions

- Some commenters noted that the variables included in the current risk adjustment model are appropriate for estimating the expected cost of a Diabetes episode.

- One commenter suggested that we include proteinuria and/or albuminuria as risk adjustors in the measure's risk adjustment model.
- One commenter said that social determinants of health may increase patient risks and costs.

3.3.5 Alignment of Cost with Quality

- Some person and family representatives stated that the following are important indicators of high quality care: decreased hospitalizations and emergency room visits related to diabetes, management of HbA1c, ability to access medications, a decrease in surgical interventions, availability of one-on-one counseling, and clinicians that are accessible and willing to adjust medications.

3.4 Melanoma Resection

3.4.1 Definition of an Episode Group

- A few commenters suggested that complications accompanied by an excision should trigger an episode, instead of the melanoma-specific excision codes.
- Some commenters suggested modifying the current sub-group specifications, summarized in the table below:

Table 3. Summary of Feedback on Sub-Group Logic

Codes	No. of Commenters	Add, Remove, or Modify	Comments
C43.8, C43.9, D03.8, D03.9	1	Add	• Add to Head/Neck sub-group logic if appropriate Head/Neck trigger code is identified
14040, 14041	1	Add	• Add these triggers into Head/Neck specifications (used to place episodes into sub-groups)

3.4.2 Assignment of Costs to the Episode Group

- One commenter suggested assigning pathology services.
- One commenter recommended that some Mohs procedures be captured by the episode because dermatologists are performing some Mohs chemosurgery procedures, which are expensive.
- One stakeholder recommended that sentinel lymph node biopsy (SLNB) codes be assigned on the trigger day, citing that these are often done in conjunction with resecting larger melanomas.
- One person and family representative recommended including costs from acute care facilities pre- and post-care, along with costs related to anesthesia, pathology, and aftercare.

3.4.3 Attribution of the Episode Group to Clinicians

- Some commenters stated that they're concerned that all services, including those outside of the attributed practice's TIN, are being used to evaluate costs in the measure for their attributed TIN.
- Some commenters recommended that a specialist exclusion, similar to one that exists in the TPCC measure, be added to the Melanoma Resection measure.

3.4.4 Risk Adjustment and Exclusions

- One commenter recommended adding risk adjustment variables for prior therapy, site of the melanoma, and immunosuppression.
- One commenter noted that the site of service and type of repair (flap/graft) shouldn't be used in risk adjustment, as these factors may represent clinician choice, and not be perfectly reflective of disease severity. Additionally, the patient may choose to go to a particular site of service for non-clinical reasons, like convenience, personal choice, or practice patterns.
- One commenter wanted clarification on whether recurrences are scored differently.

3.4.5 Alignment of Cost with Quality

- No feedback on this topic was received.

3.5 Sepsis

3.5.1 Definition of an Episode Group

- No feedback on this topic was received.

3.5.2 Assignment of Costs to the Episode Group

- One commenter appreciated the inclusion of occupational therapy services as assigned downstream costs for the Sepsis measure, as these services address the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts to support engagement in occupations, well-being, and quality of life.
- One person and family representative expressed support for assigning the costs of physical therapy, including during the hospitalization, and noted it's particularly essential for frail people to regain mobility post-discharge.
- One person and family representative recommended including the costs of surgical removal of implanted catheters due to infection, as well as patient education and prevention training for service assignment.
- One person and family representative indicated the use of home infusion as contributing to the quality of their care, though noting that there may be safety and efficacy concerns regarding home infusion versus oral antibiotics.
- One person and family representative supported the inclusion of recurrent sepsis as part of the costs the measure captures.

3.5.3 Attribution of the Episode Group to Clinicians

- No feedback on this topic was received.

3.5.4 Risk Adjustment and Exclusions

- No feedback on this topic was received.

3.5.5 Alignment of Cost with Quality

- Some person and family representatives emphasized the importance of improving clinical judgement to recognize sepsis promptly (e.g., during an emergency room visit) to improve patient outcomes.
- Some person and family representatives mentioned the importance of the clinical team listening to the patient (e.g., taking patient/caregiver input regarding signs/symptoms that may be indicative of sepsis more seriously) and ensuring they convey the seriousness and urgency of the condition.
- One person and family representative recommended a measure regarding adherence to the "American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults," particularly for elderly patients at higher risk of adverse drug effects.
- One person and family representative suggested a measure on the number of repeat infections per patient and one that surveys the patient to determine if their reported outcomes match the hospital's report.

4.0 Acumen Response and Next Steps

We appreciate the engagement of stakeholders and patient and family representatives with the measure development process and will take into consideration the feedback received during field testing. We also appreciate the interest expressed by stakeholders in remaining engaged throughout the process, such as through activities including the standing Technical Expert Panel (TEP), Clinical Subcommittees, Clinician Expert Workgroups, field testing, and public comment periods. Input and engagement from stakeholders and patient and family representatives is key to our measure development approach, and we believe the extensive clinician and stakeholder input on these measures helps ensure that they provide meaningful information to clinicians about their cost performance. As part of considering the feedback summarized in this report, we will share the relevant feedback with the Clinician Expert Workgroups and the TEP for their consideration on operationalizing this field testing input. The rest of this section includes a summary of key next steps that will be taken in response to the feedback received.

Commenters noted that the COVID-19 public health emergency impacted the measure development process, including stakeholder engagement during field testing.

- We appreciate the continued stakeholder and clinician engagement throughout the 3 waves of measure development to date and recognize the burden that the ongoing public health emergency has placed on many stakeholders. This year's field test was rescheduled based on targeted feedback about stakeholders' ability to participate in the process and provide feedback. We will take into account the feedback on improving the development timeline to mitigate these effects and continue to explore ways to engage stakeholders that also allow for flexibility in the measure development and field testing processes.

Commenters expressed concern about the inclusion of Medicare Part D prescription drug costs in cost measures.

- We appreciate stakeholder input about incorporating Part D prescription drug costs in 3 of the 5 Wave 3 episode-based cost measures and understand that stakeholders are concerned about clinicians being held accountable for costs that are neither transparent to them nor within their control. For this reason, CMS chose to use standardized costs to allow for meaningful comparisons of clinician use despite the high drug price variation and opacity associated with the market-based Medicare Part D program. The standardization methodology achieves this by assigning a single standard price to each drug based on clinical characteristics (i.e., active ingredient, strength, dosage form, route of administration) and brand/generic designation, thereby removing drug price variation from non-clinical factors such as drug manufacturer and plans. Furthermore, CMS only included Part D prescription drugs considered clinically related to the treatment of Asthma/COPD, Diabetes, and Sepsis based on extensive testing and positive stakeholder input collected in prior waves of measure development. Stakeholder feedback on this topic will be shared with CMS for their consideration as they develop future cost measures that may also include Part D prescription drug costs.

Commenters remain interested in expanding cost measure risk adjustment models to account for the social determinants of health.

- We recognize the ongoing stakeholder interest in risk adjusting for social risk factors and other patient characteristics not included in the current CMS Hierarchical Condition Categories (HCC)-based model. Our measure testing includes consideration of these factors and we'll continue to share stakeholder input on this subject with CMS to inform the agency-level decision about the inclusion of social risk factors in cost measure risk adjustment models.

Commenters noted that while Field Test Reports were accessible and provided actionable information, there is room for improvement.

- We appreciate the feedback from clinicians and stakeholders on the report template, including positive comments about the ease of access of Field Test Reports from the Quality Payment Program website and the supplemental episode-level data file. We recognize that providing up-to-date information in the episode-level data file, including Medicare Beneficiary Identifiers, can make the report more actionable and we'll consider the stakeholder feedback on this topic when generating subsequent Field Test Reports. Our goal is to ensure that the report template is user-friendly, navigable, and contains accurate and actionable information that clinicians may use to learn about their performance. We'll continue to refine the report format in future waves of measure development and field testing based on the stakeholder input we receive.

Appendix A: Post-Field Testing Measure Refinements

This appendix documents the refinements made to the cost measures after the 2020 field testing period. The measure-specific feedback included in Section 3 of this report was summarized and compiled after field testing and provided to the measure-specific Clinician Expert Workgroups for their consideration prior to a series of PFTR webinars in October 2020. The post-field testing refinements made to the cost measures are listed in the following tables. No refinements were made to the specifications of the Diabetes cost measure.

Table A1. Post-Field Testing Refinements for Asthma/Chronic Obstructive Pulmonary Disease (COPD)

Refinement Type	Asthma/COPD Refinements
Episode windows	No Changes
Triggers	No Changes
Sub-Groups	No Changes
Measure-Specific Exclusions	No Changes
Service Assignment	*Added* services: • Laboratory complete blood count with immunoglobulin level • Biologics dupilumab and reslizumab *Removed* services: • Thoracic surgery • Services associated with non-specific symptoms, including malaise, syncope, and chest pain
Measure-Specific Risk Adjustors (in addition to HCCs)	*Added* the following risk adjustors: • Allergen testing/treatment • Bi-Level Positive Airway Pressure (BiPAP)/Continuous Positive Airway Pressure (CPAP) *Edited* the following risk adjustor: • Adjusted the Smoking risk adjustment variable to differentiate between current/recent and prior history of smoking and remove codes related to non-smoking nicotine dependence. The updated risk adjustment variables are: Current/Recent Smoking and Prior History of Smoking

Table A2. Post-Field Testing Refinements for Colon and Rectal Resection

Refinement Type	Colon and Rectal Resection Refinements
Episode windows: pre-trigger and post-trigger periods	No Changes
Triggers	*Edited* triggers: • Add CPT/HCPCS 45550 (treatment of rectal prolapse) as trigger code • Remove CPT/HCPCS 45130 (repair of prolapsed rectum) as trigger code
Sub-Groups	No changes
Measure-Specific Exclusions	*Added* exclusion: • Exclude episodes without an inpatient component
Service Assignment	*Removed* the following assigned services in the 15-day pre-trigger period: • Diagnostic cardiac catheterization, coronary arteriography
Measure-Specific Risk Adjustors (in addition to HCCs)	*Removed* the following risk adjustors: • Obesity • Recent Cardiac Arrest

Table A3. Post-Field Testing Refinements for Melanoma Resection

Refinement Type	Melanoma Resection Refinements
Episode windows: pre-trigger and post-trigger periods	No Changes
Triggers	No Changes
Sub-Groups	*Added* the following logic to place episodes into the Head/Neck sub-group • Place an episode into the Head/Neck sub-group if triggered by CPT/HCPCS 14040 and 14041 and DGN C43.0-C43.4, D03.0-D03.4, C43.9, D03.9
Measure-Specific Exclusions	No Changes
Service Assignment	*Added* the following assigned services in a 7-day pre- and post-trigger window: • Pathology • Anesthesia
Measure-Specific Risk Adjustors (in addition to HCCs)	No Changes

Table A4. Post-Field Testing Refinements for Sepsis

Refinement Type	Sepsis Refinements
Episode windows: pre-trigger and post-trigger periods	No Changes
Triggers	No Changes
Sub-Groups	No Changes
Measure-Specific Exclusions	*Added* exclusion: • Exclude patients with interventional radiology (IR) abscess drainage in the 30 days prior to the sepsis hospitalization
Service Assignment	No Changes
Measure-Specific Risk Adjustors (in addition to HCCs)	*Added* the following risk adjustors: • Interventional radiology (IR) abscess drainage during hospitalization • Recent antibiotic use

Appendix B: List of Commenters

This appendix provides an index of stakeholders who submitted a comment during the Field Testing Feedback Period. Though commenters who provided feedback and didn't include their name or organization aren't included in this table, their input has been included in the report.

Table B1. Stakeholders Providing Feedback on the 2020 Field Testing

Name	Individual or Representative	Organization
Anita Erwin	Representative	Atrium Health
Ashley Hopkins	Representative	Penn Medicine
Bernadette Petravicius	Representative	Dermatology & Plastic Surgery of Arizona
Carlene Phillips	Individual	
Devika Nair	Individual	
Helen Olkaba	Representative	American Academy of Dermatology
Jennifer McLaughlin	Representative	American Medical Association
Jennifer Pfeifer	Representative	American College of Allergy, Asthma and Immunology
Lori Arreola	Individual	
Lori Johnson	Representative	Curators of the University of Missouri
Mark Ramirez	Individual	
Melissa Marsh	Representative	Retina Consultants, Ltd
Monica Wright	Representative	American Occupational Therapy Association
Phillip Ward	Representative	American Podiatric Medical Association
Randall Marsden	Individual	
Randy Marsden	Individual	
Russell Barr	Individual	
Sabrina South	Individual	
Suzanne Joy	Representative	American College of Physicians
Terry Filhart	Individual	
Tina Holland	Individual	
William Terrell	Individual	