Diabetes Workgroup Post-Field Test Refinement (PFTR) Meeting Summary

MACRA Episode-Based Cost Measures: Measure-Specific Workgroups
Post-Field Test Refinement (PFTR) Webinar, October 9, 2020
October 2020

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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] The 4 Clinical Subcommittees (CS) that convened in May-June 2019 for Wave 3 were focused on the following clinical areas: Chronic Condition and Disease Management, Dermatologic Disease Management, General and Colorectal Surgery, and Hospital Medicine.[2] These CS provided input on selecting episode groups for development in Wave 3 and the composition of smaller, targeted workgroups to build out the measure. Acumen convened the following workgroups[3] (each composed of approximately 15 members) in mid-August 2019 for in-person meetings: Diabetes, Asthma/Chronic Obstructive Pulmonary Disease (COPD), Melanoma Resection, Sepsis, and Colon and Rectal Resection. Following the workgroup in-person meetings, Acumen convened the workgroups again in January 2020 for a Service Assignment and Refinement (SAR) webinar to revisit the specifications recommended during the in-person meeting and refine the measures prior to national field testing. In October 2020, Acumen reconvened the

[1] For information on measure development in Waves 3, refer to the 2020 Episode-Based Cost Measures Field Testing Wave 3 Measure Development Process document (https://www.cms.gov/files/document/macra-cmft-ebcm-process-2020.pdf).
[2] Members for these Clinical Subcommittees were recruited through a public nomination period from March 11 to April 12, 2019.
[3] Members for these workgroups were recruited from within the CS as well as a standing pool of nominees between June and July, 2019.

workgroups for Post-Field Test Refinement (PFTR) webinars to discuss potential measure refinements based on field testing feedback.

Diabetes Post-Field Test Refinement (PFTR) Webinar, October 9, 2020

This meeting summary document outlines the purpose, discussion, and recommendations from the Diabetes Workgroup PFTR 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 Diabetes workgroup webinar on October 9, 2020, were the following:

(i) Provide a recap of the chronic condition cost measure framework, including updates to the attribution methodology for individual clinicians (identified by a unique Taxpayer Identification Number and National Provider Identifier pair, or TIN-NPI)
(ii) Discuss field testing feedback for the measure
(iii) Discuss and provide input on priority refinement topic areas and recommendations on measure specifications (based on field testing feedback and other topics)
(iv) Consider and discuss the impact of COVID-19 on measure specifications

The meeting was held online via webinar, and attended by 10 of 19 workgroup members. The webinar was facilitated by an Acumen moderator, Suzann Pershing. The Diabetes workgroup chair was Terry Lee Mills, who facilitated meeting discussions, and the Chronic Condition and Disease Management CS co-chairs were Dheeraj Mahajan and David Seidenwurm. The MACRA Episode-Based Cost Measure Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties.[4]

Stakeholders 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 stakeholder input. Mirroring National Quality Forum practices, the threshold for recommendations was >60% consensus for poll responses. This document summarizes the workgroup members' input from both the discussion as well as the polls.

[4] For a list of Diabetes workgroup members in Wave 3, please download the MACRA Episode-Based Cost Measures Measure-Specific Workgroup Composition (Membership) List available on the MACRA Feedback Page (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-workgroup-comp-list.pdf).

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 on assigning clinically-related services to the episode group and reviewing risk adjustment variables and exclusions. Additionally, there is a subsection for the session on the potential impact of COVID-19 on the Diabetes measure.

2.1 Assigning Services to the Episode Group

The workgroup discussed whether or not to assign services that were suggested by stakeholders during field testing and revisited other services that the workgroup was unable to reach consensus on during the SAR webinar. Section 2.1.1 summarizes the discussion on how to assign post-acute care (PAC) services to an episode, and Section 2.1.2 summarizes the discussion on assigning diabetes self-management and education, medical nutrition therapy, and orthotics services to the measure.

2.1.1 Discussion of Post-Acute Care Services

During the meeting, workgroup members revisited questions from the SAR webinar on how PAC services should be assigned to a Diabetes episode. Acumen provided an overview of the field testing feedback received on PAC services. Acumen explained that currently, the chronic condition episode-based cost measures cap costs from Skilled Nursing Facility (SNF) stays at 30 days, and cap costs from Long-Term Care Hospital (LTCH) and Inpatient Rehabilitation Facility (IRF) stays at the 90th percentile of grouped claim cost. The reason for these different capping methods is that while SNF stays are paid at a per diem rate and are thus based on the number of days, LTCH and IRF stays aren't paid at a per diem rate. Instead, IRF uses a pre-determined payment for resources furnished during each stay in an IRF, and LTCH is paid based on the Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) of the stay.

The workgroup began by discussing the 30-day cap for SNF stays. While some members agreed with the current cap, others expressed concerns that the 30-day period is too long and suggested that the cap be lowered to 21 days, which is the median length of stay in SNFs. One concern was that having an episode with a 30-day SNF stay could heavily impact a provider's measure score, especially for small clinician groups with only a few clinicians. There were also concerns that attributed clinicians may not always directly influence the length of SNF stays as longer stays are often the result of SNF-level decisions. Comments were also made that direct complications of diabetes can usually be managed in 2-3 weeks. Acumen noted that while having PAC stays adds a lot of spending at the episode level, the aggregate impact of these stays at the provider level on cost scores is much less once providers reach the case minimum of 20 episodes, reducing the impact of outlier costs. Further, the measure has demonstrated that it can accurately predict high-cost episodes and that the higher resulting expected costs for episodes with PAC stays ensure that a provider's observed to expected cost ratio isn't disproportionately impacted by these stays.

Workgroup members also discussed the 90th percentile cap for LTCH and IRF stays. A few members expressed concerns that capping costs at the 90th percentile of the distribution of grouped claim cost is too high and proposed alternative caps, including 50%, 75%, and 80%. One concern was that a lot of the cost from LTCH and IRF stays aren't under the control of the

attributed clinician. Another concern was that clinicians can be obligated to keep high revenue-generating patients in these PAC settings for longer periods due to facility or health system requirements. In response to this concern, another workgroup member noted that payment in LTCHs and IRFs are based on the DRG of the admission, so if the stay is longer than what's recommended, the facility will incur those extra costs.

Key Takeaways from Discussion and/or Polls for PAC Services:

- While some members recommended lowering the cap on SNF stays from 30 days to 21 days, poll results indicated that the workgroup was unable to reach a consensus on this topic. In the absence of consensus and taking into account the Asthma/COPD workgroup's recommendation to continue to cap costs from SNF stays at 30 days, the Diabetes measure will continue to cap costs from SNF stays at 30 days to ensure consistent assignment of PAC costs across the chronic condition measures.
- While some members recommended that the cap on LTCH and IRF stays be set at a lower percentile, poll results indicated that the workgroup agreed to continue capping costs from LTCH and IRF stays at the 90th percentile of the cost distribution.

2.1.2 Discussion of Assigned Services

During the meeting, workgroup members provided input on additional service assignment rules, including services related to (i) diabetes self-management education and support (DSMES) and medical nutrition therapy, and (ii) orthotics. For DSMES and medical nutrition therapy, Acumen shared field testing feedback received on these services. Patient Family Centered Care Partners (PFCCpartners) provided additional context for the feedback received from person and family representatives, adding that their comments were mostly focused on how culturally-relevant education should be delivered to patients with diabetes. Workgroup members agreed on the importance of including these services, and further discussed the promotion of culturally-relevant services and inclusion of peer-to-peer and related telehealth services for patients with diabetes. In particular, workgroup members highlighted that the current assigned services focus on those provided in a clinical setting and don't account for services provided via telehealth. Given that more patients are receiving remote care because of COVID-19, a few members agreed that continuing remote payments after the public health emergency will allow this care to be delivered to rural communities. Additionally, workgroup members noted that these culturally-relevant services highlight the importance of linking cost and quality measures.

The workgroup also briefly discussed assigning orthotics (e.g., after amputation) to the measure. Acumen explained that during the SAR webinar, when asked if orthotics should be assigned to the measure, the workgroup was unable to reach a consensus on this question. In the absence of consensus, services related to knee, ankle, and foot orthoses, and the aftercare and maintenance associated with these orthotics were assigned to the measure. During this meeting, one workgroup member said that we should exclude orthotic costs, because while orthotics are related to diabetic complications, it may be difficult for an attributed clinician to influence the type of orthoses used.

Key Takeaways from Discussion and/or Polls for Assigned Services:

- Workgroup members unanimously agreed with the current set of services related to DSMES and medical nutrition therapy and suggested no additional services.
- Workgroup members were unable to reach a consensus on whether orthotics should continue to be assigned to the measure. In the absence of consensus, the measure will continue to include the current orthotics codes.

2.2 Reviewing Risk Adjustment Variables

The workgroup discussed whether or not to include certain risk adjustors that were suggested by a stakeholder during field testing. Acumen provided an overview of the stakeholder's comment, which suggested that proteinuria and albuminuria should be added as risk adjustors to the measure's risk adjustment model. During the meeting, members agreed that the measure shouldn't separately risk adjust for patients with proteinuria and/or albuminuria. This is because the base risk adjustment model with hierarchical condition categories and appropriate diagnoses will already capture these conditions with nephropathy codes. One workgroup member added that these are 2 nonspecific ways to indicate renal disease and that many patients with diabetes have a little bit of proteinuria.

Key Takeaways from Discussion and/or Polls for Risk Adjustors:

- Workgroup members agreed that we shouldn't separately risk adjust for patients with proteinuria and/or albuminuria.

2.3 Reviewing Exclusions

During the meeting, one workgroup member suggested that the measure should exclude patients with serious mental illness (i.e., uncontrolled schizophrenia, uncontrolled bipolar disorder, and suicidal depression). The member said that patients with diabetes who have an uncontrolled mental or behavioral health condition may have altered diabetes management. For example, patients with diabetes may be taken off insulin because hypoglycemic agents can be used for suicide. A few members agreed that the measure should exclude patients with serious mental illness because it's difficult to manage these patients' diabetes, but that this exclusion should be restricted to those with the most severe diagnoses because many older beneficiaries have a depression diagnosis.

Key Takeaways from Discussion and/or Polls for Exclusions:

- While several workgroup members agreed with excluding patients with an uncontrolled severe mental illness, poll results indicated that members were unable to reach a consensus on this proposed exclusion. In the absence of consensus, the measure won't exclude episodes with these patients.

2.4 Potential Impacts of COVID-19 on Cost Measures

In this session, workgroup members had an open discussion regarding the potential impacts of COVID-19 on the measure specifications and related considerations. Members focused the conversation on whether to exclude patients with COVID-19, especially those that require hospitalization due to COVID-19. Some members cautioned that this exclusion shouldn't extend to everyone who has had a COVID-19 diagnosis (particularly a remote history of diagnosis), as it's likely that the majority of the population will have the virus at some point. Further, one workgroup member asked whether COVID-19 will be relevant when the measure is put into use and questioned the need to create an exclusion if it will rarely be applied, assuming that there are fewer acute cases present at the time it's being used. Acumen noted that since CMS is still collecting data on COVID-19, these changes likely won't be able to go into the measure specifications. Lastly, one workgroup member highlighted that some COVID-19 treatments (i.e., high-dose steroid treatments) may affect a patient's diabetes management.

2.5 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the PFTR Webinar Poll to gather input from members on the discussions held during the webinar. The survey also consisted of open comment boxes to provide additional thoughts

on quality measure alignment, future refinements based on potential impacts of COVID-19, and a space to share additional comments. Acumen will operationalize input for the measure specifications based on PFTR Webinar Poll results and will follow up with workgroup members with more information about the final 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 PFTR webinar. Section 3.3 provides a recap of concepts of the measure development process presented by Acumen. Section 3.4 provides a recap of the main concepts of the chronic condition cost measure framework 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 one week prior to the meeting and outlined the topics and process used for the webinar
- Diabetes Field Testing Feedback Summary, which provided the feedback received during field testing and the discussion topics and questions for the measure that were discussed at the webinar
- Investigation workbooks sent one week prior to the meeting, which presented detailed findings from empirical analyses:
    - An updated Sub-Population Summary Investigation Workbook, which provided updated data on the frequency and cost associated with an updated set of sub-populations, as recommended by the workgroup during the August 2019 in-person meeting and January 2020 SAR webinar
    - An updated Candidate Services Over Time Investigation Workbook, which contained updated information on frequency and cost of up to 300 of the most commonly performed services after a trigger event to inform discussions on service assignment and included the share of episodes where the service was assigned based on the service assignment rules

The materials shared were based on analyses run on triggering methodologies with the field testing version of the trigger codes and specifications, which were developed based on input from the August 2019 workgroup in-person meetings and January 2020 SAR webinars.

3.3 Overview of Cost Measure Development

At the beginning of the meeting, Acumen presented a very brief introductory session as a refresher on the following topics:

- The activities done to date since the previous convening of the workgroup, including the national field testing
- The goals of the meeting, including a session to gather workgroup members' thoughts on potential impacts of COVID-19 on measure specifications
- A recap on the different sources of information for the workgroup to consider in addition to their clinical expertise, including analyses and data, as well as the stakeholder input from field testing and the Person and Family Questionnaire

3.4 Overview of Chronic Condition Cost Measure Framework

Acumen also presented a brief introductory session on the chronic condition cost measure framework by revisiting key components and terms initially discussed during the workgroup in-person meeting, including:

- Trigger event – identifies the start or continuation of a clinician group's management of a patient's chronic disease, and is a pair of services (trigger claim and confirming claim) billed by a clinician group practice within 180 days of one another
- Attribution window – the period during which the patient's chronic care will be monitored by a clinician group, beginning from the point of the trigger claim
- Reaffirming claim – the service identified during an attribution window that reaffirms and extends a clinician group's responsibility managing a patient's chronic disease
- Total attribution window – the period that begins with the trigger claim and concludes a year after the final reaffirming claim, which can span multiple years and vary in length for different patients
- Episode – the portion of the overall time period of a clinician's or clinician group's responsibility for managing a patient that is assigned to a performance period in which it ends
- Performance period – a static year-long period (calendar year) in which a clinician or clinician group will be measured
- Service assignment – services and their associated costs that are clinically related and are under the reasonable influence of the attributed clinician or clinician group that are assigned during the episode window
- Risk adjustment – aims to facilitate a more accurate comparison of cost across clinicians or clinician groups by adjusting for factors outside of the clinician's reasonable influence that can impact spending
- Measure score calculation
    - First, the ratio of each episode's winsorized annualized standardized observed cost to annualized expected cost is calculated.
    - Then, the measure is calculated as a weighted average of these ratios across all attributed episodes, where the weighting is each episode's number of assigned days.
    - Finally, the weighted average episode cost is multiplied by the national average winsorized annualized observed episode cost to generate a dollar figure for the cost measure score, where a measure score of greater than one indicates that a clinician is more expensive than predicted and a measure score of less than one indicates that a clinician is less expensive than predicted.

Please contact **Acumen MACRA Clinical Committee Support** at macra-clinical-committee-support@acumenllc.com if you have any questions. If you are 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.