Kidney Transplant Management Post-Field Test Refinement (PFTR) Webinar Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, March 24, 2023
April 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 5, we obtained input on candidate clinical areas and episode groups through a public comment period from February 18, 2022, to April 1, 2022.[2] This approach provided flexibility for a wider range of interested parties to participate around their schedule. The prioritization criteria used to identify strong candidate episode groups and concepts were developed based on input from our technical expert panel (TEP), Person and Family Engagement (PFE), Clinical Subcommittees (CS), and Clinician Expert Workgroups ("workgroups"). The following Wave 5 episode groups were finalized based on the prioritization criteria, public comments received, and discussions with CMS: (i) Kidney Transplant Management, (ii) Rheumatoid Arthritis, and (iii) Prostate Cancer. In addition to Wave 5 of cost measure development, which is currently underway, Acumen is developing cost measures for Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD).

We held a nomination period for workgroup members between June 3, 2022, and July 1, 2022. The workgroups are composed of clinicians with expertise directly relevant to the selected

[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 public comment period, refer to the Wave 5 Measure Development Public Comment Summary Report (https://www.cms.gov/files/document/wave-5-public-comment-summary-report.pdf).

episode groups. Workgroups (of about 15-20 members) were finalized in July 2022, and they provided detailed input on the development of the selected episode groups during their first workgroup webinars from July 26 to 28, 2022. Acumen convened the workgroups again for a Service Assignment and Refinement (SAR) Webinar to revisit the specifications recommended during the workgroup webinar and refine the measures prior to national field testing. After the national field test from January 17, 2023, to February 14, 2023, Acumen convened the workgroups for a Post-Field Test Refinement (PFTR) Webinar to continue measure specification and refinement discussions in March 2023. For Wave 5, all workgroup meetings were held virtually.

Kidney Transplant Management PFTR Webinar, March 24, 2023

This meeting summary document outlines the purpose, discussion, and recommendations from the Kidney Transplant Management 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 Kidney Transplant Management PFTR Webinar on March 24, 2023, were the following:

(i) Review feedback on the measure from the national field test
(ii) Provide input to specify the cost measure for potential use in MIPS that can accurately distinguish between good and poor performance among clinicians in terms of cost efficiency
(iii) Consider results of empirical analyses and the Person and Family Partner (PFP) findings
(iv) Provide input on incorporating information about kidney quality, risk adjusting for transplant failure, excluding belatacept (an anti-rejection drug), and increasing the minimum number of days between a trigger and confirming claim ("minimum trigger gap") in the chronic condition measure framework as it relates to Kidney Transplant Management

The meeting was held online via webinar and attended by 11 of the 14 workgroup members. The webinar was facilitated by Acumen moderators, Kevin Erickson and Laurie Feinberg. The Kidney Transplant Management workgroup chair was Krista Lentine, who also facilitated meeting discussions. Derek Forfang and Keisha Payton were the PFPs that attended the webinar to discuss and address questions regarding the PFP findings. The MACRA Episode-Based Cost Measure Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties; it's available on the MACRA Feedback Page.[3]

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 polled on their preferences to ensure the measures are developed based on well-documented input. Based on similar meeting discussion practices, the

[3] CMS, "MACRA Episode-Based Cost Measures Wave 5 Clinician Expert Workgroup Composition (Membership) List" (https://www.cms.gov/files/document/wave-5-workgroup-comp-list-922.pdf).

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 subsection summarizes the PFP findings discussed during the webinar. The remaining subsections describe workgroup member discussions and recommendations on risk adjustment methods, accounting for transplant failure aversion, whether or not to include belatacept (an anti-rejection drug), and modifying the minimum trigger gap. The final subsection 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 that would inform cost measure development for Kidney Transplant Management, in addition to receiving comments from the PFE field testing survey. During the webinar, 2 PFPs shared these findings and fielded questions from the workgroup members.

The PFE survey feedback supported aspects of the measure's specifications, including the mix of specialties seen through attribution testing as part of their care team. Services that were particularly helpful included lab tests, medication management, durable medical equipment (DME), patient education, and virtual appointments.

Some commenters raised concerns related to the treatment of cases with delayed graft function, which may have higher costs due to the recipient's medical complexity or difficulty in placing these kidneys; commenters noted the importance of not disincentivizing clinicians for treating these types of scenarios. Some feedback included suggestions to add risk adjustors for dual eligibility in both Medicare and Medicaid and for acute kidney injury hospitalization to the measure.

PFPs summarized the challenges of prolonging kidney function, which requires extensive support. PFPs shared their experiences with returning to dialysis, the extreme emotional turmoil associated with it, the stress of managing expectations from kidney donors, and the long wait times until receiving a subsequent transplant. PFPs felt they might have done better if there was a social worker or therapist who could help them manage the emotional toll of returning to dialysis. Several PFPs noted difficulty managing the disease and with their access to treatment medications. Care coordination was also highlighted as a challenge by the PFPs, especially for medication management, and it was noted that the responsibility for coordinating between clinicians largely falls to patients and their family members; changes in medication were often delayed due to this coordination burden. PFPs also mentioned some comorbidities that can complicate transplant management, such as diabetes, chronic fatigue, or high blood pressure.

Members asked questions to understand more about the PFPs' experiences during the transplant, the transparency of communication in patient-clinician interactions as they progress into dialysis, care coordination, and overall access to transplant medication. The PFPs emphasized that having the same care coordination team for longer periods of time has been helpful. One of the PFPs also shared how access to transplant medication has been extremely

challenging as a patient with Type 1 diabetes. Having a dietician or nutritionist post-transplant was highlighted as helpful.

2.2 Risk Adjusting for Kidney Quality

Interested parties have commented throughout the development process that the quality of a transplanted kidney affects the costs of managing that transplant and should be accounted for in the measure. They've suggested factors, including whether the donor is living or deceased, the Kidney Donor Profile Index (KDPI), Hepatitis C donor status, human leukocyte antigen (HLA) immune-incompatibility, ABO blood type incompatibility, and high sensitization.

While this information isn't available in claims data, it's captured in registry data. Workgroup members reviewed and discussed analyses. There was general agreement among workgroup members that using registry kidney quality data in risk adjustment would be useful for fairly comparing clinicians' costs.

Key Takeaways from Discussion and/or Polls for Risk Adjusting for Kidney Quality:

- Members were in favor of risk adjusting for factors affecting kidney quality.

2.3 Transplant Failure

The current Kidney Transplant Management measure risk adjusts for episodes ending in transplant failure, with the aim to neutralize higher costs observed around kidney failure, as episodes that end in kidney failure are rare and more expensive than overall episodes. Though less than 1% of all episodes end in renal failure, the mean risk-adjusted episode cost for episodes that end in renal failure is significantly more expensive compared to the mean risk-adjusted cost for all episodes. Previous workgroup discussions suggest that monitoring is often the best way to treat potential kidney failure, while in some cases, hospitalization may be necessary to prevent it.

The workgroup's discussion revolved around 3 questions prompted by field testing comments and other considerations: (i) whether or not to continue risk-adjusting for episodes ending in transplant failure, (ii) whether or not it's possible to reliably identify hospitalizations that avert transplant failure from claims data, and (iii) whether or not to extend the post-surgery exclusion to be longer than 90 days, and whether this extension would help to exclude expensive services that avert transplant failure. One workgroup member responded by discussing the challenges of accurately accounting for all the costs involved in preventing and treating transplant failure, as different clinicians may treat patients differently. Acumen suggested that the workgroup could consider whether or not to risk adjust for prior rejection, as workgroup members agreed that managing rejection is critical for this measure cohort. There was a discussion on how this might interact with costs assigned to episodes, specifically on whether or not rejections that happen later should be included. Members considered whether a post-surgery exclusion longer than 90 days could exclude expensive individual services that might prevent transplant failure, but were ultimately in favor of keeping the post-transplant surgery exclusion at the current length of 90 days.

Key Takeaways from Discussion and/or Polls for Transplant Failure Topics:

- Members recommended to keep risk adjusting for episodes ending in transplant failure.
- Members recommended to keep the post-transplant surgery exclusion at 90 days.
- Members were in favor of Acumen conducting further investigation on the potential impact of risk adjustment for prior transplant rejection treatment.

2.4 Transplant Medication (Belatacept)

The workgroup also discussed a field testing comment expressing concerns about including belatacept, a high-cost drug with long-term benefits for graft survival, in the measure. Acumen's analysis indicates that the drug is used in approximately 4% of episodes and costs approximately $22,000 annually for patients who use it. The commenters' concerns about belatacept centered around the idea that including its costs could create a disincentive for its use. During the workgroup discussion, workgroup members considered excluding its costs from service assignment or risk adjusting for episodes with belatacept. Ultimately, workgroup members generally concluded that it's difficult to carve out belatacept from service assignment alone without the consideration of other similar drugs, agreeing not to make changes to service assignment, and the group considered whether to implement a method of risk adjustment for the drug but ultimately did not recommend to add a risk adjustor.

Key Takeaways from Discussion and/or Polls for Transplant Medication (Belatacept):

- Members weren't in favor of adding a risk adjustor around belatacept.

2.5 Minimum Trigger Gap Window

Members engaged in discussions regarding increasing the minimum number of days between a trigger claim and a confirming claim from the 1-day minimum (informally the "minimum trigger gap"). For reference, the measure construction logic for the Kidney Transplant Management measure states that an episode is triggered if a confirming claim occurs between 1 and 180 days after a trigger claim. A workgroup member in a prior meeting brought up the rationale that clinicians who only see a patient once could be attributed the ongoing measure. For example, under the default framework, if a clinician has a patient visit on day 1, and then a test done on day 2, this would be considered 2 separate encounters and would trigger an episode. Because of this, the member was interested in reviewing testing results based on increased minimum trigger gaps to evaluate the impacts. From the results that Acumen produced and shared during the workgroup meeting, increasing the minimum trigger gap would likely have minimal effect on the overall number of episodes triggered. This topic was also discussed with the CKD/ESRD workgroup, given that changes to this specification would likely impact those measures as well as other measures.

The workgroup considered these results and discussed the possibility of considering a larger minimum than the current 1-day minimum. Evaluating the options of 2, 7, and 14 days that were tested in Acumen's analysis, one member also expressed interest in a 30-day gap. Overall, most members agreed that increasing the minimum gap between claims would likely have minimal effect.

Key Takeaways from Discussion and/or Polls for Minimum Trigger Gap Window:

- Members recommended retaining the current default minimum trigger gap of 1 day for all measures.

2.6 Next Steps

In the last session, Acumen provided a wrap-up of the discussion and 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. Acumen will operationalize input for the measure specifications based on PFTR Webinar discussion and 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 workgroup webinar. Section 3.3 provides a recap of concepts of the measure development process presented by Acumen.

3.2 Overview of Meeting Materials

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

- Agenda and Slide Deck outlined the topics and process used for the webinar, including embedded empirical analysis results.
- Investigation workbooks sent prior to the meeting, which presented detailed findings from empirical analyses:
    - A Sub-Population Analysis, which provided data on the frequency and cost associated with a set of sub-populations informed by public comments received, prior workgroup discussions, and deliberations among the Acumen clinical team
    - Service Utilization over Time Analysis, which lists the top 200 most frequent services for each claim setting across episodes for the draft version of the measure along with various metrics regarding those services (e.g., share of episodes with that service, average cost of the service per episode, share of attributed clinicians who furnished the service).

The materials shared were based on analyses run on draft measure specifications that the Acumen clinical team created, based on input from the previous meetings, field testing feedback, and discussions with CMS.

3.3 Overview of Cost Measure Development

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

- The activities done to date for the development of episode-based cost measures, including the Wave 5 measure development public comment period
- The goals of the meeting and timeline of activities for Wave 5
- A recap of applicable background and context related to the cost measure, framework items, and information from the previous meetings