Listening Session: Episode-Based Cost Measure Development

April 5, 2017

Feedback Session Information

- Feedback will be accepted after the presentation portion of today's webinar through the chat box and on the phone line.
  - Use the phone number provided later in the webinar to provide feedback by phone.
- The slides from today's presentation are available online here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html
  - The recording and transcript from the webinar will be posted on the same page in the next week or so.
- If you have questions about the Quality Payment Program that are not related to cost measure development, please contact: qpp@cms.hhs.gov or 1-866-288-8292.
- The December 2016 Posting is on the MACRA Feedback page under the heading "Help us learn from you": https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html
- Information about the Call for Clinical Subcommittee Nominations can be found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TechnicalExpertPanels.html
- Email additional comments on the draft list of episode groups and trigger codes to: macra-episode-based-cost-measures-info@acumenllc.com.

Topics

- Introduction
- What is a Cost Measure?
- Opportunities for Stakeholder Engagement
- Feedback Session

Introduction

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The Quality Payment Program

- The Quality Payment Program policy reforms Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

Advanced Alternative Payment Models (APMs)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

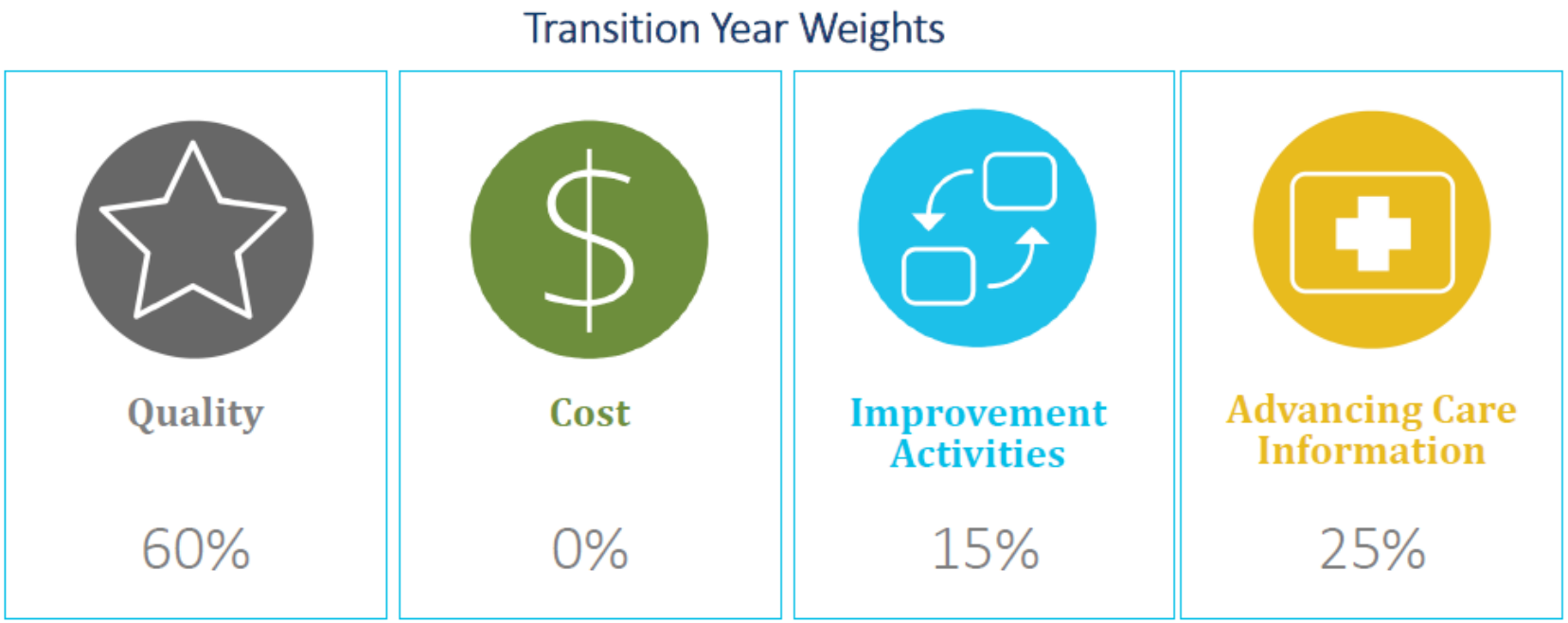
What is the Merit-based Incentive Payment System?

Performance Categories

- Moves Medicare Part B clinicians to a performance-based payment system
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
- Reporting standards align with Advanced APMs wherever possible

What are the Performance Category Weights?

- Weights assigned to each category based on a 1 to 100 point scale



Note: These are default weights; the weights can be adjusted in certain circumstances

Cost Measure Development

- Builds upon December 2016 posting for public comment that included:
  - (i) Paper describing approach to cost measure development, and
  - (ii) Draft list of episode groups and trigger codes
- Today we will cover:
  - What is a cost measure?
  - What role do stakeholders have in developing cost measures?
- At the end of the presentation, we will offer a forum for stakeholder feedback

What is a Cost Measure?

Five essential components of cost measures

Relationship between cost measures and episode groups

What is a Cost Measure?

- Represents the Medicare payments for the medical care furnished to a patient during an episode of care
- Based on episode groups that:
  - Identify items and services furnished in addressing a condition
  - Serve as a unit of comparison
  - For example, an episode group for meniscus repair identifies care services furnished for this procedure and enables comparison of clinicians providing these services
- Informs clinicians on the costs of their patients' care for which they are responsible
- Can be aligned with quality of care assessment so that patient outcomes and smarter spending can be pursued together
- Calculated using Medicare claims data so no additional data submission is required (i.e., no additional clinician burden)

Components of a Cost Measure

1. Defining an episode group
2. Assigning costs to the episode group
3. Attributing episode groups to clinicians
4. Risk adjusting episode groups
5. Aligning cost with quality

Component 1: Defining an Episode Group

- An episode group focuses on clinical conditions requiring treatment (the condition itself or procedures to treat the condition)
  - Example: a procedural episode group that is surgical in nature could include: pre-operative services, surgical procedure, anesthesia, follow-up care, services related to complications, readmissions
- An *episode* is a specific instance of an *episode group* for a given patient and clinician
  - Example: A clinician might be attributed 20 *episodes* (instances of the episode group) from the *episode group for heart failure* in a year
- Can vary in scope (e.g., narrow and precise or broad and general)
  - Example: An episode group for cataract removal with insertion of intraocular lens prosthesis has a narrow scope. In comparison, an episode group for gastrointestinal hemorrhage has a broad scope.
- Can be divided into sub-groups to define more homogeneous patient cohorts
  - Example: Gastrointestinal hemorrhage may be divided into sub-groups for upper and lower gastrointestinal hemorrhage
- Three types of episode groups in December posting:

1. Acute Inpatient Medical Condition
2. Chronic Condition
3. Procedural

Component 2: Assigning Costs to the Episode Group

- Assignment of items and services determines what is included in episode costs and depends on role of attributed clinician
- Episode window determines the period of time during which claims are eligible to be assigned to the episode

Items and Services that Are Assigned to the Episode Group

Direct Services

Provided by the attributed clinician

Indirect Services

Provided or ordered by other clinicians in the same clinical context

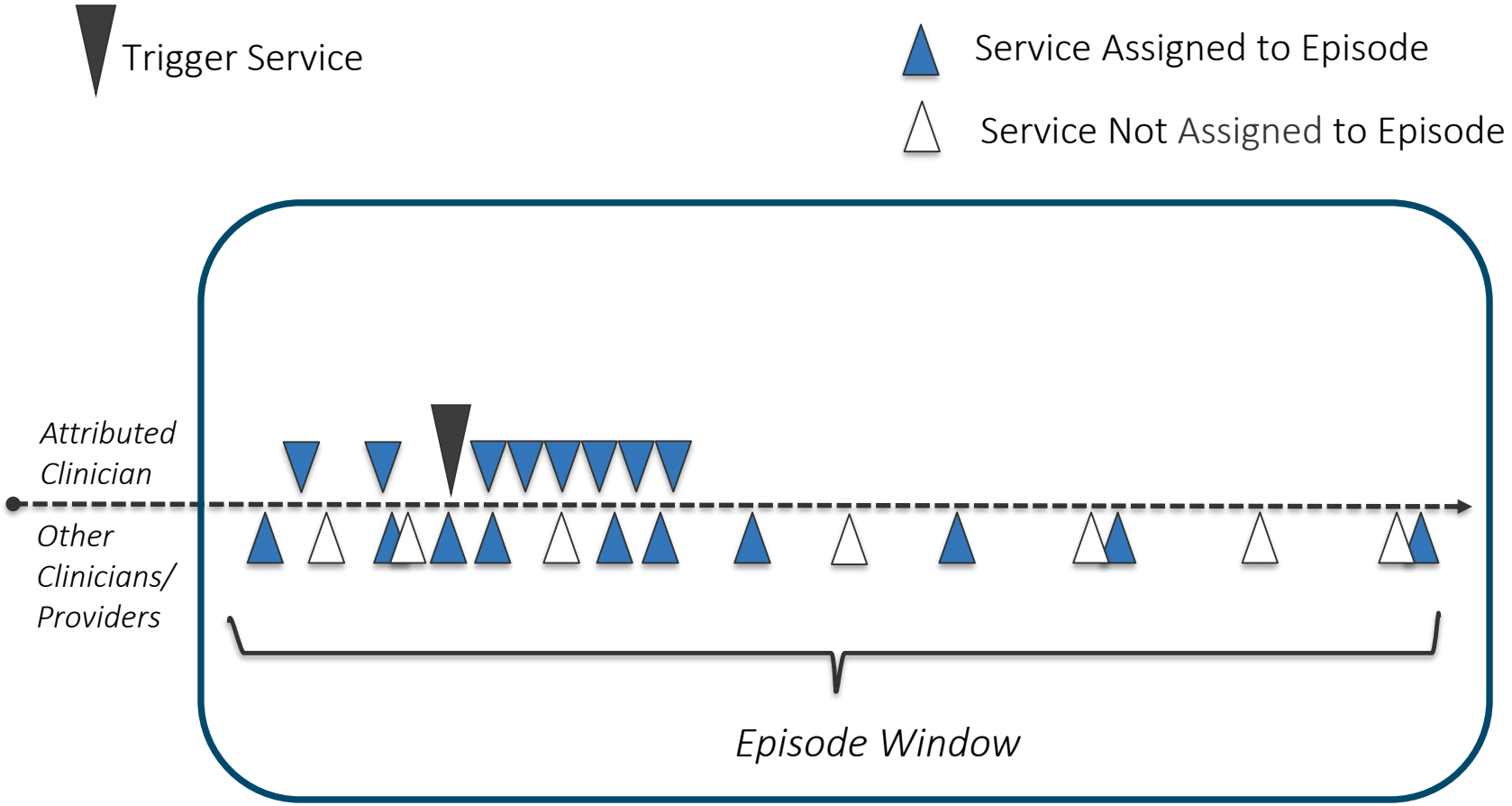
- Post-acute care
- Ancillary care
- Consequences of care (e.g., complications)

Items and Services that Are Not Assigned to the Episode Group

Unrelated Services

Unrelated to the clinical management of the patient's condition or procedure that is the focus of the episode group

Elements of an Episode of Care for a Given Patient and Clinician



Component 3: Attributing Episode Groups to Clinicians

- Attribution is the assignment of responsibility for an episode of care to a principal (or managing) clinician
- Attribution should be transparent to clinicians and only hold them responsible for outcomes they can reasonably be expected to influence
- Patient relationship categories and codes being developed under MACRA can be used in conjunction with claims-based rules for attribution

Development Timeline for Patient Relationship Categories and Codes

Component 4: Risk Adjusting Episode Groups

- Adjusts for factors outside the clinician's control that can influence cost
  - Age, comorbidities, illness stage/severity, other aspects of patient's clinical history
- Aims to avoid penalizing clinicians who treat unhealthy or complex patients
- Selection of risk adjustment method will be informed by analyses, technical expert panels, clinical committees, and public comment

Component 5: Aligning Cost with Quality

- Alignment with indicators of quality is necessary to compensate for information not adequately captured by episode costs
- Quality assessments might include:
  - Complications, rehospitalizations, unplanned care and other consequences
  - Outcomes of care
  - Overuse, underuse, misuse
  - Processes of care
  - Functional status of patient
  - Patient experience

Opportunities for Stakeholder Engagement

Stakeholder Input Gathered to Date

Postings Related to Existing CMS Episode Groups (Method A and B)

- CMS Episode Groups Posting (October 2015)
- Supplemental CMS Episode Groups Posting (April 2016)

Rulemaking

- Quality Payment Program Proposed Rule (May 2016)
- Quality Payment Program Final Rule with Comment Period (November 2016)

Technical Expert Panel (TEP)

- Serves a high-level advisory role and provides guidance on overall direction of measure development
- Includes representatives from specialty societies, academia, healthcare administration, and patient advocacy organizations
- Meetings in August 2016, December 2016, and March 2017

Clinical Committee

- Makes recommendations about clinical specifications for episode groups
- Initial input activities occurred in August-September 2016
- 70+ clinical experts from 50+ professional societies
- Provided expert input to develop draft list of episode groups and trigger codes

Posting Related to Cost Measure Development

- December posting of cost measure development paper and draft list of episode groups and trigger codes
- Public comment period closing April 24, 2017

Key Points from Prior Stakeholder Feedback

- **Defining episode groups** and cost measures must yield actionable information that can guide improvements to patient care
- **Assignment of costs to episode groups** should only hold clinicians accountable for patient outcomes that are within the scope implied by their clinical role
- **Attribution** of claims and episodes to clinicians should be clear and credible at the time of service
- Cost measures should account for patient complexity through appropriate **risk adjustment**
- Cost measures must be **aligned with quality measures**
- Broad **stakeholder feedback** is crucial to the development and implementation process

Cost Measure Development Approach Directly Incorporates Stakeholder Input on Every Component

- Defining an episode group:
  - ☑ TEP #1: Provided guidance on essential concepts for defining an episode group
  - ☑ Clinical Committee #1: Identified conditions/procedures for episode groups, selected trigger codes
  - ☐ Clinical Subcommittees: Will review and refine draft list of episode groups and trigger codes
- Assigning costs:
  - ☑ TEP #2: Provided input on approaches for assigning costs to episode groups
  - ☐ Clinical Subcommittees: Will select which claims are counted in episode costs
- Attributing to clinicians:
  - ☑ TEP #2: Provided feedback on potential rules for attributing episode groups to clinicians
  - ☐ Clinical Subcommittees: Will recommend rules to assign clinician responsibility for episodes
- Risk adjusting:
  - ☐ Future TEP: Will provide feedback on potential risk adjustment approaches
  - ☐ Clinical Subcommittees: Will identify relevant patient characteristics for use in statistical models
- Aligning with quality:
  - ☑ TEP #1 and #3: Provided feedback on approaches for aligning of cost and quality
  - ☐ Clinical Subcommittees: Will share feedback on aligning cost and quality

Opportunity to Provide Input on December 2016 Posting

- CMS currently seeking comment on:
  - A document outlining the approach to cost measure development, including specific questions for stakeholder feedback
  - A draft list of care episode and patient condition groups and codes ("episode groups")
- Draft list incorporates stakeholder feedback on Component 1: defining an episode group
  - Detailed clinical review from a Clinical Committee, feedback from earlier postings relating to existing CMS episode groups, and a technical expert panel
- Draft list serves as a starting point for future development
- Comment period open until April 24, 2017

Upcoming Stakeholder Engagement Activities Build Upon Prior Feedback

- TEPs provide conceptual input on measure selection and specifications for all five components
- Clinical Committees provide detailed clinical input on the five components for each measure, with upcoming input focused on
  - Component 1: refining episode triggers from the December 2016 draft list
  - Component 2: recommending what services should be included in episode costs
- Clinical Committee will be structured into Subcommittees, with 7 Subcommittees starting activities this spring for procedural/acute inpatient medical condition episode groups:

Cardiovascular Disease Management	Gastrointestinal Disease Management – Medical and Surgical	Musculoskeletal Disease Management – Non-Spine	Neuropsychiatric Disease Management
Ophthalmologic Disease Management	Peripheral Vascular Disease Management	Pulmonary Disease Management	

Call for nominations is open until 4/24/17

- Future Clinical Committees will focus on additional procedural/acute inpatient medical condition and chronic condition episode groups

Feedback Session

Feedback Session Information

- Please dial **1 (866) 452-7887** to provide feedback in response to the discussion questions.
- If prompted, use Conference ID: **81331606**
- You can also provide feedback in the chat box.

Discussion Topics

1. Are the criteria proposed for prioritizing the development of episode groups (cost share, clinician coverage, opportunity for improvement and linkage to quality) appropriate? Are there other criteria to add? Are any of these criteria more important than others?
2. Should the focus of episode development be on comparing discrete events, such as acute hospitalizations or procedures? Alternatively, should the focus be on the clinical conditions for which those events occur? How can cost measure development take into account multiple options that might be available in the care of a particular clinical condition?
3. We intend to inform you on the resource use of each member of the clinical team. Direct and indirect service assignment enables one clinician's directly-performed services to be considered as another clinician's indirect services when performed in the same clinical context. How can this concept be used to determine accountability for each member of the clinical team as an alternative to the entire episode being attributed to a single clinician?

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Discussion Topics (cont.)

4. Considering the cost of clinical services needs to account for the effects of those services on the quality of care. What options are available now that enable consideration of quality? Also, what infrastructure improvements can be considered over time to improve the linkage between cost and quality?

5. Measuring the cost of caring for chronic conditions remains a challenge in terms of linking discrete services to specific clinical conditions when treating patients with multiple comorbidities. This challenge is compounded by the relative short time frame of episode windows compared to the ongoing nature of chronic conditions. How can we best overcome this difficulty and capture the cost of caring for chronic conditions?

6. How can cost measurement best account for medical complexity and other risk factors?

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