Quality Payment
PROGRAM

2023 Field Testing Feedback Summary Report for 5 Episode-Based Cost Measures:

- Chronic Kidney Disease (CKD)
- End-Stage Renal Disease (ESRD)
- Kidney Transplant Management
- Prostate Cancer
- Rheumatoid Arthritis

May 2023

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1.0 Introduction

1.1 Project Title

MACRA Episode-Based Cost Measures: 2023 Cost Measures Field Testing

1.2 Project Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program (QPP). QPP incentivizes clinicians to provide high-quality, high-value care through Advanced Alternative Payment Models (APM) or the Merit-based Incentive Payment System (MIPS). MIPS-eligible clinicians will receive a performance-based adjustment to their Medicare payments based on a MIPS final score that assesses evidence-based and practice-specific data in four performance categories: (i) quality, (ii) cost, (iii) improvement activities, and (iv) Promoting Interoperability.

CMS has contracted with Acumen, LLC, to develop new episode-based cost measures for potential use in the Cost performance category of MIPS. This work is under the contract, "Physician Cost Measures and Patient Relationship Codes (PCMP)" (contract number 75FCMC18D0015, Task Order 75FCMC19F0004). Acumen has implemented a measure development process that relies on input from several interested parties, including multiple groups of clinicians affiliated with a broad range of professional societies and Person and Family Partners (PFP), to develop clinically appropriate and transparent measures that provide actionable information to clinicians.

This document summarizes the feedback from interested parties on the five episode-based cost measures that were field tested as part of the measure development process from January 10 to February 14, 2023. Section 1.0 provides background on the measure development process and the five episode-based cost measures being developed. Section 2.0 summarizes the general feedback Acumen received on the episode-based cost measures and the field testing process. Section 3.0 provides more detailed feedback on each of the five episode-based cost measures that underwent field testing. Section 4.0 outlines the next steps for potential measure refinement based on field testing feedback.

1.3 Measure Development and Field Testing Overview

The Wave 5 episode-based cost measure development process started in 2022 (when Acumen gathered input from interested parties to help inform which measures to develop). This process continued through 2023, gathering input on measure specifications:

- The public comment period from February to April 2022 invited interested parties to provide feedback on prioritizing episode-based cost measures and preliminary specifications for several measure areas.
- Clinician Expert Workgroups that convened beginning in July 2022 provided clinical specifications for the episode-based cost measures.

The Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD) measures were first developed as cost-of-care measures for the Kidney Care First (KCF) Option in the Kidney Care Choices (KCC) APM. Acumen began respecifying these measures for use in MIPS in 2021 and continued to develop the measures in Wave 5 by reconvening the Clinician Expert Workgroup in 2022 to review the measures and provide input on potential refinements to the current specifications. For more detailed information on field testing and the episode-based cost measure development process, please refer to the MACRA Feedback Page.

Once the five episode-based cost measures were specified through clinician input, person and family engagement (PFE), public input, and empirical analyses, CMS and Acumen conducted field testing on the draft measures from January 17 to February 14, 2023. Field testing is a crucial part of the measure development process. It allows clinicians and other interested parties to learn about episode-based cost measures and provide input on the draft specifications.

During field testing, clinicians and clinician groups had the opportunity to view a Field Test Report on the QPP website with information about their performance. Field Test Reports were available to clinicians and clinician groups who had 20 or more episodes for at least one of the Wave 5 episode-based cost measures during the measurement period (1/1/2021 - 12/31/2021). The five episode-based measures undergoing field testing focus on the outpatient treatment and management of particular chronic conditions:

- Chronic Kidney Disease (CKD)
- End-Stage Renal Disease (ESRD)
- Kidney Transplant Management
- Prostate Cancer
- Rheumatoid Arthritis

Specifically, 533 clinicians and clinician groups downloaded a Field Test Report from the QPP website during field testing. 447 clinician groups (identified by Tax Identification Number or TIN) downloaded a report and 86 clinicians (identified by TIN-National Provider Identifier or TIN-NPI) downloaded a report.

For the duration of field testing, all interested parties were invited to provide feedback on the measures by completing an online survey or submitting a comment letter,[1] regardless of whether they received a report. Acumen and CMS made several materials publicly available for interested parties' review: (i) draft measure specifications, (ii) mock Field Test Reports, and (iii) supplemental documentation.[2] Acumen and CMS also hosted the MACRA 2023 Cost Measures Field Testing Webinar at the start of the field testing period to provide interested parties with details regarding the field testing process and draft measure specifications.[3]

Acumen also held 2 specialty society office hours before and during field testing to provide information about Field Test Reports and allow interested parties, including specialty societies who represent clinicians likely to be attributed the measures, to ask questions about field testing and the measure specifications.

Acumen received:

- A total of 16 comments through the 2023 Measure-Specific Cost Measure Field Testing survey, including 3 letters that were attached to a survey response.
- A total of 32 PFE Cost Measures Field Testing surveys, including 2 letters that were attached to a survey response.

The list of commenters who submitted feedback through the online field testing feedback surveys is provided in Appendix A. The feedback about each measure was shared with the

[1] The survey was previously available online at the 2022 Cost Measures Field Testing Feedback Survey (qualtrics.com).
[2] Field testing materials are available for download on the MACRA Feedback Page.
[3] MACRA 2022 Cost Measures Field Testing Webinar materials are available on the Quality Payment Program Webinar Library.

Clinician Expert Workgroups to help inform measure refinement recommendations after field testing. Acumen and CMS will also evaluate the general feedback on measure specifications, the measure development process, and field testing, and consider ways to improve future episode-based cost measure development processes.

2.0 General Feedback Summary

This section summarizes general feedback received on the episode-based cost measures. Section 2.1 summarizes feedback on the episode-based cost measures framework. Section 2.2 provides feedback on the field testing engagement approach. Section 2.3 summarizes feedback on the use of measures in MIPS.

2.1 Episode-Based Cost Measures Framework

2.1.1 Assignment of Costs

- A commenter expressed concern over including prescription drugs in the assignment of costs, stating that drug manufacturers and payers (e.g., CMS and Medicare Prescription Drug Plans) and not physicians negotiate formularies, coverage, and price. They felt that to hold physicians accountable for transactions they aren't responsible for negotiating is fundamentally problematic.
- The commenter was additionally concerned about including Part D drug costs in the measures. They felt that the COVID-19 pandemic affected the quality of data on MIPS scores for 2020 and 2021, and including these costs would complicate the measures, especially since the most recent feedback clinicians have received about cost performance dates to 2019.
    - They suggested that if CMS is going to include Part D costs in the measure, CMS should do so on an informational basis in the first year and report 2 rates: one with Part D costs and one without. They felt that introducing the new cost measures and Part D costs simultaneously could compound the potential to inadvertently penalize physicians for costs outside their control.

2.1.2 Risk Adjustment

- A commenter stated measures should be risk-adjusted for payment to avoid penalizing physicians that care for marginalized and minoritized communities.

2.1.3 Alignment of Cost and Quality

- Several commenters stated that they experienced issues with care coordination, including the ability to access electronic medical records, which affected the quality of care they received.

2.2 Field Testing Engagement Approach

- Commenters expressed appreciation for being able to provide feedback on the draft episode-based cost measures.
- A commenter stated that several field testing materials helped them understand the performance of the cost measures: mock field test reports and measure specifications. They noted any patient-level information and any ways to standardize test and metrics across measures were also helpful.

- One commenter expressed concern that the field test reports and measure specification documents were complicated to interpret for a typical physician so they can make actionable changes.
- A commenter stated that CMS should ensure there's a diverse sample of participants from both patient/family and physician populations during measure field testing.
    - Because Black, Indigenous, and Latinx people still are markedly underrepresented among physicians, they felt CMS should make extra efforts to seek out these physicians for comment.
    - Additionally, they noted that, with persistent inequities, CMS should make extra efforts to seek out patients from communities most impacted by these health issues for comment.
- A commenter suggested that the measures should be stratified for reporting based on demographics to highlight persistent disparities that need to be addressed.

2.3 Measure Reporting and/or Use in MIPS

- One commenter requested that CMS provide clinicians and clinician groups with available data on cost performance at least 2 times a year to help inform their care practice.

3.0 Measure-Specific Field Testing Feedback

This section includes the measure-specific feedback received on the five episode-based cost measures during the field testing period. The feedback was shared with the Clinician Expert Workgroups prior to the Post-Field Test Refinement (PFTR) webinars in March 2023 for their review as they considered potential refinements to the measures.

Each section provides detailed feedback on the Wave 5 episode-based cost measures. Section 3.1 summarizes feedback on the Chronic Kidney Disease and End-Stage Renal Disease measures. Section 3.2 summarizes feedback on the Kidney Transplant Management measure. Section 3.3 summarizes feedback on the Prostate Cancer measure. Section 3.4 summarizes feedback on the Rheumatoid Arthritis measure.

3.1 Chronic Kidney Disease and End Stage Renal Disease

3.1.1 Definition of an Episode Group

3.1.1.1 Episode Window

- Several PFE commenters noted that they saw their nephrologists and received CKD- and ESRD-related care in 3-month, 6-month, or annual frequency intervals, which fits within the 1-year attribution window to capture these services. Additionally, a commenter thought the episode windows were appropriate.
- One commenter noted that they didn't start seeing a nephrologist until they were diagnosed with acute kidney failure.
- One commenter agreed with the endpoints of the kidney care measures in relation to transition points of kidney care.

3.1.1.2 Subgroups

- A few PFE commenters noted the stage of CKD when they were first diagnosed, which could be subgrouped and distinguished from the risk adjustments of other CMS-

Hierarchical Condition Categories (HCC). This was confirmed by a separate comment about a patient who was diagnosed very late-term and had subsequently more intensive care.

3.1.1.3 Episode Triggering Logic

- One commenter found the trigger codes to be straightforward.

3.1.2 Attribution of the Episode Group to Clinicians

- Some of the PFE commenters noted their kidney care team clinicians, including:
  - Nephrologist
  - Case manager
  - Family internist/primary care provider (PCP)/general practitioner (GP)
  - Endocrinologist
  - Nurses
  - Nutritionist
  - Vascular specialist for placement of fistula for dialysis
- Several PFE commenters stated that a social worker was part of their care team, in addition to the normally attributed clinicians.
- One commenter stated that attribution for the CKD measure requires considering whether a PCP, a nephrologist, or a combination of the two will primarily oversee a patient's care. They noted that the specialist may not necessarily be part of the same clinical group as the primary care provider. They also added that management and goals of care might vary a lot based on the patient's overall medical condition, life expectancy, and willingness to consider dialysis or transplantation.

3.1.3 Assignment of Costs to the Episode Group

- Several PFE commenters stated that some various health support services were most influential on their care experience, including:
  - CKD peer support group therapy or sessions with current dialysis patients
  - Physical therapy (PT)
  - Home health aids
  - Mental health services
  - Appointments with a renal dietitian
  - Transplant and dialysis education classes

3.1.4 Risk Adjustment

3.1.4.1 Heart Conditions and Associated Care

- Several PFE commenters noted heart conditions that contributed to their renal system function and could be included in risk adjustment. These conditions and procedures are:
  - General cardiac conditions
  - Blood pressure control
  - Atrial fibrillation
  - Coronary artery disease
  - Triple heart bypass
  - Sleep apnea
  - Stroke
  - Hypertension

3.1.4.2 Other Variables

- PFE commenters suggested other factors to account for:
    - Below the knee amputations
    - Diabetes
    - Cancer
    - Hypoglycemia
    - Mental health conditions
    - Erectile dysfunction
    - Infertility
    - Other kidney related issues (e.g., kidney stones)
    - Non-medical factors that contribute to care (e.g., living conditions, transportation to medical appointments)
- PFE commenters who noted mental health conditions, seemed to experience variable care, lack of trust in care providers, and had issues maintaining medication consistency.
- A commenter agreed that an ESRD measure risk factor to account for dialysis crash starts would be appropriate, since these patients tend to have higher care costs.
- A commenter suggested acute kidney injury hospitalization as a risk adjuster, as it may not be preventable and would impact the course of the CKD measure.
- Another commenter noted that race and kidney function assessment calculations have historically disadvantaged Black patients. They voiced concern that the measure doesn't account for past use of a race-based formula and successor formulas, and the subsequent difference in costs for CKD and ESRD patients based on race.
    - They added that the Organ Procurement and Transplantation Network (OPTN) recently called for reassessing transplant waiting lists based on this issue, and could serve as a model to help avoid penalizing clinicians for factors which these old models have affected.

3.1.4.3 Risk Adjustment Model and Variables

- A commenter agreed with the current risk adjustment model and felt it would show that clinicians appropriately provide care based on patients' medical resource needs.
- Another commenter felt the transplant measure's social risk factor adjustment isn't comprehensive enough to counteract the costs and care outcomes of historically marginalized groups.
    - They noted they aren't confident that the MIPS complex patient bonus is sufficient to avoid unfairly penalizing physicians who care for a greater proportion of beneficiaries who are dually eligible for Medicare and Medicaid, as research[4] has shown these physicians have significantly lower MIPS scores.
    - Further, they have significant concerns that a recent study[5] found MIPS may be divorced from achieving meaningful clinical outcomes, and the commenter urged CMS to improve the measures and Cost performance category.

3.1.5 Exclusions

- A commenter suggested excluding patients with calciphylaxis from the CKD measure. This is a serious, uncommon disease in which calcium accumulates in small blood vessels of the fat and skin tissues, which can lead to death.

3.1.6 Alignment of Cost with Quality

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7489811/
[5] https://jamanetwork.com/journals/jama/article-abstract/2799153

- One PFE commenter was unsatisfied with the quality of care provided to their family member receiving dialysis care, given the cost. They found that care providers at various levels were indifferent to suggestions to improve care.
- A few PFE commenters discussed their care coordination. Most comments were positive and indicated that the patient had to instigate the coordination. Those dissatisfied with the coordination or advocacy provided to them felt that this negatively impacted their overall care quality and experience.
- Multiple PFE commenters stated that earlier detection of their disease would have prevented long-term damage, medication use, and procedure intensity. Early detection is also related to care costs, since timely diagnoses and management are usually associated with lower costs.

3.2 Kidney Transplant Management

3.2.1 Definition of an Episode Group

3.2.1.1 Episode Window

- One commenter was satisfied with the 90-day episode window.
- A group of PFE commenters noted their recoveries within the 1-year attribution window, post-transplant.

3.2.1.2 Subgroups

- PFE commenters shared a range of experiences which led them to need kidney transplants which could be used to subgroup the measure. These were:
    - Polycystic kidney disease
    - ESRD
    - Glomerulonephritis
    - CKD/ESRD combination
- A few PFE commenters also provided their donor type assignment: living or deceased.

3.2.1.3 Episode Triggering Logic

- A commenter found the trigger codes to be straightforward.

3.2.2 Attribution of the Episode Group to Clinicians

- Some of the PFE commenters noted their kidney care team clinicians, including:
    - Nephrologist
    - Case manager/transplant coordinator
    - Family internist/PCP/GP
    - Transplant surgeon
    - Endocrinologist
    - Nurses
    - Nutritionist
- A few PFE commenters included health care providers outside of renal specialties as a part of their care team for parallel health conditions affecting their renal care, including
    - PCP
    - Cardiologists
    - Ophthalmologists
    - Patient coordinator
    - Nurse
    - Obstetrics and Gynecology (OB-GYN)

    - Dermatologist
    - Gastroenterologist
    - Infectious disease specialist
    - Endocrinologist
    - Hematologist
- There were mixed PFE comments about the quality of care coordination and its effect on the care provided. The commenters felt that patient self-advocacy seems inevitable to maintain high levels of care coordination. Generally, the consistency of care coordination is lacking.

3.2.3 Assignment of Costs to the Episode Group

- A PFE attributed monthly labs for ensuring transplant failure didn't occur. Some other PFE commenters had noted labs were useful, but didn't note frequency.
- Several PFE commenters affirmed that lab testing, medication management, and durable medical equipment were used to improve their care. However, some commenters had to advocate for these improvements.

3.2.4 Risk Adjustment

3.2.4.1 Non-Renal Complications

- Several PFE commenters reported non-renal complications post-transplant and the ability to coordinate care across medical issues, including:
    - Atrial fibrillation
    - Cytomegalovirus
    - Chronic Irritable Bowel Syndrome
    - Plasmapheresis
    - Tacrolimus toxicity continuation from liver failure
    - Polycystic liver disease
    - Gall bladder issues
    - Enlarged prostate requiring transurethral resection
    - Warts
- A PFE commenter noted that convalescing conditions, such as the ability to rest, contributed to recovery/management.
- Another PFE noted that transportation was a hardship to maintain consistency with medical appointments. They found the COVID-19 PHE (Public Health Emergency) protocol of virtual appointments greatly reduced this burden.
- A PFE noted that they had a language barrier with their medical team which made it difficult to understand their care process and communicate.
- One commenter noted that patient groups with different comorbidities and illness severities, especially those without the financial resources to treat them prior to their kidney episode, are disincentivized from being treated under the current measure specifications.

3.2.4.2 Renal Complications

- Some PFE commenters reported on their transplant failure or success. A commenter also noted that tolerance to medications is just as critical as renal function post-transplant. This commenter had an adverse reaction to transplant medications, which caused vascular weakness and resulted in abdominal aneurysm. Another commenter required additional durable medical equipment to regulate and monitor blood sugar management, affected by transplant medications.

- A PFE noted that their recovery management was complicated and extended by a post-surgical hernia and gastrointestinal issues.
- A commenter suggested acute kidney injury hospitalization as a risk adjuster that may not be preventable and would impact the course of the transplant measure.

3.2.4.3 Risk Adjustment Model and Variables

- A commenter felt the transplant measure's social risk factor adjustment isn't comprehensive enough to counteract costs and care outcomes of historically marginalized groups.
    - They noted they aren't confident that the MIPS complex patient bonus is sufficient to avoid unfairly penalizing physicians who care for a greater proportion of beneficiaries who are dually eligible for Medicare and Medicaid, as research[6] has shown these physicians have significantly lower MIPS scores.
    - Further, they have significant concerns that a recent study[7] found MIPS may be divorced from achieving meaningful clinical outcomes, and urge CMS to improve the measures and the MIPS cost performance category.

3.2.5 Exclusions

- N/A

3.2.6 Alignment of Cost with Quality

- Several PFE commenters noted that quality of care was associated with how well their doctors listened and proactively communicated with them. Some PFE commenters felt their transplant could have been avoided if better renal care was provided up front. Others felt that their medical issues had been synergistically taken care of to improve overall health and wellness management.
- Some PFE commenters noted that support groups and patient education were useful in improving their quality of care.

3.3 Prostate Cancer

3.3.1 Definition of an Episode Group

3.3.1.1 Episode Triggers

- Commenters offered mixed feedback on episode triggers.
    - One commenter responded that the current trigger codes list is appropriate.
    - Another commenter was concerned about having pathology-specific Current Procedural Terminology (CPT) codes for both triggering and confirming claims. They stated that although pathologists are part of the care team, they don't have primary responsibility for a patient's care management over a prostate cancer episode. They recommended pathology codes be considered only as confirming codes to avoid accidental attribution of an episode to a non-patient-facing pathologist.

3.3.1.2 Sub-groups

- Commenters offered mixed feedback regarding the subgrouping strategy:
    - One commenter noted that they agreed with the approach.

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7489811/
[7] https://jamanetwork.com/journals/jama/article-abstract/2799153

    - Three other commenters noted that, while it may be clinically relevant to separate metastatic and non-metastatic cancer patients and that this is a good start, it's still not adequate.
    - One commenter stated that claims data shouldn't be used for risk stratification or subgrouping. This commenter emphasized that claims data are unable to reflect the actual stratification that physicians use in a clinical setting to decide treatment based on cancer severity. This commenter added that prostate-specific membrane antigen (PSMA) positron emission tomography (PET)/computed tomography (CT) imaging practices may lead to non-metastatic patients being treated under metastatic paradigms if suspicious areas outside of the prostate are identified. As such, the commenter worried there may be some confounding of whether a patient has metastatic or localized cancer.
    - Another commenter noted that additional stratification (or risk adjustment) is needed to account for risk of disease progression in non-metastatic patients.
    - Another commenter noted that patients with different symptoms presenting have different outcomes and costs of care, and that improving ICD-10 coding to include more descriptors is probably needed to help risk stratify.
- A commenter noted that Black men are more likely to present with advanced disease, so this subgrouping strategy could be beneficial so long as the payments for caring for metastatic disease are sufficient to avoid incentivizing physicians to shift their care predominantly toward patients with local disease.
- One PFE commenter noted that their prostate cancer was diagnosed at Stage 2, and Stage 3-4 is for a 7 Gleason score.

3.3.2 Attribution of the Episode Group to Clinicians

- One PFE commenter noted that their care team comprises multiple specialties, including urology, radiation oncology, internal medicine, and nurse practitioner. This PFE's care team coordinated, which was essential in helping them understand treatment options, side effects of treatments, and potential outcomes.
- Another PFE commenter noted very poor care coordination around the diagnosis, surgery, and initial treatment for complications from the surgery. The diagnosing urologists referred this patient to a surgeon for robotic prostatectomy.
- One commenter stated that attribution requires considering whether a PCP, urologist, oncologist, or some combination will oversee a patient's care. They noted that the specialist may not necessarily be part of the same clinical group as the PCP. They also added that management and care goals may vary greatly based on the patient's overall medical condition, life expectancy, and willingness to undergo treatment.

3.3.3 Assignment of Costs to the Episode Group

- One commenter noted that no changes were needed on service assignment.
- A commenter noted that they worry about including Part D medications in service assignment, as physicians don't have control over drug prices.
- PFE commenters provided information about their care decisions for watchful waiting and surgery.
    - One PFE commenter who received a timely diagnosis of prostate cancer had options of watchful waiting, surgery, or radiation.
    - Two PFE commenters noted that watchful waiting would include regular prostate-specific antigen (PSA) tests, and one noted occasional biopsies. One commenter added that patient education was an essential part of this stage.

    - One PFE commenter chose a prostatectomy, and experienced PSA rising with an option to pursue salvage radiotherapy or adjuvant deprivation therapy. This commenter reported two hospitalizations with strange side effects from the prostatectomy.
    - One PFE commenter chose watchful waiting until their PSA was rising, and then they chose robotic prostatectomy based on the fact that the patient also had CKD. This patient experienced sepsis following the surgery and was hospitalized.
- One PFE commenter noted that patient education and the care team assessing whether the patient can care for themselves are the care services that are most effective in helping their care.

3.3.4 Risk Adjustment

- Commenters noted that the risk adjustment model currently doesn't account for risk in the same way that clinicians do when making care decisions.
    - One commenter noted that it's potentially harmful to consider the costs of prostate cancer treatment for localized prostate cancer without stratifying by the National Comprehensive Cancer Network (NCCN) risk groups in localized prostate cancer and by castration-resistance status in metastatic cancer. This commenter worried that the proposed stratification system using claims data would lead to confusion and incorrect conclusions about practice patterns, resulting in inappropriate care as teams try to minimize the cost attributions. They stated that claims data shouldn't be used for risk stratification for these reasons, and that patient safety may be at risk if teams try to minimize cost using the risk stratification system proposed. The commenter concluded that NCCN risk stratification should be used for localized prostate cancer and castration-resistance for metastatic cancer if the goal is to improve the value of care provided to patients.
- Another commenter noted that the current specifications are to subgroup metastatic and non-metastatic patients as a way to compensate for the lack of risk stratification in the current International Classification of Diseases, Tenth Revision (ICD-10) coding system.
    - However, they expressed that this could miss out on the many algorithms of treatment among non-metastatic cases (from just active surveillance to surgery, radiation, and hormone therapy) and metastatic cases (supportive care only, i.e. hospice, to any form of radiation therapy with many forms of systemic therapy). Depending on how the physician and patient want to proceed, the severity of cancer doesn't always correlate with cost.
- Another commenter who expressed concern with the risk adjustment methodology noted that they aren't advocating the removal of the factors, but more clarity on the provider and timeframe for the recent chemotherapy/immunotherapy variables would be helpful (e.g., would that therapy have been done by the attributed clinician?).
- One commenter stated that it may be more appropriate to look back 3-5 years instead of just one for risk adjustment.
- Another commenter noted that access to appropriate care, medications, and other social needs should be considered.
- One commenter suggested accounting for older patients with low-risk prostate cancer for whom the risks of treatment outweigh the benefits.
- A commenter noted that Black men have worse outcomes and greater incidence of prostate cancer than white men. The commenter worries that the cost measure may incentivize physicians to prioritize less costly patients, exacerbating inequalities. It could also discourage discussing treatment options more with historically mistreated patients.

- They also raised concerns with how the social risk factor adjustments may work in the measure to affect care and outcomes for marginalized groups. They expressed concern that social risk factors outside of the control of physicians are shown to contribute to higher costs for dually eligible patients.
- The commenter noted that risk adjusting for dual status appears to change the performance ranking for many providers, though it appears that patient-level factors are more influential than provider-level factors, which is concerning to the commenter.

3.3.5 Exclusions

- To determine if there are any exclusion changes needed, one commenter requested data describing how these risk factors correlate with treatment or the NCCN risk factors used to guide treatment.

3.3.6 Alignment of Cost with Quality

- One commenter recommended aligning the Prostate Cancer measure with QPP102 *Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients*, QPP104 *Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer*, and QPP462 *Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy*.
- However, another commenter noted that there are no agreed-upon measures for prostate cancer that are in existence that apply to all specialties, though there are treatment modality specific measures, such as one for radiation oncology developed by American Society for Therapeutic Radiology and Oncology (ASTRO)/Veterans Affairs.

3.4 Rheumatoid Arthritis

3.4.1 Definition of an Episode Group

3.4.1.1 Episode Triggers

- Commenters offered supportive but constructive feedback on the episode trigger codes.
  - One confirmed that the trigger codes can successfully identify a patient cohort.
  - Two others made recommendations for amendments, such as including a PT/occupational therapy (OT) assessment in the trigger criteria since trigger criteria drive referrals to other practitioners.
  - Another commenter felt that the trigger list should include other diagnosis codes with a secondary diagnosis of rheumatoid arthritis (RA) to better capture rehabilitation services, which are important to address/prevent complications in RA.
- One commenter noted that physical therapy evaluation codes 97161, 97162, 97163 should be included as confirming codes.

3.4.1.2 Other

- One PFE commenter said that more rheumatologists are needed, and that a shortage of physicians is an area where care can improve.
- One commenter mentioned that rheumatologists believe the measure is too complicated for a typical physician to understand and most won't be able to take meaningful action or change their behavior. There is concern about what takeaways they should get from their reports when deciding on changes to make to treatment plans.

3.4.2 Attribution of the Episode Group to Clinicians

- PFE commenters discussed attribution for medication and complications.
    - One PFE commenter noted that the medication plan is discussed between physicians, and that there's a strict follow-up schedule for evaluating medications for effectiveness and side effects. If there are side effects, changes are made.
    - Another PFE commenter noted that decisions for medications were made based on outcomes and that they're involved in the decision-making. The rheumatologist handles the medications for them.
    - One PFE commenter had follow-ups after surgery to coordinate the care plan with the rheumatologist(s), surgeon, internal medicine physician(s), and physical therapist(s).
- PFE commenters recounted mixed but generally negative care coordination for RA.
    - One PFE commenter described their care team as primary care for the annual visit and non RA-related care, the rheumatologist for semiannual visits and flare-ups, and the ophthalmologist for semiannual visits for dry eye. This commenter said that their care wasn't directly coordinated (it was only done so through medical records).
    - Another PFE commenter noted that their care team is comprised of rheumatologists. This commenter has regular follow-up appointments and sometimes urgent appointments during flare-ups. There's coordination between rheumatologists and PCPs.
    - Another PFE commenter noted that their rheumatologist and PCP tend to stay in their own silos and that they don't coordinate on their own. Another commenter noted that there's no communication in their care team.
- One commenter noted that they felt their cost report included costs clinically unrelated to the treatment and management of RA, such as costs attributed to their TIN for services rendered by clinicians outside of the TIN.
- One commenter recommended considering whether care will be overseen by a primary care provider, rheumatologist, or some combination. They also advised considering a scenario where the specialist may not be part of the same clinical group.

3.4.3 Assignment of Costs to the Episode Group

- PFE commenters shared that they haven't experienced side effects for the medications they take for rheumatoid arthritis. One PFE commenter noted that difficulty walking and back pain are the complications they've experienced, and that they didn't require medical care. Further, they didn't change anything in their care plan when experiencing these complications.
- Medications PFE commenters stated that they take for rheumatoid arthritis included:
    - Xeljanz
    - Oxycodone
    - Medical marijuana; one commenter's doctor switched them from oxycodone to their state's medical marijuana program
    - Only Excedrin Migraine or Tylenol Extra Strength due to renal disease; this commenter mostly has their medications overseen by their nephrologist and cardiologist (due to comorbidities)
    - Methotrexate or Sulfasalazin or Plaquanil
    - Humira
    - Restasis generic for eyes
- One PFE commenter noted that they discuss medications and pain management at every visit with their rheumatologist. For determining what medication(s) to use, another noted

that they start with methotrexate, and if the response is incomplete, then they start a biologic (e.g., Anti-tumor necrosis factor(TNF)).

- PFE commenters had varied feedback on effective services.
    - One commenter noted that the most effective services at making them feel better are steroids (e.g., Medrol) and stretching, while some of the medications they tried and physical therapy were the least helpful. This commenter felt that their doctor does a great job of managing their care.
    - Alternatively, one commenter said non-steroidal anti-inflammatory drugs and high-dose steroids were the least effective treatment in helping them feel better.
    - One commenter noted that the type of treatment that's most effective in helping them to feel better is medication that works for them personally. One noted that it took trial and error to find what works.
    - Another commenter noted that early management to prevent deformity was most helpful in feeling better.
- Mental health as an important component of care for PFE commenters.
    - One PFE commenter said that they didn't have mental health care support.
    - Another said that the treatment of depression associated with rheumatoid arthritis is very important, and that antidepressants were started based on the need for them.
    - A third PFE commenter noted that the diagnosis of RA was depressing, but that education and treatments to resume desired activity were most important in improving mental health.
    - One PFE commenter noted that the condition can cause mental fatigue. They noted that the importance of mental health became clearer over time.
    - Another PFE commenter noted that experience with juvenile rheumatoid arthritis helped them to be used to it mentally.
- PFE commenters described their experiences with flare-ups. They said that flare-ups include joint pain, can be affected by weather, and include fluid retention alongside joint pain. One commenter noted that they sometimes have bad enough flare-ups to see their rheumatologist and get a Depo-Medrol shot, which usually helps. One PFE commenter noted that their care plan hasn't changed following complications or flare-ups.
- PFE commenters shared their experiences with complications and how this affected or didn't affect their care plans.
    - One commenter noted that they experienced infection, malignancy, and abnormal lab results as complications. Another noted that flare-up pain and inflammation in their hand, elbow, and hips at different times have been the complications they've experienced. Ibuprofen was less helpful than steroid injections. They didn't feel that flare-ups could be anticipated or avoided as they were isolated incidents. They don't take other medications frequently because Humira works well. Methotrexate and hydroxychloroquine didn't help. The care plan has remained unchanged throughout the complications.
    - One commenter noted that the care team working together to treat complications quickly to decrease hospital admission would have been helpful in avoiding/reducing complications.
    - Another commenter noted that treating infections early is an example of complications requiring medical care.
    - One commenter had complications related to medication, noting that an allergic reaction to methotrexate while having comorbid RA and interstitial lung disease led to respiratory distress and admission into the intensive care unit.
- PFE commenters had varied experiences with surgery for their RA, including carpal tunnel surgery, epidural treatments, and hand surgery. Other commenters indicated that they

didn't have surgery; one of whom said there was no need for surgery due to starting proper treatment.

- PFE commenters mentioned the types of durable medical equipment they use for RA include tape on their thumbs and fingers to help during flare-ups, heating pads, shoe inserts, compression wraps, wrist braces, splints, canes, walkers, and wheelchairs.
- A commenter stated that rheumatologists are aware of RA drugs being expensive, but that drugs are the standard of care for the condition. They expressed concerns that a rheumatologist has no recourse when drugs are labeled "high-cost" other than to withhold drugs from patients.
- A commenter noted that rheumatologists felt the reports didn't separate patients who have a treatment which is directly related to rheumatoid arthritis as opposed to another diagnosis. They would like more clarity on how hospitalizations and surgeries are assigned to an RA episode.
- Another commenter said that medication choices for RA are made using clinical guidelines, patient health status (allergies, intolerances, inability to self-inject due to hand deformities, etc.), patient exposure/experience/failure with prior medications, cost and patient access to medications, and social determinants of health (transportation, home support, etc.). This commenter wondered how Part D stratification will be achieved for RA.
- Another person commented that medication choice is dependent in most cases on the extent and severity of disease, while yet another stressed that physicians consider many factors such as cost, insurance coverage, access to care, interactions, allergies, patient preference, ability to self-administer, other comorbid and chronic conditions, life span, physician comfort with prescribing, other risk factors like mental health and health literacy in understanding how to administer, functional capacity, etc.
- Commenters expressed conflicting opinions regarding physical, occupational, and speech therapy. A commenter noted that occupational therapy services are critical to this cost measure. Another commenter suggested that a larger set of diagnostic codes may be helpful in assigning relevant services and that speech therapy may not be helpful in the measure.
    - A commenter recommended that all physical, occupational, and speech therapy services be included as assigned services regardless of diagnosis code if they occur during an RA episode.
    - A commenter noted that PT and OT services for referrals following trauma, sprains, and strains including back impairments when RA is a secondary diagnosis should be included. However, another commenter said that non-specific PT/OT/speech codes shouldn't be included in the specifications for now. A third commenter noted that therapy services should only be assigned if they're paired with an RA diagnosis code.

3.4.4 Risk Adjustment

3.4.4.1 Variables

- A few commenters supported the list of risk adjustors but offered opinions on some additions to the list.
    - One commenter noted that prior history of osteoporotic fracture is a sign of frailty and should be included in the frailty risk adjustor.
    - One commenter noted that they believe that stress fractures should also be considered, as there's a correlation between rheumatoid arthritis and stress fractures of the hands, wrists, and lower extremities in additional traumatic fractures from falls.

    - Another commenter noted that many types of fractures contribute to the cost of care for RA patients, and all relevant ones should be included.
    - A commenter stated the wrist numeral and hip fractures should be included. This commenter noted that no other changes are needed to the current list of risk adjustors.
- One commenter shared that research has shown disparities in patients with RA based on race and access. They're concerned that providers treating Black patients could be penalized for providing appropriate care for these patients based on their higher relative costs; Black patients tend to have worse outcomes with RA than Caucasian patients due to issues of access and detection. This commenter noted that less access can lead to later detection, greater loss of function, higher pain, more deformities, and therefore higher downstream costs for Black patients compared to Caucasian patients. This commenter also noted that opioids are prescribed at higher rates for Black patients.

3.4.5 Exclusions

- One commenter noted that there were no changes needed to exclusions.

3.4.6 Alignment of Cost with Quality

- One commenter noted that scores on functional tests and quality of life measures are most relevant to align with Rheumatoid Arthritis.
- Another commenter noted that balancing measures could help ensure there aren't unintended consequences of the measure. For example, one way to reduce biologic use is to increase the use of glucocorticoids, which usually have universal adverse effects in relation to duration and dose. Therefore, measuring exposure to glucocorticoids as a balancing measure for both disease control and overall cost for RA patients would be important to reduce unintended consequences of measurement.
- A commenter noted that Q178, Rheumatoid Arthritis (RA) Functional Status Assessment; Q222 Functional Status Change for Patients with Elbow, Wrist or Hand Impairments; Q217 Functional Status Change for Patients with Knee Impairments (rationale being that RA most commonly is seen in the hands, wrists and knees); NQF #0420 pain assessment and follow-up; Q155 falls plan of care; and Q134 preventative care and screening for depression with follow-up plan are quality measures that could be relevant to this cost measure.

4.0 Next Steps for Measure Specification Refinements

This section outlines the discussion topics and subsequent questions that Acumen brought to the Clinician Expert Workgroups during the Post-Field Test Refinement webinars. Acumen identified these topics for discussion largely based on commenters' feedback gathered during field testing and subsequent empirical analyses. The Clinician Expert Workgroups' discussions about these questions directly help to inform refinements to the measures' specifications.

4.1 Chronic Kidney Disease and End-Stage Renal Disease

The following discussion topics were brought to the CKD and ESRD workgroup:

- Accounting for crash starts in ESRD

- Trigger gap between trigger and confirming claims
- Service assignment
    - Alignment with the Kidney Transplant Management measure
    - Inclusion of prescription drugs

4.2 Kidney Transplant Management

The following discussion topics were brought to the Kidney Transplant Management workgroup:

- Identifying averted kidney failure
    - Hospitalizations that avert transplant failure from claims data
    - Excluding services that avert transplant failure by extending the post-surgery exclusion beyond 90 days
- Risk Adjustment
    - Capturing kidney quality information using OPTN data or other sources
    - Avoiding disincentives for treating patients with hard-to-place kidneys
    - Episodes ending in transplant failure
- Imposing a minimum trigger gap for consistency with other measures

4.3 Prostate Cancer

The following discussion topics were brought to the Prostate Cancer workgroup:

- Length of lookback window
- Risk Adjustment
    - Adjusting for social risk factors
    - Additional subpopulations for risk adjustment
- Service Assignment
    - Inclusion of Part D medications

4.4 Rheumatoid Arthritis

The following discussion topics were brought to the Rheumatoid Arthritis workgroup:

- Confirming the episode group definition
- Service Assignment
    - PT/OT services within an RA episode
    - Limiting to rehabilitation-specific diagnoses (e.g., muscle weakness, gait abnormality, joint pain)
    - Additional diagnoses to determine which procedures or hospitalizations to assign
    - Additional services (e.g., ophthalmologic services to address dry eye for RA-related care)
- Risk adjustment
    - Variable for prior RA with a one-year lookback period
    - Variables for certain higher risk RA diagnoses or autoimmune diseases
        - Length of lookback period

Appendix A: List of Commenters

This appendix provides an index of interested parties who submitted a comment during field testing. 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 A1. Commenters Providing Feedback on the 2023 Field Testing

Name	Individual or Representative	Organization
Elisabeth Volpert	Individual	-
Forrest Pettengill	Individual	-
Thomas Raccuglia	Individual	-
Robert Crabtree	Individual	-
Joseph Waters	Individual	-
Terry Peeler	Individual	-
Jeff Nelson	Individual	-
Janine Reed	Individual	-
Robert Friedman	Individual	-
Dolores Hostert-McGrath	Individual	-
Melissa M. Tolzien	Individual	-
Jane B DeMeis	Individual	-
Michael Varnal	Individual	-
Liz Lusk	Individual	-
Haley Jensen	Individual	-
Keith Plummer	Individual	-
Cathy Simon	Individual	-
Katie Summers	Individual	-
Stephen Hasper	Individual	-
Abhishek Solanki	Individual	-
Jon Luh	Individual	-
June Succow	Individual	-
Samy Metyas	Individual	-
Jan Lambert	Individual	-
Lisa G Suter	Individual	-
Shraddha Jatwani	Individual	-
Kandi Cooper	Individual	-
Shaley Walters	Individual	-
Janice Starling	Individual	-
Sarah Ruiz	Individual	-
Amanda Halter	Individual	-
Shelley Salamensky	Individual	-
Mary Raines	Individual	-
Anne Bina	Individual	-
Kimberly Harrigan	Individual	-
Amanda Holt; Robert Richardson	Representative	American Academy of Family Physicians
Jennifer Hananoki	Representative	American Medical Association
Karen Johnson	Representative	American Urological Association
Joseph Vassalotti	Representative	National Kidney Foundation
Emily Graham	Representative	Coalition of State Rheumatology Organizations
Eric B. Bass	Representative	Society of General Internal Medicine
Diana Cardona	Representative	College of American Pathologists
Alice Bell	Representative	American Physical Therapy Association

Name	Individual or Representative	Organization
Ann Marslett	Representative	Rheumatology Associates of Baltimore LLC
Kim Karr	Representative	American Occupational Therapy Association