Quality Payment
PROGRAM

Questions for Field Testing Measure Specifications

Winter 2024 Field Testing

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2024 Cost Measures Field Testing Feedback Survey

1.0 Introduction

We are gathering input on the draft measure specifications for the 2 episode-based cost measures undergoing field testing. This document includes questions on each of the measures, and accompanies the draft specifications for each measure, comprising a Draft Measure Methodology document and Draft Measure Codes List file.[1]

Stakeholders may submit feedback in response to the questions included in this document as well as on other aspects of the measures through this online survey[2] between February 1 and February 29, 2024. When submitting feedback through the survey, stakeholders can also attach a PDF or Word document with their comment. Stakeholders may submit comments anonymously.

Field testing is taking place from February 1 to February 29, 2024. It is part of the measure development process and is an opportunity for clinicians and other stakeholders to learn about episode-based cost measures and provide input on the draft specifications. During field testing, we will:

- Distribute Field Test Reports on the Quality Payment Program website[3] for group practices and solo practitioners who meet the minimum number of cases for each measure.
- Post draft measure specifications (i.e., measure methodology and codes lists), and supplemental documentation, such as testing results, on the QPP Cost Measure Information Page.
- Collect stakeholder feedback on the draft specifications for each measure.

The feedback from field testing helps inform refinements to the measures before consideration of their potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS). The following measures will be field tested: (1) Movement Disorders and (2) Non-Pressure Ulcers.

The cost measures were developed with extensive input from Clinician Expert Workgroups, comprising clinician experts with experience in the clinical area of the measures under development. Patient and family representatives, who have lived experience with the conditions in question, participated in structured interviews and Clinician Expert Workgroup meetings to give their perspective. These workgroups took place in June and October of 2023. After field testing, the workgroups will refine the draft measure specifications based on the stakeholder feedback. The Wave 6 Measure Development Process document on the QPP Cost Measure Information Page provides more information on the development process of these measures.

2.0 Measure Specific Questions

We are interested in your feedback on the draft measure specifications for the five episode-based cost measures.

- Movement Disorders

[1] The draft measure specifications for each measure, comprising the draft Cost Measure Methodology document and the corresponding draft Measure Codes List file, are available on the QPP Cost Measure Information Page.

[2] The field testing online survey is available here: https://acumen.qualtrics.com/jfe/form/SV_bgybmMURrwVqDrM

[3] CMS, "Quality Payment Program Account," *Quality Payment Program,* https://qpp.cms.gov/login.

- Non-Pressure Ulcers

2.1 Movement Disorders

This section lists questions specific to the Movement Disorders measure.

1. Trigger codes are used to identify a clinician-patient relationship and define the patient cohort. Two codes (trigger and confirming claim) must be billed by the same TIN within 180 days to establish this relationship. The Movement Disorders measure uses outpatient evaluation and management (E/M) codes or rehabilitative services codes (either accompanied by a diagnosis code indicating movement disorders) to start an episode and either another trigger code, or a confirming code for infusion services accompanied by a diagnosis code indicating movement disorders to confirm the continuation of it. Refer to the Measure Codes List to see the specific service and diagnosis codes used in the trigger logic ("Triggers_HCPCS" and "Triggers_DGN" tabs).

   Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).

2. Movement Disorders measure episodes should be attributed to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of clinically related services during an episode. Including rehabilitation as trigger services significantly increases the number of TINs attributed to the measure, but adds only a nominal number of new beneficiaries. This suggests that including rehabilitation services in the trigger logic would greatly increase the number of groups providing rehabilitation services that are attributed to the measure (e.g., physical therapy groups).

   Some chronic condition episode-based cost measures include a medication prescribing requirement as part of the attribution methodology. A medication prescribing attribution requirement, i.e., ensuring that clinicians are only attributed a Movement Disorders episode if they prescribe at least 2 condition-related medications to 2 different patients during the current plus prior performance period, is one way to narrow the population of attributable clinicians to only those who provide medication management related to the condition. However, this requirement prevents attribution of non-prescribing clinicians such as physical and occupational therapists and speech language pathologists. Workgroup members discussed whether physical therapists, occupational therapists, and speech language pathologists should be considered for attribution. Ultimately, the workgroup recommended including a medication prescribing requirement such that physical therapists, occupational therapists, and speech language pathologists are not attributed the episode.

   Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.

3. The Movement Disorders measure evaluates the care and management for a number of progressive neurodegenerative disorders affecting movement. Since these conditions are similar in this regard but otherwise unrelated diseases, the measure sub-groups for each of the movement disorders in the measure. Risk adjustment is done separately for each sub-group so that episodes are only directly compared against other episodes in the same sub-group. Currently, the measure includes Parkinson's Disease, Other Degenerative Diseases of Basal Ganglia, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS). Huntington's Disease was removed from the measure due to the small sample size and the variability in costs. Refer to the Measure Codes List to see the specific diagnoses used to define the measure ("Triggers_DGN" tab).

   Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson's and fit the measure's intent?

4. Clinician Expert Workgroup members provided feedback that the current measure name, "Movement Disorders," isn't reflective of the conditions currently included (Parkinson's and Related Disorders, MS, and ALS) in the measure. The Clinician Expert Workgroup recommended changing the name to "Progressive Neurological Disorders Affecting Movement" to better encompass the conditions included in the measure. The measure name should also be easily identifiable by clinicians and patients dealing with the conditions.

   Does the new proposed name appropriately account for Parkinson's and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?

5. The Movement Disorders measure includes clinically related services that encompass variations in treatment options, the intensity or duration of treatment, routine care and monitoring, acute exacerbations, complications, side effects from treatment, and supportive care. The goal is to include broad enough sets of services that the measure can capture variation in care while still being refined enough to focus on condition-related costs. Clinicians and other interested parties have also pointed out that simpler service assignment rules make the measures easier to understand.

   The Movement Disorders measure currently includes the following service categories:
   - Routine provider visits; rehabilitation services; labs; related hospitalizations and post-acute care; imaging; Home Health; Emergency Department visits; Durable Medical Equipment; pulmonary services; sleep-related studies; contractures; nutrition services; gastrostomy, tracheostomy; fall-related care; swallow studies; infusions; Part D medications; deep brain stimulation; drug-administration intrathecal pumps; G-tubes for medications; hip fractures; joint replacements related to falls; pressure injuries; pneumonia; medication toxicity syndromes; subdural hematomas

   Refer to the Measure Codes List to see the specific services included in service assignment ("Service_Assignment_AB" and "Service_Assignment_D" tabs).

Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?

6. The Movement Disorders measure uses a standard set of risk adjustors based on the CMS Hierarchical Condition Category (CMS-HCC) model, as well as measure-specific adjustors that affect costs for the conditions included in the measure. Risk adjustors should meet the following conditions:
    - Present at the start of care
    - Clinical/conceptual relationship with the outcome of interest (i.e., is this cohort different in a way that affects costs?)
    - Variation in the prevalence of the factor
    - Is not an indicator of the care provided
    - Resistant to manipulation or gaming
    - Not redundant with other variables
    - Service assignment mitigates need to adjust for unrelated heterogeneity

    The Movement Disorders measure currently risk adjusts for:
    - Dependence of respirator; frailty binary indicator; other degenerative diseases of basal ganglia; past bowel or bladder incontinence, past cognitive status impairment, decline or deficit; past deep brain stimulators; past difficulty swallowing; past dysarthria and anarthria; past dysphonia; past sleep apnea; history of falling; past contracture diagnoses; wheelchair dependence

    Refer to the Measure Codes List to see the specific risk adjustment variables and codes used to define the variables ("RA" and "RA_Details" tabs).

    Are there any changes that should be made to the current risk adjustors, such as to add or remove variables? Are there measure-specific variables that should have their specifications updated?

7. Exclusions remove small sets of patients where there is extreme variability that is not susceptible to performance improvement. More complex patients may have higher costs, but this complexity can be addressed through risk adjustment and service assignment to include just clinically related costs. There may also be greater opportunities to improve care and impact Medicare spending with more complex patients. The Movement Disorders measure does not currently exclude any patient cohorts.

    Should any patient cohorts be considered for exclusion from the measure? How might such patients be identified using Medicare claims data?

8. The intent is for the Movement Disorders measure to be used in the MIPS Cost performance category. If added to MIPS in the future, it would be one part of the MIPS final score; the other performance categories are quality measures, improvement activities, and promoting interoperability.

Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are the other indicators of quality that are not currently captured in a MIPS quality measure?

2.2 Non-Pressure Ulcers

This section lists questions specific to the Non-Pressure Ulcers measure.

1. Trigger codes are used to identify a clinician-patient relationship and define the patient cohort. Two codes (trigger and confirming claim) must be billed by the same group practice (TIN) within 1 and 180 days of each other to establish this relationship.
    - For the draft Non-Pressure Ulcers measure, **a trigger claim,** which marks the start of an episode**,** is a Part B Physician/Supplier claim for a clinically relevant outpatient service when paired with an ICD-10 diagnosis code indicating a non-pressure ulcer. These outpatient services can be summarized as:
        - Outpatient evaluation and management (E/M)
        - Measure-specific E/M
    - A **confirming claim**, which indicates the continuation of a patient-clinician relationship, is a second Part B Physician/Supplier claim. The draft measure uses another outpatient E/M, measure-specific E/M or any of the following confirming services when paired with a non-pressure ulcer diagnosis:
        - Rehabilitation service
        - Debridement
        - Skin grafts and flaps
        - Wound dressing products
        - Wound modalities (e.g., vacuum assisted closure)

    Refer to the Measure Codes List to see a more detailed list of the CPT/HCPCS codes used to trigger and confirm a Non-Pressure Ulcers episode ("Triggers_HCPCS" tab).

    Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? *Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).*

2. When the beginning of a patient-clinician relationship has been identified and a Non-Pressure Ulcers episode has been defined, it is attributed to individual clinicians (TIN-NPIs) and TINs. A Non-Pressure Ulcers episode should be attributed to TIN-NPIs or TINs who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a patient. While various specialties may be involved in managing and treating patients with non-pressure ulcers, some specialties may be more influential in non-pressure ulcer care than others. Similarly, some clinicians may have more influence over the frequency and intensity of services provided to a patient than others, even those within the same specialty or group practice.
    For instance, physical and occupational therapy services can confirm a care relationship but not trigger one on their own, such that physical/occupational therapists may be attributed as a part of a clinician group practice. This is because physical/occupational therapists develop care plans and provide treatment services for non-pressure ulcers, such as those in multidisciplinary facilities/practices, but outside of such practices, may

have less influence over the frequency, intensity, or occurrence of clinically related services. For a more detailed description of how we define and attribute episodes, please reference Section 4 of the draft Measure Information Form (MIF).

How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?

3. The draft Non-Pressure Ulcers measure stratifies episodes into more granular, mutually exclusive, and exhaustive patient cohorts (i.e., sub-groups) based on ulcer type such that a separate regression for the measure score is run for each type. These include:
    - Diabetic Ulcer (i.e., episodes with diagnosis codes indicating only diabetic ulcers)
    - Arterial Ulcer (i.e., episodes with diagnosis codes indicating only arterial ulcers)
    - Venous Ulcer (i.e., episodes with diagnosis codes indicating only venous ulcers)
    - Multiple Ulcers (i.e., episodes with diagnosis codes indicating at least 2 different types of ulcers)
    - Non-specific Ulcer (episodes with no diagnosis codes for diabetic, arterial, or venous ulcers, and characterized by only chronic non-pressure ulcers diagnoses, i.e., L97/L98 ICD-10 codes)

    Sub-grouping by ulcer type also ensures we fairly compare clinicians with a similar patient case mix. The current sub-grouping methodology identifies ulcer type based on ulcer diagnoses in the 120-day lookback period, including the episode start date. For more information on the sub-grouping methodology, please reference Appendix B in the draft MIF.

    Refer to the Measure Codes List to see a detailed list of the codes used to create sub-groups for the measure ("Sub_Groups_Details" tab).

    Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?

4. The draft Non-Pressure Ulcers measure includes clinically related services that encompass variations in treatment options, the intensity or duration of treatment, routine care and monitoring, acute exacerbations, complications, side effects from treatment, and supportive care. The goal is to include broad enough sets of services such that the measure captures variation in care while still being refined enough to focus on condition-related costs. Clinicians and other interested parties have also pointed out that simpler service assignment rules make the measures easier to understand.

    The Non-Pressure Ulcers measure currently includes the following service categories:
    - Outpatient E/M services
    - Inpatient hospital services (e.g., amputations, skin grafts and debridement, hospitalizations for cellulitis, hospitalizations for osteomyelitis)
    - Physician services during hospitalization
    - Imaging services (e.g., x-ray, ultrasound, CT scan)
    - Major/minor procedures (e.g., skin procedures, joint injections, hyperbaric oxygen, vascular procedures)

- Physical, occupational, or speech and language pathology therapy
- Post-acute care services
- Emergency department services
- Durable medical equipment and supplies (e.g., skin allograft, orthotic devices, wheelchairs and accessories, oxygen and supplies)
- Part B covered drugs (e.g., nononcologic injections and infusions)
- Part D services (i.e., antibiotics, wound care products, bandages, gauze pads, and dressings)

Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale.

Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.

5. MIPS episode-based cost measures use a robust risk adjustment model to account for factors deemed outside the reasonable influence of the attributed clinician or group practice. The risk adjustment model includes a standard set of risk adjustors used across cost measures from the CMS Hierarchical Condition Category (CMS-HCC) model. This includes comorbidities captured by 86 HCC codes that map with thousands of ICD-10-CM codes, and other standard risk adjustors, including interaction variables accounting for a range of comorbidities, patient-level demographics (i.e., age) and health status (i.e., disability status, end-stage renal disease [ESRD] status, recent use of long-term care), patient dual eligibility status, and types of clinician specialties from which the patient has received care. Specific to the draft Non-Pressure Ulcers measure, the risk adjustor variables include smoking and frailty indicators.

   Refer to the Measure Codes List to see more information on the standard and measure-specific risk adjustors for the measure ("RA" and "RA_Details" tabs).

   Please note that the risk adjustors should meet the following conditions:
   - Present at the start of care
   - Clinical/conceptual relationship with the outcome of interest (i.e., is this cohort different in a way that affects costs?)
   - Variation in the prevalence of the factor
   - Is not an indicator of the care provided to a patient
   - Resistant to manipulation or gaming
   - Not redundant with other variables
   - Service assignment mitigates need to adjust for unrelated heterogeneity

   Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?

6. Exclusions remove small sets of patients where there is extreme variability that is not susceptible to performance improvement. More complex patients may have higher costs, but this complexity can be addressed through risk adjustment and service assignment to include only those costs of services or items that are clinically related to the attributed clinician's role in managing care during a Non-Pressure Ulcer episode. There may also

be greater opportunities to improve care and impact Medicare spending with more complex patients. The draft Non-Pressure Ulcers measure excludes the following patient cohorts:

- Patients with pyoderma gangrenosum
- Patients with calciphylaxis
- Patients with sickle cell anemia
- Patients with vasculitis
- Patients with scleroderma

Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.

7. The intent is for the Non-Pressure Ulcers measure to be used in the MIPS Cost performance category. If added to MIPS in the future, it would be one part of the MIPS final score; the other performance categories are quality measures, improvement activities, and promoting interoperability.

   Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?