

# Rheumatoid Arthritis Service Assignment and Refinement (SAR) Webinar Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups  
Workgroup Webinar, September 30, 2022

November 2022

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## Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC to develop episode-based cost measures for potential use in the Merit-based Incentive Payment System (MIPS) to meet the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Acumen's measure development approach involves convening clinician expert panels to provide input in cycles of development ("Waves").<sup>1</sup> 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.<sup>2</sup> This approach provided flexibility for a wider range of interested parties to participate around their schedules. 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.

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 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. Then, Acumen convened the workgroups again for a Service Assignment and Refinement (SAR) Webinar to revisit the specifications

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<sup>1</sup> For information on measure development in Wave 4, refer to the [Wave 4 Measure Development Process](https://www.cms.gov/files/document/wave-4-measure-development-process-macra.pdf) document (<https://www.cms.gov/files/document/wave-4-measure-development-process-macra.pdf>).

<sup>2</sup> 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) (<https://www.cms.gov/files/document/wave-5-public-comment-summary-report.pdf>).

recommended during the initial meeting and refine the measures prior to national field testing. For Wave 5, all workgroup meetings will be held virtually. The workgroups will convene for a third meeting to continue measure specification and refinement discussions after a national field test, which is currently slated for early 2023.

## **Rheumatoid Arthritis SAR Webinar, September 30, 2022**

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This meeting summary document outlines the purpose, discussion, and recommendations from the Rheumatoid Arthritis SAR 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 Rheumatoid Arthritis SAR Webinar on September 30, 2022, were the following:

- (i) Provide input to specify a cost measure for potential use in MIPS that can accurately distinguish between good and poor performance among clinicians in terms of cost efficiency
- (ii) Consider the results of empirical analyses and the Person and Family Partner (PFP) findings
- (iii) Provide input on episode group trigger codes, how to account for sub-populations to ensure that the measure allows for meaningful clinical comparisons, and categories of services to assign to the episode group

The meeting was held online via webinar and attended by 13 of the 14 workgroup members. The webinar was facilitated by an Acumen moderator, Heather Litvinoff. The Rheumatoid Arthritis workgroup chair was Alex Limanni, who also facilitated meeting discussions. Jan Lambert and Barbara Wicht 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.<sup>3</sup>

All interested parties beyond the workgroup members had access to a public dial-in number to observe the meeting as part of Acumen's continued effort to increase the transparency of the measure development process.

Prior to the webinar, workgroup members were provided with information and materials to inform their meeting discussions (see Section 3). After the webinar, workgroup members were sent a recording of the webinar and polled on their preferences to ensure the measures are developed based on well-documented input. Based on National Quality Forum practices, the 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.

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<sup>3</sup> 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>).

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 refinements to draft specifications and identifying clinically related services, respectively. The final subsection provides an overview of the next steps for the measure development process.

### **2.1 Person and Family Partner (PFP) Findings and Discussion**

We conducted surveys with 5 PFPs to gather input that would inform cost measure development for Rheumatoid Arthritis. During the webinar, 2 PFPs shared these findings and fielded questions from the workgroup members.

PFPs reported on the types of care they received and how this care contributed to their management of the disease. For routine care, PFPs reported primary care clinicians, rheumatologists, orthopedists, and occupational/physical therapists as part of their main care team. The services that they routinely received were medications and medication evaluations, physical therapy, bloodwork, injections for inflammation, imaging, and other services to assist in mobility. Other services for rheumatoid arthritis-related care include cardiological services, infusions, treatment of infections, vascular services, social services, and durable medical equipment maintenance and repair. All patients reported that they were told joint replacements/surgeries would be required as their symptoms progressed. PFPs reported that pain management and trying to determine which treatments would be the most necessary and cost-effective were a difficult part of their care.

Medication management was consistently an important part of rheumatoid arthritis care for the PFPs. All of the PFPs received methotrexate, but only 2 were offered and tried biologics due to their high cost. PFPs reported that methotrexate became ineffective over time, which was physically, mentally, and financially stressful for patients. PFPs noted that they weren't made privy to all of the side effects of the medications they were offered.

PFPs noted a range of areas where their care for rheumatoid arthritis could have been improved. PFPs mentioned that they would like more support to understand the medications they're given. PFPs also reported that delays in diagnoses and doctors not believing the amount of pain patients were in led to worse care. PFPs also noted detrimental financial and familial outcomes due to the stresses of care management. Finally, PFPs consistently noted that barriers to accessing medication and certain specialists affected their disease outcomes.

A workgroup member asked if any PFPs had an early diagnosis and how that affected their outcomes. One PFP was diagnosed relatively early and was able to resume activities that they had paused after 2-4 years of medication management. A workgroup member also asked if PFPs saw occupational and physical therapists, and if therapy costs were prohibitive. PFPs reported seeing both types of therapist and did note that costs and Medicare physical therapy caps were a barrier to that type of care. They found physical therapy to be effective and motivating. Lastly, workgroup members asked if PFPs experienced falls due to their rheumatoid arthritis, and the PFPs noted that they had, and one experienced amputation as a result.

## 2.2 Refinements to Draft Specifications

Acumen reviewed the methodology for constructing an episode-based cost measure and the specifications that the workgroup discussed in the first webinar. This discussion consisted of 2 parts: (i) one to recap the trigger services and diagnoses used to define the episode group, and (ii) one to review risk-adjusted episode costs and then discuss how to account for certain sub-populations where a consensus wasn't reached previously.

### 2.2.1 Defining the Episode Group

During the webinar, the workgroup reviewed the process of defining an episode through a triggering and confirming event. A trigger event begins a care relationship between a clinician group (Taxpayer Identification Number, or TIN) and a patient with rheumatoid arthritis, and it's identified when 2 claims (trigger and confirming claims) with a relevant diagnosis code are billed within 180 days by the same TIN. Trigger and confirming claims initially only included outpatient evaluation and management (E&M) codes. After the first webinar, the workgroup reached consensus to add condition-specific Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes to the trigger logic as confirming services (i.e., biologic/biosimilar medications, methotrexate, laboratory and screening tests, and joint and tendon injections). The workgroup also previously reached consensus to remove Adult Onset Still's Disease (M06.1), inflammatory polyarthropathy (M06.4), enteropathic arthropathies (M07), and juvenile arthritis (M08) diagnoses from the trigger logic. Additional information about the decisions from the first workgroup meeting are available in the workgroup summary from that webinar.<sup>4</sup>

### 2.2.2 Accounting for Patient Heterogeneity

Acumen reviewed and presented refinement topics for accounting for patient heterogeneity. In the last workgroup webinar, Acumen introduced this subject and collected feedback on what risk factors or comorbidities are relevant to the Rheumatoid Arthritis measure. As a reminder, there are 4 strategies for accounting for this heterogeneity:

1. We can **monitor** for future testing and discussion. This option allows us to review additional analyses for deciding whether and how to account for certain patient characteristics.
2. We can stratify the patient cohort into **sub-groups**. These would be mutually exclusive and exhaustive sub-populations. Sub-groups are warranted if we believe the sub-populations are so different that they deserve their own risk adjustment model. In general, we should be judicious in forming sub-groups because they must be large (at least 10,000 episodes) and because each layer of complexity exponentially increases its size. Workgroup members didn't previously identify any measure-specific sub-populations that would warrant sub-grouping.
3. We can **risk-adjust** for the sub-population. This is the standard method for accounting for patient heterogeneity. The Centers for Medicare & Medicaid Services-Hierarchical Condition Categories (CMS-HCC) risk adjustment model contains many of the key comorbidities important for risk adjustment, but it's important to identify other characteristics not part of the standard model.
4. We can **exclude** sub-populations that are small and substantially different from most patients with rheumatoid arthritis.

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<sup>4</sup> The Workgroup Webinar meeting summary is available on the [MACRA Feedback Page](https://www.cms.gov/files/zip/summary-wave-5-workgroup-meeting.zip) (<https://www.cms.gov/files/zip/summary-wave-5-workgroup-meeting.zip>).

Following the first workgroup webinar, the workgroup voted to risk adjust for the following sub-populations listed in Table 1 (beyond the standard risk adjustment model). Table 1 summarizes the size of the sub-populations as well as their mean observed and mean risk-adjusted episode costs.

Table 1. Risk-Adjusted Sub-Populations' Costs

Episode Group Sub-Population	# Episodes	% Episodes	Mean Observed Episode Costs	Mean Risk-Adjusted Episode Costs
<b>Final Episodes</b>	<b>522,442</b>	<b>100.00%</b>	<b>\$13,353</b>	<b>\$13,353</b>
Cognitive status/dementia	21,678	4.15%	\$11,151	\$12,546
Depression	116,915	22.38%	\$14,723	\$13,006
Fractures	134,574	25.76%	\$15,663	\$12,374
Frailty	18,218	3.49%	\$14,214	\$11,799
Interstitial lung disease	20,639	3.95%	\$16,971	\$12,154
Smoking	74,821	14.32%	\$14,748	\$12,931
Vasculitis	565	0.11%	\$15,532	\$12,701

Falls were included as a part of the “Frailty” sub-population, and both reached consensus for inclusion. This includes coding for repeated falls and for falls with injury.

The workgroup also voted to risk adjust for fractures, which is currently defined as any International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) fracture diagnosis in the 120 days prior to the start of the episode. During the SAR Webinar, we discussed whether a subset of fractures would be more appropriate to use in the risk adjustment methodology. Workgroup members noted that some fractures may be more relevant to rheumatoid arthritis (e.g., hand and wrist fractures), while others (e.g., traumatic fractures) may or may not be related to rheumatoid arthritis. Workgroup members agreed that there are certain fractures most commonly associated with rheumatoid arthritis, though many noted that all types of fractures could be related to rheumatoid arthritis and the resulting weakening of the joints. For instance, workgroup members mentioned that compression fractures may be a result of frailty exacerbated by rheumatoid arthritis. Another workgroup member noted that traumatic fractures could be a result of falling due to gait problems caused by rheumatoid arthritis. Still, the discussion maintained that some fractures are more directly tied to rheumatoid arthritis than others.

Table 2 lists the sub-populations that either didn't reach consensus for risk adjusting after the first workgroup webinar, were already included in the standard risk adjustment model, or weren't included in risk adjustment for some other reason; the table indicates how the draft measure specifications ahead of the SAR Webinar addressed the sub-population. These topics and approaches were discussed again during this webinar.

Table 2. Current Approaches for Other Sub-Populations Considered

Episode Group Sub-Population	Pre-SAR Webinar Approach
Transplants	Included in standard HCC risk adjustment model (HCC 186)
Malignancies	Included in standard HCC risk adjustment model (HCCs 8-12)
Fibromyalgia	Monitored for potential future inclusion
Osteoarthritis	Monitored for potential future inclusion
Rural vs urban	Included in sub-population monitoring analysis via proxy (urban/rural hospital use in prior 120 days); additional testing to be conducted during field testing

Episode Group Sub-Population	Pre-SAR Webinar Approach
Regional musculoskeletal syndromes	Codes aren't available (i.e., can't be specified)

During the SAR webinar, the workgroup discussed how to account for these sub-populations that weren't included in risk adjustment prior to the meeting. One workgroup member noted that a sizable portion of rheumatoid arthritis patients have fibromyalgia, so it would be best to include these episodes. Another agreed, mentioning that the condition is both undercoded and underreported, so it should be included. However, other members noted that fibromyalgia requires fairly intensive treatment, and so its costs should be risk-adjusted in the measure. However, based on the average cost of these episodes following application of the standard risk adjustment model alone, the workgroup member noted additional risk adjustment might not be necessary, and that it may be best to continue to monitor these episodes for differences that become apparent in field testing.

The discussion of osteoarthritis was similar. One workgroup member noted that the majority of rheumatoid arthritis patients who have knee replacements also have osteoarthritis. Another workgroup member mentioned that, since these conditions aren't mutually exclusive, osteoarthritis should be risk-adjusted. Still, members noted that the standard risk adjustment model appears to account for the cost differential adequately already.

Further, workgroup members noted that patients with malignancies and transplants sometimes require drugs with immunosuppressive effects that can impact rheumatoid arthritis care. However, the workgroup indicated it was satisfied with the current risk adjustment model, seeing as the mean risk-adjusted costs for these sub-populations were close to the mean risk-adjusted costs for all episodes.

Table 3 summarizes the size of the sub-populations, mean observed costs, and mean risk-adjusted costs for these sub-populations. The risk-adjusted costs use the standard risk adjustment model and draft measure-specific risk-adjustors. Based on the mean risk-adjusted costs, the workgroup generally felt that the current risk adjustment model adequately accounts for the differences in observed costs for these sub-populations.

Table 3. Other Sub-Populations' Costs

Episode Group Sub-Population	# Episodes	% Episodes	Mean Observed Costs	Mean Risk-Adjusted Costs
<b>Final Episodes</b>	<b>522,442</b>	<b>100.00%</b>	<b>\$13,353</b>	<b>\$13,353</b>
Fibromyalgia*	40,392	7.73%	\$17,090	\$13,249
Osteoarthritis*	217,535	41.64%	\$14,647	\$13,217
Inpatient (IP) or Outpatient (OP) care from rural hospital*	68,721	13.15%	\$13,928	\$13,832
IP or OP care from urban hospital*	304,290	58.24%	\$14,373	\$13,548
HCC8: Metastatic Cancer and Acute Leukemia^	3,168	0.61%	\$11,919	\$13,651
HCC9: Lung and Other Severe Cancers^	5,840	1.12%	\$11,095	\$12,897
HCC10: Lymphoma and Other Cancers^	7,293	1.40%	\$11,123	\$13,180
HCC11: Colorectal, Bladder, and Other Cancers^	6,387	1.22%	\$10,572	\$13,428
HCC12: Breast, Prostate, and Other Cancers and Tumors^	21,278	4.07%	\$11,542	\$13,419



Episode Group Sub-Population	# Episodes	% Episodes	Mean Observed Costs	Mean Risk-Adjusted Costs
HCC186: Major Organ Transplant or Replacement Status <sup>^</sup>	693	0.13%	\$8,770	\$12,789

\*Monitor sub-populations (120-day lookback)

<sup>^</sup> Standard HCC risk adjustors for transplants/malignancies (120-day lookback)

During the SAR Webinar, the workgroup also mentioned additional sub-populations that may warrant further consideration and discussion, such as socioeconomic and cultural characteristics (e.g., health literacy, health beliefs), race/ethnicity, gender, and age.

#### Key Takeaways from Discussion and/or Polls for Defining the Patient Cohort:

- Members recommended including fractures related to osteoporosis but excluding common traumatic fractures and other atraumatic fractures (e.g., those due to metastasis and cancer).
- Members recommended continuing monitoring for the fibromyalgia and osteoarthritis sub-populations.
- Members noted that the standard HCC risk adjustment model adequately accounts for transplants and malignancies.
- Members suggested further monitoring socioeconomic sub-populations during field testing.

### 2.3 Identifying Clinically Related Services

Acumen described the purpose of service assignment so that members could discuss which services associated with the attributed clinician's role in managing the patient's care should be included in the cost measure. These assigned services should be inclusive enough to identify a measurable performance difference between clinicians but also not introduce excessive noise. Episode-based cost measures aim to only include clinically relevant costs whose occurrence, intensity, and/or frequency are within the reasonable influence of the attributed clinician. Service assignment can be an effective form of adjusting for patient risk by omitting unrelated costs.

Acumen presented the following list of preliminary categories of assigned services, which were informed by the survey following the first workgroup webinar.

Table 4. Service Assignment Categories

Service Category	Example Services
Pharmacological treatment (i.e., Part B and Part D medications)	Biosimilars, biologics, methotrexate
Imaging	X-ray, magnetic resonance imaging (MRI), ultrasound, bone density scan
Lab work/monitoring	Erythrocyte sedimentation rate, c-reactive protein, screening tests for tuberculosis and hepatitis
Physical and occupational therapy	Outpatient physical therapy (PT) / occupational therapy (OT) services
Speech therapy	Services for speech and swallow dysfunction
Injections	Joint injections, tendon injections
Joint surgery	Joint replacement/revisions

Service Category	Example Services
Post-acute care following surgery	Post-acute care following joint replacement/revisions
Durable Medical Equipment (DME)	Braces, wheelchair, walkers
Management of comorbidities	Fibromyalgia symptom management, weight management
Psychological services	Psychotherapy for conditions such as depression/anxiety
Infections	Complications due to infection, sepsis, respiratory inflammation and infection
Emergency department visits	Complications with emergency department visit
Home health services	PT, OT, speech language pathology
Hospitalizations	Complications with IP hospitalization
Post-acute care following complications	Post-acute care following complications

During the SAR Webinar, the workgroup discussed services related to the treatment of rheumatoid arthritis that should and shouldn't be included in the measure. There was a general consensus to include services only with a relevant rheumatoid arthritis diagnosis. However, some workgroup members noted that certain services might be specific to rheumatoid arthritis but not be coded with a rheumatoid arthritis diagnosis. For example, a diagnosis of steroid-induced osteoporosis could represent a rheumatoid arthritis complication. Further, a service may be specific to this diagnosis but have a more immediate diagnosis listed instead. In these cases, the rheumatoid arthritis diagnosis might be implied in the greater scope of the patient's care. For example, a physical therapist may see a rheumatoid arthritis patient for balance issues, weakness, or joint pain. Although the patient has rheumatoid arthritis, the attached diagnosis may be something else, such as pain in the wrist/hand.

The discussion first touched on non-pharmacological rheumatoid arthritis services. Two workgroup members recommended adding ultrasound and bone density scans to the imaging category. One workgroup member asked about platelet-derived plasma injections. Others noted that platelet-derived plasma injections aren't supported in the literature for rheumatoid arthritis treatment and shouldn't be included. Other recommendations were to add various categories of rehabilitation services which take place in different settings and to consider speech therapy services. However, not all workgroup members were in favor of including the latter. Another recommendation was to separate different types of complications and hospitalizations. Some workgroup members expressed concern about the attribution to rheumatologists of post-acute care after joint revisions or replacements, as they might not have reasonable influence over the costs. The workgroup voted to include all of the above categories except for speech therapy. Further, the workgroup voted to only include services with a rheumatoid arthritis or other relevant triggering diagnosis.

The workgroup members also discussed the inclusion of Parts B and D drug costs in service assignment for the Rheumatoid Arthritis measure. In the first workgroup webinar, clinicians identified concerns over whether clinicians' and patients' decisions to use Part B or Part D drugs may impact measure performance (i.e., for patients with Part D coverage). As a follow-up to this, Acumen investigated the difference in cost and usage between Parts B and D drugs for rheumatoid arthritis patients and presented their findings. Acumen accounts for patient



heterogeneity related to Part D enrollment by sub-grouping for patients with and without Part D coverage. The research, restricted to episodes for beneficiaries with Part D enrollment, stratified those beneficiaries into 2 comparison groups: (i) those that receive **only** Part B rheumatoid arthritis-related drugs (38.4% of episodes), and (ii) those that receive **only** Part D rheumatoid arthritis-related drugs (33.2% of episodes). 28.4% of episodes contained both Part B and Part D drugs, but the main purpose of this analysis was to investigate cost differences between equivalent Part B and Part D drugs.

For the 2 cohorts, the mean observed cost for beneficiaries with Part B-only drugs was \$19,363, while the mean observed cost for beneficiaries with Part D-only drugs was notably lower at \$15,628. After risk adjustment, however, these differences largely disappear, with a mean risk-adjusted cost of \$16,634 for Part B-only drugs and \$16,710 for Part D-only drugs. These similar numbers suggest that an attributed clinician or group would neither be favored nor penalized based on this factor. As a note, this analysis considers all Part B and Part D drugs of the same type as similar/substitutable treatment options.

Acumen further noted that Part D drug costs are standardized by CMS to remove cost variation between drugs that share active ingredient, route, dosage, and strength. Acumen presented the following list of drug categories to the workgroup to consider for inclusion:

- Nonsteroidal anti-inflammatory drugs (NSAIDs)
- Corticosteroids
- Cyclooxygenase 2 (COX-2) Inhibitors
- Phenylbutazone
- Antimalarials (hydroxychloroquine)
- Gold compounds
- Sulfasalazine
- Methotrexate
- Anakinra
- Adalimumab
- Golimumab
- Leflunomide
- Etanercept
- Abatacept
- Rilonacept
- Canakinumab
- Sarilumab
- Tocilizumab
- Baricitinib
- Tofacitinib Citrate
- Upadacitinib
- Opioids
- Gabapentin
- Fibromyalgia drugs
- Biosimilars

Workgroup members voted to include all of these drug categories except for fibromyalgia drugs.

Workgroup members were asked what aspects of drug cost variation should be standardized away, and which should remain in the attributed cost. Workgroup members noted that specialty

pharmacies may be required for these medications, and that the costs between these pharmacies may vary significantly. Workgroup members also noted that, while brand and generic prices equalize over time, standardizing the price between the 2 would disincentivize switching to lower-cost drugs. Workgroup members further stressed that there's a cost to the patient as a result of taking new biologics or switching drugs due to coverage changes. One workgroup member noted that we don't have a way of assessing the cost to patients who recently turned 65 and joined Medicare, and who sometimes must change their medication as a result.

Acumen plans to examine how the choice of drug may impact cost measures. We're interested in knowing more about "equivalent" drugs, or drugs that may be substituted for one another due to factors such as the patients' insurance coverage or their preference on how and where medications are administered.

#### Key Takeaways from Discussion and/or Polls for Identifying Clinically Related Services:

- Members recommended including only services with a relevant diagnosis (from the list of triggering diagnoses).
- Members didn't recommend including speech therapy.
- Members recommended including all drug categories except for fibromyalgia drugs as assigned services.

## 2.4 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the SAR Webinar Poll to gather input from members on the discussions held during the webinar. Acumen will operationalize input for the measure specifications based on SAR Webinar Poll results and follow up with workgroup members with more information about the next 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, and 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, which were sent prior to the meeting and outlined the topics and process used for the webinar, including embedded empirical analysis results
- A Chronic Condition Cost Measure Framework Overview, which provided an at-a-glance summary of the chronic condition measure framework and lists the initial set of draft codes used in triggering for the meeting analyses, as well as HCCs used in the base risk adjustment model
- Investigation workbooks sent prior to the meeting, which presented detailed findings from empirical analyses:
  - 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 Wave 5 measure development public comments, discussions with CMS, and the input the workgroup provided during the July 2022 Workgroup Webinar.

#### 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 brief recap of the Quality Payment Program and episode-based cost measures for MIPS
- A recap on the different sources of information for the workgroup to consider in addition to their clinical expertise, including analyses and data, a literature review, and findings from the PFPs

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Please contact **Acumen MACRA Clinical Committee Support** at [macra-clinical-committee-support@acumenllc.com](mailto:macra-clinical-committee-support@acumenllc.com) if you have any questions. If you're interested in receiving updates about MACRA Episode-Based Cost Measures, please complete this [Mailing List Sign-Up Form](#) to be added to our mailing list.