Melanoma Resection Workgroup Post Field Testing Refinement (PFTR) Meeting Summary

MACRA Episode-Based Cost Measures: Measure-Specific Workgroups
Post Field Testing Refinement (PFTR) Webinar, October 8, 2020
October 2020

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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 (MACRA) of 2015. Acumen's measure development approach involves convening clinician expert panels to provide input in cycles of development ("waves").[1] The 4 Clinical Subcommittees (CS) that convened in May-June 2019 for Wave 3 were focused on the following clinical areas: Chronic Condition and Disease Management, Dermatologic Disease Management, General and Colorectal Surgery, and Hospital Medicine.[2] These CS provided input on selecting episode groups for development in Wave 3 and the composition of smaller, targeted workgroups to build out the measure. Acumen convened the following workgroups[3] (each composed of approximately 15 members) in mid-August 2019 for in-person meetings: Diabetes, Asthma/Chronic Obstructive Pulmonary Disease (COPD), Melanoma Resection, Sepsis, and Colon and Rectal Resection. Following the workgroup in-person meetings, Acumen convened the workgroups again in January 2020 for a Service Assignment and Refinement (SAR) webinar to revisit the specifications recommended during the in-person meeting and refine the measures prior to national field testing. In October 2020, Acumen reconvened the

[1] For information on measure development in Waves 3, refer to the 2020 Episode-Based Cost Measures Field Testing Wave 3 Measure Development Process document (https://www.cms.gov/files/document/macra-cmft-ebcm-process-2020.pdf)
[2] Members for these Clinical Subcommittees were recruited through a public nomination period from March 11 to April 12, 2019.
[3] Members for these workgroups were recruited from within the CS as well as a standing pool of nominees between June and July, 2019.

workgroups for Post-Field Test Refinement (PFTR) webinars to discuss potential measure refinements based on field testing feedback.

Melanoma Resection Post Field Testing Refinement (PFTR) Webinar, October 8, 2020

This meeting summary document outlines the purpose, discussion, and recommendations from the Melanoma Resection Post-Field Test Refinement (PFTR) webinar. Section 1 provides an overview of the webinar goals and process. Section 2 summarizes the discussion and recommendations from the workgroup. Section 3 is an appendix that describes the materials and information provided to workgroup members prior to and at the beginning of the webinar as preparation for discussion on detailed measure specifications.

1. Overview

The goals of the Melanoma Resection workgroup webinar on October 8, 2020, were to provide detailed recommendations on the following:

(i) Discuss the field testing feedback for this measure.
(ii) Discuss and provide input on priority refinement topic areas and recommendations on measure specifications (based on field testing feedback and other topics).
(iii) Consider and discuss the impacts of COVID-19 on measure specifications.

The meeting was held online via webinar, and attended by 6 of 13 workgroup members. The webinar was facilitated by an Acumen moderator, Suzann Pershing. The Melanoma Resection workgroup chair was Oliver Wisco, who also facilitated meeting discussions, and the Dermatologic Disease Management CS co-chairs were Howard Rogers and Aamir Siddiqui. The MACRA Episode-Based Cost Measure Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties.[4]

Stakeholders 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 were polled on their preferences to ensure the measures are developed based on well-documented stakeholder input. Mirroring 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.

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.

[4] For a list of Melanoma Resection workgroup members in Wave 3, please download the MACRA Episode-Based Cost Measures Measure-Specific Workgroup Composition (Membership) List available on the MACRA Feedback Page (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2019-workgroup-comp-list.pdf)

2. Summary of Sessions and Discussion

This section is organized based on meeting topics and describes workgroup member discussions and recommendations on placing episodes into sub-groups, risk adjustment, and assigning clinically-related services to the episode group. Additionally, there is a sub-section for the session on the potential impact of COVID-19 on the Melanoma Resection measure.

2.1 Addressing Patient Sub-Populations for Meaningful Clinical Comparison

Acumen noted that stakeholder feedback suggested amending the logic for placing episodes into the Head/Neck sub-group. Specifically, feedback suggested that the Current Procedural Terminology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes 14040 and 14041 can be used for Head/Neck procedures and should also fall into the Head/Neck sub-group, instead of placing all episodes into the Trunk/Extremity sub-group as in current measure specifications. The workgroup generally agreed that these codes could be used to place episodes into the Head/Neck sub-group. The workgroup noted that these codes principally indicate procedures performed on the Head/Neck area, even though they contain other body sites in their descriptions. The workgroup added that these codes should warrant placement into the Head/Neck group if accompanied by a Head/Neck or unspecified diagnosis code (DGN), as there is no other ability to parse for body location beyond the current procedure code-diagnosis combination. However, these codes in conjunction with a Trunk/Extremity diagnosis code remain appropriate for the Trunk/Extremity subgroup.

Key Takeaways from Discussion and/or Polls for Sub-Groups:

- Workgroup members recommended adding CPT/HCPCS 14040 and 14041 to the logic for placing some episodes into the Head/Neck sub-group if accompanied by either a Head/Neck diagnosis code (C43.0-C43.4, D03.0-D03.4) or unspecified diagnosis code (C43.9, D03.9).

2.2 Risk Adjustors

Stakeholder feedback provided during measure field testing suggested removing flap/graft procedures occurring on the trigger day from the risk adjustment model. Specifically, stakeholders cited concerns that a flap/graft procedure may be more heavily influenced by clinician choice, rather than patient characteristics, thus contributing variation that is important to retain by not risk adjusting. Some workgroup members agreed with the feedback, noting that flap/graft procedures may be overused, such as for closures less than 10cm on the trunk, represented by CPT/HCPCS 14000. However, workgroup members also discussed situations where this code (and other small flap/graft closures) would be clinically justified. Members posited that flap/graft closures on the hands/feet/genitalia, and even for small melanomas on the trunk that are used to retain full mobility for the patient (e.g., using a graft on an axillary closure to preserve skin elasticity for full range of motion), are often medically necessary, regardless of size. Several workgroup members cited that using CPT/HCPCS 14000 would be unlikely for a procedure on the trunk but agreed that removing this code from risk adjustment wouldn't be a precise approach to filter out unnecessary use of this code. Acumen noted that utilization of 14000 was infrequent in Medicare code-based analysis. Workgroup members also briefly discussed how to account for potential incentives for misuse of flap codes, e.g., up-coding to receive higher payment if CPT/HCPCS 14000 was removed from risk adjustment. One member suggested using anesthesia time as a proxy for flap/graft severity, but the moderator and other workgroup members noted that this would be challenging to use reliably due to granularity of documentation and other confounding clinical factors outside the influence of the attributed clinician.

Workgroup members also revisited a monitored sub-population of episodes with presumed recurrent/concurrent melanoma, per stakeholder feedback. Acumen noted that episodes that had another melanoma trigger procedure occurring within a 90-day lookback from the assessed trigger procedure had risk-adjusted costs over $1,000 greater, on average, than all Melanoma Resection episodes ($2,526 versus $1,501). Workgroup members agreed that staged/related procedures can be parsed from unrelated/separate procedures occurring in the global period (e.g., a melanoma resection occurring on a different body location than the trigger procedure) if appropriate claim modifier codes are used (58 and 79, respectively). However, one workgroup member noted that many of the trigger codes have 10-day post-operative global period. As a result, some procedures related to the trigger procedure may fall outside of this window and may not be coded as staged in connection with the trigger code. Overall, members agreed to continue to monitor this population and evaluate use of modifier codes, suggesting that subsequent procedures occurring on the same body location (as determined by diagnosis code) were likely to be related.

Key Takeaways from Discussion and/or Polls for Risk Adjustors:

- Members recommended continuing to monitor the presumed concurrent/recurrent melanoma sub-population.
- Members didn't reach consensus to remove 14000 from risk adjustment models; the majority of members voted not to do so.

2.3 Assigning Services to the Episode Group

The Acumen team summarized the field testing feedback regarding assigned services, which included recommendations to include services that the workgroup had previously voted to not assign during the January 2020 SAR webinar, specifically services related to pathology, anesthesia, aftercare, and anemia. These services were voted to not be included as part of episode costs at that time because members suggested they aren't always under the influence of the attributed clinician.

2.3.1 Pathology and Anesthesia Services

Workgroup members cited that the clinician performing the trigger procedure may not always be able to choose the pathologist or specific pathology services provided. For example, workgroup members noted that not all dermatologists have access to more than one dermatopathologist due to regional or health system/payer plan constraints, and thus may not be able to influence potential overuse of special stains or other more nuanced, costly procedures. Additionally, one workgroup member noted that attributed clinicians may be contractually obligated to use certain pathologists due to pressures from the health care system or relationships with in-house departments. However, workgroup members agreed that including pathology costs would capture meaningful variation in the use of pathology services, and that not including these services now would remove the potential to influence this aspect of practice moving forward. Workgroup members shared similar sentiments for anesthesia services, namely that the attributed clinician doesn't have complete influence on what/when anesthesia services are used. Workgroup members noted that, while the attributed clinician may choose to use anesthesia based on clinical appropriateness, there may be facility requirements for the use of certain services/staff, such as required use of an anesthesiologist in a hospital outpatient department. However, it was also noted that these costs are important and that current measure specifications include a risk adjustment variable for site of service (e.g., hospital outpatient department or ambulatory surgery center).

2.3.2 Aftercare and Anemia Services

Workgroup members agreed that services related to aftercare and anemia were likely not related to the melanoma excision procedure and thus should not be included in episode costs.

2.3.3 Mohs Chemosurgery

Workgroup members generally agreed that costs related to Mohs chemosurgery shouldn't be included as assigned services due to rapidly evolving education/standards, as well as treatment guidelines and specifications, are not as clearly defined as those for standard melanoma resections. The workgroup noted that these costs weren't suited for inclusion in the current cost measure specifications or scope.

Key Takeaways from Discussion and/or Polls for Assigned Services:

- The following services were assigned:
  - Pathology services
  - Anesthesia services
- Workgroup members recommended to continue to not assign the following categories of services:
  - Mohs chemosurgery
  - Aftercare
  - Anemia

2.4 Potential Impacts of COVID-19 on Cost Measures

In the final session, Acumen provided an opportunity for workgroup members to discuss future considerations for the Melanoma Resection measure due to COVID-19. Workgroup members shared that COVID-19 may have resulted in delayed diagnoses, resulting in more severe presentation of disease upon subsequent examination for patients who have sought care during COVID-19. One workgroup member noted that the severity/staging of melanoma was anecdotally elevated in the months following the start of COVID-19, with a higher proportion of patients presenting with aggressive clinical factors, such as satellite metastases. Workgroup members discussed the difficulty in operationalizing differences in patients that presented with more severe disease due to delay in follow-up from COVID-19 versus more severe patient disease overall. However, workgroup members noted that there may be differences in service utilization in the episode window, and discussed that telehealth services be included since they may have replaced some peri-operative services during COVID-19.

2.5 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the PFTR Webinar Poll to gather input from members on the discussions held during the webinar. The survey also consisted of open comment boxes to provide additional thoughts on quality measure alignment, future refinements based on potential impacts of COVID-19, and a space to share additional comments. Acumen will operationalize input for the measure specifications based on PFTR Webinar Poll results and will follow up with workgroup members with more information about the final steps in the measure development process.

3. Appendix: Overview of Workgroup Member Preparation and Shared Materials

3.1 Introduction

Section 3.2 provides an overview of materials shared with the workgroup members prior to the PFTR 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 was sent one week prior to the meeting and outlined the topics and process used for the webinar
- Melanoma Resection Field Testing Feedback Summary, which provided the feedback received during field testing and the discussion topics and questions for the measure that were discussed at the webinar
- Investigation workbooks sent one week prior to the meeting, which presented detailed findings from empirical analyses:
    - An updated Sub-Population Summary Investigation Workbook, which provided updated data on the frequency and cost associated with an updated set of sub-populations, as recommended by the workgroup during the August 2019 in-person meeting and January 2020 SAR webinar
    - An updated Candidate Services Over Time Investigation Workbook, which contained updated information on frequency, cost, and timing for up to 200 of the most commonly performed services after a trigger event to inform discussions on service assignment and included the share of episodes where the service was assigned based on the service assignment rules

The materials shared were based on analyses run on triggering methodologies with the field testing version of the trigger codes and specifications, which were developed based on input from the August 2019 workgroup in-person meetings and January 2020 SAR webinars.

3.3 Overview of Cost Measure Development

At the beginning of the meeting, Acumen presented a very brief introductory session as a refresher on the following topics:

- The activities done to date since the previous convening of the workgroup, including the national field testing
- The goals of the meeting, including a session to gather workgroup members' thoughts on potential impacts of COVID-19 on measure specifications
- A recap on the different sources of information for the workgroup to consider in addition to their clinical expertise, including analyses and data, as well as the stakeholder input from field testing and the Person and Family Questionnaire