Melanoma Resection Workgroup In-Person Meeting Summary

MACRA Episode-Based Cost Measures: Measure-Specific Workgroups
In-Person Workgroup Meeting, August 22, 2019
September 2019

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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 four 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 Resection.

[1] For information on measure development in Waves 1 and 2 (2017 and 2018), refer to the Episode-Based Cost Measure Field Testing Measure Development Process document (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2018-measure-development-process.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 August, 2019.

Melanoma Resection Workgroup Meeting, August 22, 2019

This meeting summary document outlines the purpose, discussion, and recommendations from the Melanoma Resection workgroup in-person meeting. Section 1 provides an overview of the meeting 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 meeting as preparation for discussion on detailed measure specifications.

1. Overview

The goals of the Melanoma Resection workgroup meeting that convened on August 22, 2019 were to provide detailed recommendations on the following:

(i) Episode trigger codes and scope
(ii) How to account for sub-populations to ensure that the measure allows for meaningful clinical comparisons (either as episode group sub-groups, variables to include in the risk adjustment model, measure-specific exclusions, or sub-populations to monitor for future testing and consideration)
(iii) Episode window length
(iv) Categories of services that are associated with the clinician's role in managing care for the condition and that should be assigned to the episode group (i.e., included as costs in the cost measure)

The meeting was held in Washington, DC, and attended by 11 of 13 workgroup members (9 attended in person and 2 via webinar). The meeting was facilitated by an Acumen moderator, Suzann Pershing. The Melanoma Resection workgroup chair was Oliver Wisco, 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 meeting, workgroup members were provided with information and materials to inform their meeting discussions (see Section 3). During and after the meeting, workgroup members 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 recommendations was >60% consensus. 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 an initial step of the measure development process to gather expert clinical input; as such, these are preliminary discussions and materials, which do not 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 Discussion

This section is organized based on meeting sessions and describes workgroup member discussions and recommendations on each topic, with Section 2.1 containing the discussion on defining episode group scope and trigger codes, Section 2.2 addressing patient cohort sub-populations to ensure meaningful clinical comparison, and Section 2.3 discussing assigning clinically-related services to the episode group.

2.1 Defining the Episode Group

In this session, Acumen reviewed the framework for defining an episode group and provided an overview of trigging methodologies. This section provides a summary of the discussion on the triggering methodology and trigger Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) codes list used to define the episode group. This section also contains a brief summary of the discussion regarding potentially expanding the scope of the measure to include other cutaneous malignancies often solved by resection, such as Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), and Melanoma in Situ (MIS), given relatively low initial coverage counts for Melanoma Resection alone. Analyses conducted using a preliminary specification of the Melanoma Resection measure from the May 2019 CS meeting indicated that the measure may have low patient coverage and episode counts, so Acumen presented potential ways to expand episode and patient counts to the workgroup (such as including BCC, SCC, and/or MIS in the measure scope).

2.1.1 Discussion of Scope

Given the potentially low coverage for a Melanoma Resection-only measure as indicated by preliminary analyses, the workgroup discussed benefits and drawbacks of potentially expanding the episode group to include other non-melanoma skin cancers (NMSCs) commonly solved by resection. The Acumen team presented episode and patient coverage statistics for other NMSCs, including BCC and SCC, which were originally considered as an option for measure development at the Dermatologic Disease Management Clinical Subcommittee meeting in May.

In discussion, several members stated that the strict treatment guidelines for melanoma is what allows for a more homogenous episode group, thus potentially making it a better candidate for development compared to BCC and SCC. Furthermore, the workgroup agreed that the availability of claims data uniquely permits melanomas to be risk-stratified based on several factors, which include but are not limited to in situ status, invasive resection, severity, and location. In contrast, the workgroup added that the coding for BCC and SCC is less defined due to less well-established treatment guidelines and thus more variation in treatment protocols, which could make defining an episode of care for those NMSCs more difficult in comparison.

Another consideration was raised that having multiple melanomas is exceedingly rare compared to having multiple NMSCs, which makes a melanoma-specific episode group more clinically coherent because the specifics of its disease progression is more defined compared to other NMSCs. The workgroup reiterated that the lack of coding specificity makes parsing multiple resections for several NMSCs extremely difficult to identify in claims data. Due to these complexities, the workgroup recommended against including NMSCs in the measure at this time. If resections for other NMSCs were to be included, the workgroup recommended they ought to be treated differently (such as through sub-grouping or risk adjustment) as compared to melanoma resections.

<u>Key Takeaways from Discussion and/or Polls for Scope:</u>

- Ultimately the workgroup suggested that, because of the above factors, the measure scope should not be expanded to include other skin cancers treated by resection at this point in time.

2.1.2 Discussion of Trigger Codes

After confirming the scope of the measure, the workgroup considered the preliminary list of trigger codes and triggering logic, in which an episode is triggered by a CPT/HCPCS procedure code indicating an excision is present and also accompanied by a C43 or D03 melanoma diagnosis code on the same claim.

Several workgroup members indicated that episodes triggered by Mohs surgery codes (which involves the progressive removal of thin layers of tissue where each layer examined for presence of malignant cells, and with the procedure stopping when the layer of tissue removed is malignancy free) should not be included as triggers (CPT/HCPCS 17311 and 17313). Workgroup members noted that Mohs surgery is traditionally used for melanoma in situ (MIS) and not typically for invasive melanoma, which the workgroup agreed is the focus of the measure. Several workgroup members added that the appropriate use criteria for Mohs surgery is still under development, and that only a small fraction of melanomas, in situ or otherwise, are treated via Mohs surgery which is more commonly used in the treatment of NMSCs, including BCC and SCC. In addition to suggesting removing Mohs surgery codes from the draft trigger code list, the workgroup also recommended removing the CPT/HCPCS surgical pathology code 88305 as a trigger code because the pathology procedure may not be performed by the surgeon performing the excision.

The workgroup continued to discuss more nuanced triggering logic, considering that the CS discussed the trigger to be the first excision used for treatment. Workgroup members added that a cleaner episode might be constructed through just the initial resection by the treating clinician, as the members noted that the clinician responsible for any necessary reconstruction may not necessarily have complete control over the characteristics of the reconstruction which could add complexity. Several workgroup members indicated that the services rendered by the treating clinician might differ on a case-by-case basis, as some cases may necessitate lymphadenectomies (removal or dissection of lymph nodes), additional resections to ensure that the margins are clear of disease, or immediate reconstruction if deemed reasonable (codes may be bundled). The workgroup recognized that reconstructive procedures are often taken care of after resection, if feasible, or otherwise referred to a plastic surgeon for reconstruction, depending on the size and/or location.

Given that some episodes require follow-up procedures for either additional excisions or reconstruction, the workgroup considered how separate billing for staged procedures may relate to the trigger discussion. Specifically, the workgroup discussed how separate procedures could trigger one episode for the excision and one episode resulting from a reconstruction trigger CPT/HCPCS code if both codes are included in the list of triggering CPT/HCPCS. The workgroup agreed that excision and reconstruction codes should trigger an episode, though they acknowledged that this allows for more instances where multiple clinicians are contributing to the costs of an episode, as they indicated that it is common for multiple clinicians to be involved, especially for more complex cases. Members added that the more complex a case is, the less likely that the resecting clinician does the reconstruction as well. Regardless, the workgroup agreed that excision and adjacent tissue transfer codes should trigger an episode.

<u>Key Takeaways from Discussion and/or Poll for Trigger Codes:</u>

- The workgroup recommended that the following codes should be removed from the trigger code list:
    - Surgical pathology code CPT/HCPCS 88305
    - Mohs surgery codes CPT/HCPCS 17311 and 17313

2.2 Addressing Patient Sub-Populations for Meaningful Clinical Comparison

Members held detailed discussions about how to account for various sub-populations within the Melanoma Resection episode group. Sub-populations are patient cohorts as defined by particular characteristics. To ensure meaningful clinical comparisons, specific sub-populations/patient cohorts can be handled in the following ways: (i) stratifying the episode group into mutually exclusive and exhaustive sub-groups to define more homogeneous patient cohorts, (ii) including as a variable in the risk adjustment model, (iii) excluding the sub-population from the measure, and (iv) monitoring and testing the sub-population for future consideration.

After Acumen provided a description of each method and presented analytic data on preliminary sub-populations (recommended either by the CS or Acumen clinicians for initial consideration), workgroup members discussed their preferences for how to address each patient cohort, and completed a post-discussion Sub-Population Poll during the meeting.

2.2.1 Sub-Groups

The workgroup recommended stratifying the overall Melanoma Resection population into two episode group sub-groups by body location, one for Head/Neck, and one for Trunk/Extremity. Members suggested this because they noted that head and neck melanomas tend to have a different disease process compared to trunk and extremity melanomas, with several workgroup members citing that trunk and extremity melanomas tend to have a more predictable excision margin and disease trajectory than head and neck melanomas. Additionally, members noted that head and neck melanomas tend to have more complicated reconstruction required, often requiring additional excisions, more intense anesthesia, and generally higher resource use compared to reconstructions elsewhere on the body, and that excisions performed on the hands and feet are complex.

<u>Key Takeaways from Discussion and/or Poll for Sub-Groups:</u>

- The workgroup recommended that there be two sub-groups for the Melanoma Resection episode group:
    - Head/Neck
    - Trunk/Extremity/Unspecified

2.2.2 Risk Adjustors

The workgroup had numerous recommendations regarding sub-populations to add as risk adjustment variables. Beginning with melanomas on different parts of the face, the workgroup recommended risk adjusting for melanomas of the ear and external canal, eyelid (including canthus), lip, and nose, as they indicated that these are highly specialized and especially costly due to larger resection margins, with considerations for careful reconstruction due to aesthetics post-treatment.

Regarding disease severity, members indicated that sentinel lymph node (SLN) excisions/biopsies and immunosuppressed patients, including those undergoing non-melanoma immunotherapy, be risk adjusted for as they may represent more advanced disease and higher risk. Similarly, the workgroup discussed adding risk adjustment variables for different sizes of excisions and reconstructions, as well as MIS, all of which may indicate different disease states.

Workgroup members agreed, however, that the reconstruction size does not necessarily correlate with the excision size, and as such reconstruction size and excision size may be separate risk adjustment variables. For reconstructing melanomas, the workgroup discussed how certain CPT/HCPCS codes may represent more complex procedures, especially ones performed on the head, with specific mention given to lip, nose, eyelid, and face melanomas.

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

- Ultimately, the workgroup recommended adding risk adjustors for the following sub-populations:
    - Face
    - Lip
    - Nose
    - Eyelid
    - SLN biopsy
    - MIS
    - Excision size (>4cm and ≤4cm)
    - Reconstruction size (>30cm and ≤30cm)
    - Flap/Graft CPT/HCPCS codes 15730, 15731, and 15733

2.2.3 Measure Exclusions

Following with the trigger codes discussion, workgroup members indicated that Mohs surgery should be excluded. Additionally, in accordance with the excision trigger codes, the workgroup reiterated that only cutaneous melanomas be included in the measure, recommending that mucosal melanomas be excluded.

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

- The workgroup recommended that the following sub-populations be added as measure exclusions:
    - Mohs surgery
    - Mucosal melanoma

2.2.4 Monitor for Testing

The workgroup discussed whether malignant melanomas of unspecified site ought to be addressed (e.g., through risk adjustment or exclusion) or whether this sub-populations ought to be monitored for future testing and consideration. Members indicated that malignant melanomas of unspecified site can be allocated into the appropriate Head/Neck or Trunk/Extremity sub-group if it is possible to reliably identify them in the data, but would just be lumped into the Trunk/Extremity sub-group (making it Trunk/Extremity/Unspecified) if that is not possible.

Key Takeaways from Discussion and/or Poll for Monitor Variables:

- The workgroup recommended the following sub-populations be monitored:
    - Melanomas of unspecified site

2.3 Assigning Services to the Episode Group

Acumen described the purpose of service assignment so that members could identify and discuss which services associated with the clinician's role in managing the condition should be included in the cost measure. Assigned services should be inclusive enough to identify a measureable performance difference between clinicians but also not introduce excessive noise. Acumen also re-introduced the concept of the episode window to facilitate this session's discussion. Section 2.3.1 presents the discussion of episode window length, and Section 2.3.2 summarizes the assigned services discussion.

2.3.1 Discussion of Episode Window Length

The workgroup deliberated on episode window length, discussing when and for how long to include related procedures commonly performed alongside a melanoma resection. One key consideration for the workgroup was that the default window for other procedural episode groups has often been 30 days pre-trigger and 90 days post-trigger. Members discussed what episode window length they preferred, as well as the clinical feasibility of assigning different procedures and categories of assigned services as costs for the measure, both within the full episode window and shorter periods of time.

Key Takeaways from Discussion and/or Poll for Episode Window:

- Pre-trigger window: 30 days
- Post-trigger window: 90 days

2.3.2 Discussion of Assigned Services

Approximately four weeks prior to the workgroup meeting, workgroup members had participated in an optional *Categories of Assigned Services Survey* to provide preliminary input on the types of services to assign to the episode group. This was intended to serve as the starting point for discussion during this portion of the session.

Workgroup members discussed which melanoma-related services to assign during the episode window. Most of the discussion was focused on which services were under the influence of the attributed physician in the post-trigger window. Some workgroup members expressed that there is significant variability outside of their influence when reconstructing a melanoma, as reconstruction heavily depends on the characteristics of the excision, with members generally agreeing that clinicians should be held accountable for what they have reasonable influence over.

At a high level, the workgroup noted that holding clinicians accountable for just the services under their influence would incentivize under-treatment, as providing a service that could be rendered by someone else increases the cost of the episode of care assignable to them. Several members were in accordance that much of the variability ends up on the reconstruction end of the treatment trajectory and that including staged excision and reconstruction would necessitate providers being comfortable with the factors outside of their control. Other members mentioned that much of the cost variability may end up on the reconstruction end of the treatment trajectory and that including staged procedures and reconstruction procedures in the triggers means that clinicians may need to be comfortable with the inclusion of additional assigned services or noted that holding clinicians responsible for only a small set of clinically related services could incentivize under-treatment.

Considering categories of assigned services, workgroup members recommended that pathology codes should not be assigned, especially in the pre-trigger window, as they deemed these costs not under the influence of the attributed clinician. One member added that the pathology code can be used to test for such a wide variety of items that it may not be specific to the melanoma excision. The workgroup continued to discuss how certain radiological procedures, like x-rays, may only be assigned if they are present alongside the appropriate relevant melanoma diagnosis code. Workgroup members suggested that unrelated imaging procedures during the episode window should not be assigned and recommended that these imaging procedures only be assigned if accompanied by an appropriate melanoma diagnosis. Similarly, the workgroup discussed assigning SLN biopsies if they carry a melanoma diagnosis. They also mentioned or that assigning these kinds of services would require knowing when they were performed relative to a melanoma excision, such as only assigning an SLN biopsy after a melanoma resection in

the post-trigger period, which would suggest that the SLN biopsy is related to the melanoma resection.

Several members suggested that services under Skin Cellulitis in the post-trigger period would not necessarily be melanoma-related and that infection and bleeding services may not be billed under a melanoma diagnosis. Because of this, workgroup members recommended that the window for assigning these services be short in the post-trigger period (i.e., less than the full 90-day post-trigger period).

The workgroup considered the chance of having a spontaneous deep vein thrombosis (DVT) during the episode window (which may form when a patient is motionless for too long, like when on an operating table, due to the stagnation of blood flow) and considered it could be assigned if it could be determined that it was newly occurring from the procedure itself.

The workgroup talked about how to assign Evaluation & Management (E&M) services, with members noting that there are costs on the procedure day that occur prior to the procedure, such as having an oncologist meet with a patient before the surgeon excises the melanoma. The Acumen team noted that, for other procedural measures, the window for assigning E&M visits has been equal to the full episode window for the measure (in this case, 30 days pre-trigger and 90 days post-trigger).

Workgroup members provided their input on these categories of assigned services as well as other categories of assigned services that they did not have time to fully discuss during the meeting in a follow-up survey after the meeting. Acumen clinical and technical teams will take into consideration these results in producing a draft set of measure specifications for future refinement.

2.4 Next Steps

In the final session, Acumen provided an overview of the next steps in the measure development process. Acumen will gather and review the input provided during the workgroup meeting's discussions and polls to create draft measure specifications. These can then be used for future testing and potential measure refinement.

After the meeting, Acumen distributed the *Service Assignment and Episode Window Poll* to gather input from members on episode window and services assignment, which were discussed during one of the last sessions of the meeting. The survey also consisted of open comment boxes, including a question about the patient, family, and caregiver perspective.

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

Section 3.1 provides an overview of materials shared with the workgroup members prior to the meeting. Section 3.2 provides a recap of the main concepts of the measure development process and measure framework presented by Acumen. Section 3.3 presents various stakeholder input and research from a brief literature review conducted by Acumen that workgroup members could consider.

3.1 Overview of Meeting Materials

One week prior to the meeting, workgroup members were provided with the following information to inform their discussions and votes during the meeting:

- *Analytic Key Findings Document*, which summarized a selection of high-level key findings from empirical analyses ("investigations")
- Investigation workbooks presenting detailed findings from empirical analyses:
    - *Flaps and Grafts Investigation Workbook,* which provided data on the frequency and cost of different flap and graft reconstruction codes across different clinician specialties and places of service and which was intended to inform the workgroup about how different reconstruction services are utilized across clinician specialties and places of service
    - *Sub-Population Summary Investigation Workbook,* which provided data on the frequency and cost associated with an initial set of potential sub-populations suggested by Clinical Subcommittee members during and after their May meeting, and by Acumen internal clinicians, to serve as a starting point for workgroup member discussions
    - *Candidate Services Over Time Investigation Workbook,* which contained information on frequency, cost, and timing for up to 200 of the most commonly performed services before and after a trigger event to inform service assignment
    - *Clinician Attribution Investigation Workbook*, which provided the frequency and cost of episodes attributed to (i) individual clinicians (identified by TIN-NPI) by HCFA specialty and (ii) clinician groups (identified by TIN) by the TIN size
- *Literature Review/Quality Alignment Document*, which was an environmental scan that provided an overview of (i) opportunity for improvement for the cost measure identified through the literature, and (ii) quality measures with potential for alignment
- *Person and Family Committee (PFC) Findings Document*, which summarized input from PFC regarding patient and caregiver perspectives

The materials shared were based on analyses run on triggering methodologies with preliminary trigger codes and specifications, which will be revised during measure development.

3.2 Overview of Cost Measure Development and Framework

In the beginning of the meeting, Acumen presented a short session to cover the following topics:

- Role of episode-based cost measures within the context of the cost performance category of MIPS
- Recap of measure development to-date with 19 acute inpatient medical condition and procedural episode-based cost measures developed
    - Eight of these are currently used in the 2019 MIPS performance period alongside two broader cost measures that have been in use since the 2017 performance period: Medicare Spending Per Beneficiary and Total Per Capita Cost

- Details of Acumen's measure development approach, which includes stakeholder input throughout, including a guiding Technical Expert Panel (TEP), CS and workgroups providing detailed clinical input, and a Person and Family Committee (PFC) providing patient and caregiver perspectives[5]
- Overview of Wave 3 CS structure and input on cost measure components, which include defining an episode group, attributing episodes to clinicians, assigning costs, risk adjusting, and aligning cost with quality

Acumen also introduced the episode-based cost measure framework covering the following topics:

- The types of episode-based cost measures (acute inpatient medical condition, procedural, and chronic condition)
- The five essential components of episode-based cost measures (defining the episode group, attributing the episode group to clinicians, assigning costs to the episode group, risk adjusting episode groups, and aligning cost with quality) along with an example illustration of how episodes work
- The steps for construction of an episode-based cost measure and goals that cost measures are meant to accomplish
- Information on the various types of data, literature, and stakeholder input that is considered in the development of episode-based cost measures

3.3 Overview of Stakeholder Input and Literature Review

Prior to discussion on measure specifications, Acumen presented additional information for workgroup members to consider, including existing literature that identifies opportunities to improve cost performance and care outcomes and a list of quality measures for potential alignment consideration.

Additionally, the Westat team provided a summary of the PFC input on cost measure development. The PFC was a focus group of Medicare patients and caregivers that shared their feedback and perspectives regarding care management for procedures and clinician cost performance.

Please contact **Acumen MACRA Clinical Committee Support** at macra-clinical-committee-support@acumenllc.com if you have any questions. If you are 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.

[5] Additional detail on the measure development process and stakeholder roles is available on the MACRA Feedback Page within the Episode-Based Cost Measure Field Testing Measure Development Process document (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2018-measure-development-process.pdf)