Colon and Rectal Resection Workgroup Post-Field Test Refinement (PFTR) Meeting Summary

MACRA Episode-Based Cost Measures: Measure-Specific Workgroups Post-Field Test Refinement (PFTR) Webinar, October 5, 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 of 2015 (MACRA). 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 Wave 3, refer to 2020 Episode-Based Cost Measure 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.

Colon and Rectal Resection Post-Field Test Refinement (PFTR) Webinar, October 5, 2020

This meeting summary document outlines the purpose, discussion, and recommendations from the Colon and Rectal Resection Workgroup 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 Colon and Rectal Resection workgroup webinar on October 5, 2020, were the following:

(i) Discuss 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 the COVID-19 on the measure specifications

The meeting was held online via webinar and attended by 9 of the 18 workgroup members. The webinar was facilitated by an Acumen moderator, Walter Park. The Colon and Rectal Resection workgroup chair was Walter Peters, who also facilitated meeting discussions, and the General and Colorectal Surgery CS co-chairs were Alice Coombs and Guy Orangio. 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. 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.

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 Colon and Rectal 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 sessions and describes workgroup member discussions and recommendations on defining the episode group, addressing patient cohort sub-populations, assigning clinically-related services to the episode group, and quality alignment. Additionally, there is a sub-section for the session on the potential impact of COVID-19 on the Colon and Rectal Resection measure.

2.1 Defining the Episode Group

The workgroup discussed adding Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes that were recommended by a commenter during field testing. The commenter suggested adding CPT/HCPCS codes 44320, 45116, 44620, 44625, 44626, 44188, 44227, and 45550 because they were frequently used by their colorectal surgery division. Out of that list, 2 had already been discussed by the workgroup (e.g., 44320 and 45116) and were recommended for removal because the procedures differed in scope or were associated with lower morbidity and/or pain. Therefore, the workgroup discussed whether or not to add the 6 remaining CPT/HCPCS codes as triggers (i.e., 44620, 44625, 44626, 44188, 44227, and 45550).

Members generally agreed that out of the list of codes suggested by the commenter, only CPT/HCPCS code 45550 would align with the measure's intent, as the rest of the codes entailed mainly small bowel resections. Specifically, members noted that CPT/HCPCS codes 44620 and 44625 were used to close colostomies as well as small bowel enterostomies and 44626 was used for the closure of a Hartmann procedure. Members also noted that 44188 was a laparoscopic code used for a surgical or skin level cecostomy, and 44227, also a laparoscopic code, was used for the closure of an enterostomy following a small bowel injury (i.e., laparoscopic version of 44625). However, members supported adding 45550, a proctopexy code. More specifically, members noted that this code was used for the treatment of a rectal prolapse with sigmoid resection, abdominal approach. The workgroup commented that this code, while older and infrequently used, would be a true resection procedure and should be captured in the measure.

Finally, the workgroup revisited a previously added rectal resection trigger code for repair of a prolapsed rectum (45130). The workgroup was generally in agreement with removing this code as a trigger because it was dissimilar to other procedures. Specifically, the procedure doesn't require an abdominal incision and is for the resection of the rectum and distal sigmoid.

Key Takeaways from Discussion and/or Polls for Episode Triggers:

- The workgroup didn't recommend adding the following CPT/HCPCS codes as episode triggers: 44620, 44625, 44626, 44188, and 44227.
- The workgroup recommended adding CPT/HCPCS code 45550 as an episode trigger.
- The workgroup recommended removing CPT/HCPCS code 45130 from the current list of trigger codes.

2.2 Addressing Patient Sub-Populations for Meaningful Clinical Comparison

Members also revisited recommendations the August 2019 Workgroup In-Person Meeting and the SAR webinar regarding how to account for various sub-populations within the Colon and Rectal 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 presented analytic data on sub-populations (based on recommendations from the workgroup during the SAR webinar), workgroup members discussed their preferences for how to refine given patient cohort sub-populations and confirmed their recommendations in the PFTR Webinar Poll.

2.2.1 Risk Adjustors

The workgroup revisited 2 previously added risk adjustors (e.g., recent cardiac arrest and obesity) because Acumen mentioned that the effects would likely be captured through variables in the Hierarchical Condition Category Version 22 (CMS-HCC V22) 2016 Risk Adjustment Model. In the absence of clinical rationale supporting the inclusion of duplicate variables, Acumen mentioned that removing the specific risk adjustors would lead to a more parsimonious regression model and reduce concerns around collinearity. Members agreed with Acumen's suggestion to remove recent cardiac arrest and obesity as risk adjustors since the effects for these conditions will already be accounted for in the CMS-HCC V22 risk adjustment model.

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

- Members recommended removing the following as specific/additional risk adjustment variables given that they are already included in the base risk adjustment model:
    - Obesity
    - Recent Cardiac Arrest

2.2.2 Exclusions

The workgroup considered whether to exclude episodes without an inpatient (IP) component (i.e., episodes without a concurrent IP stay) as these patients may have different care needs from the overall patient cohort. Members commented that these episodes could be the result of coding errors, but most likely the small number of episodes (i.e., 1,020 or 1.81% of all final episodes) and lower mean episode cost when compared to the final episodes ($8,238 versus $25,042, respectively) suggested that the sub-population represented a different patient cohort, and wouldn't be comparable to other episodes. Even after accounting for patient characteristics through risk adjustment, a slight cost difference persisted, where the mean risk-adjusted cost was $24,123 (compared to $25,171 for final episodes). In the absence of additional analyses to understand which CPT/HCPCS codes were included in this sub-population, workgroup members supported the exclusion of episodes that didn't have an IP component.

Key Takeaways from Discussion and/or Polls for Exclusions:

- Members recommended excluding the sub-population of episodes without an IP component.

2.2.3 Monitor Variables

The workgroup discussed 2 sub-populations for patients who underwent a vascular embolization (i.e., CPT/HCPCS 37244), an interventional radiology (IR) procedure, during the inpatient stay. The first sub-population was for IR procedures that occurred in the pre-trigger period, and the second sub-population was for IR procedures that occurred on the procedure date or in the post-trigger period. These sub-populations were created in response to previous workgroup discussions at the SAR Webinar, where the timing of an IR procedure was noted as an important factor to consider but wasn't captured in the sub-population as it was specified.

During the webinar, workgroup members agreed that it would be appropriate to add a risk adjustor for IR procedures that occurred during the pre-trigger period. Members were also in

agreement that IR procedures occurring on the procedure date or in the post-trigger period during the IP stay shouldn't be accounted for in risk adjustment because they would likely suggest a surgical complication. In the PFTR Webinar Poll, members reached consensus and recommended to continue to monitor (instead of risk adjusting) patients who undergo IR procedures on the procedure date or in the post-trigger period during the IP stay. However, workgroup members didn't reach a consensus in the PFTR Webinar Poll to risk adjust for IR procedures that occurred during the IP stay in the pre-trigger period; therefore, Acumen will continue to monitor this sub-population as well.

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

- Members recommended continuing to monitor the following sub-population:
    - Patients who undergo a vascular embolization (i.e., CPT/HCPCS 37244), during the IP stay in the pre-trigger period
- Members didn't reach consensus to add the following sub-population as a risk adjustor, such that it will also remain monitored:
    - Patients who undergo a vascular embolization (i.e., CPT/HCPCS 37244), on the procedure date or in the post-trigger period during the IP stay

2.3 Assigning Services to the Episode Group

The workgroup revisited the list of cardiac diagnostic procedures currently assigned in the 15-day pre-trigger period, after receiving stakeholder feedback requesting to modify the list (i.e., diagnostic cardiac catheterization, coronary arteriography, echocardiograms, electrocardiograms, cardiac stress tests, and electrographic cardiac monitoring). Additionally, Acumen received feedback from a person and family representative who commented that cardiac procedures should only be performed if medically necessary.

During the webinar, there were recommendations made in favor of continuing to assign these services because of the potential to capture overutilization of in-depth cardiac evaluations. There were also arguments in favor of no longer assigning these services because they aren't regularly ordered by the surgeon and may not be under the reasonable influence of the attributed clinician. The workgroup also considered changing the episode window for diagnostic cardiac catheterization, coronary arteriography to potentially capture therapeutic services as well. Ultimately, the workgroup decided against altering the episode window and reached a consensus to no longer assign diagnostic cardiac catheterization, coronary arteriography services in the pre-trigger period via the PFTR Webinar Poll.

The workgroup didn't reach a consensus for the other 4 cardiac diagnostic procedures during the webinar discussions. However, in the PFTR Webinar Poll, the workgroup reached a consensus, and recommended to continue assigning echocardiograms, electrocardiograms, cardiac stress tests, and electrographic cardiac monitoring in the 15-day pre-trigger period.

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

- Members recommended continuing to assign the following cardiac diagnostic services in the 15-day pre-trigger period:
    - Cardiac Stress Tests
    - Echocardiograms
    - Electrocardiograms
    - Electrographic Cardiac Monitoring
- Members recommended to no longer assign diagnostic cardiac catheterization, coronary arteriography services in the 15-day pre-trigger period.

2.4 Quality Alignment

Members discussed stakeholder feedback from field testing about lymph node staging being an important quality indicator. During the webinar, some workgroup members noted that it wouldn't be feasible to identify the presence of lymph nodes in claims data, and other workgroup members noted this quality indicator would only be applicable for colorectal cancer patients. There was also a consensus among workgroup members during the webinar that lymph node staging would only align with a small portion of episodes in the Colon and Rectal Resection measure. Additionally, in the PFTR Webinar Poll, a member commented that there was an existing quality measure (i.e., NQF #0225) that captured the percentage of patients who had their first diagnosis of colon cancer, and had at least 12 regional lymph nodes removed and examined.

2.5 Potential Impacts of COVID-19 on Cost Measures

Members had an open discussion about future adjustments to the measure specifications and other related considerations in response to COVID-19. Members mentioned that pre-operative testing has changed slightly with the introduction of a COVID-19 test; a member suggested potentially excluding the costs of the COVID-19 test in the future. Other members were concerned that COVID-19 limited elective surgeries, like routine colonoscopies, and colorectal surgeons began to see, on average, sicker patients presenting with later staged diseases as the general population limited seeking medical care beyond urgent visits. To account for the shift in the population seeking medical care during COVID-19, a member suggested including a time-varying covariate (i.e., by quarter) to indicate the severity of the illness.

2.6 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 Shared 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
- Colon and Rectal 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 potential 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