

Routine Cataract Removal with Intraocular Lens (IOL) Implantation Comprehensive Reevaluation Webinar Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, October 6, 2022
January 2023

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Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC to develop and maintain 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 ("workgroups") to provide input in cycles of development ("Waves"). As needed, workgroups are reconvened to provide input on measure maintenance.

Eight episode-based cost measures were added to the MIPS cost performance category in the 2019 performance year and are now being considered for comprehensive reevaluation as they've been in MIPS for 3 years. The purpose of comprehensive reevaluation is to ensure that measures continue to meet criteria for importance, scientific acceptability, and usability in line with the Measures Management System (MMS) Blueprint. In this process, we holistically review the measure, seek public comment, and consider whether any changes need to be made to measure specifications.

The following Wave 1 episode-based cost measures were selected for comprehensive reevaluation based on information gathering, public comments,¹ and discussions with CMS:

- (i) Routine Cataract Removal with IOL Implantation
- (ii) Simple Pneumonia with Hospitalization

¹ For a summary of comments we received during the public comment period, refer to the [Wave 1 Comprehensive Reevaluation Public Comment Summary Report \(PDF\)](https://www.cms.gov/files/document/wave-one-public-comment-summary-report.pdf) (<https://www.cms.gov/files/document/wave-one-public-comment-summary-report.pdf>).

- (iii) ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)

We held a nomination period for workgroup members between August 19, 2022, and September 9, 2022. The workgroups are composed of clinicians with expertise directly relevant to the selected episode-based cost measures. Workgroups were finalized in October 2022, and they provided detailed input on potential updates to the selected episode-based cost measures groups during their webinars from October 6 to 12, 2022. For Wave 1 Comprehensive Reevaluation, all workgroup meetings will be held virtually. The workgroup discussions informed updates to the measure specifications to be used for a public comment period, which is currently slated for early 2023.

Routine Cataract Removal with IOL Implantation Comprehensive Reevaluation Webinar, October 6, 2022

This meeting summary document outlines the purpose, discussion, and recommendations from the Routine Cataract Removal with IOL Implantation Comprehensive Reevaluation 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 discussions on detailed measure specifications.

1. Overview

The goals of the Routine Cataract Removal with IOL Implantation Comprehensive Reevaluation Webinar on October 6, 2022, were the following:

- (i) Provide input to refine a cost measure for potential continued use in MIPS that can accurately distinguish between good and poor performance among clinicians in terms of cost efficiency
- (ii) Consider findings from information gathering conducted since initial development (e.g., empirical analyses, public comments, literature reviews) and measure monitoring from measure implementation
- (iii) Provide input on defining the patient cohort, how to account for subpopulations to ensure that the measure allows for meaningful clinical comparisons, and categories of services to assign to the episode

The meeting was held online via webinar and attended by all 7 workgroup members. The webinar was facilitated by an Acumen moderator, Suzann Pershing. The Routine Cataract Removal with IOL Implantation workgroup chair was David Glasser, who also facilitated meeting discussions. The MACRA Episode-Based Cost Measure Workgroup Composition List will contain the full list of members, including names, professional roles, employers, clinical specialties, and disclosures of interest; it will be posted on the MACRA Feedback Page.²

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 and maintenance process.

² The composition list will be posted on the [MACRA Feedback Page \(https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback\)](https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback).

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 revised 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.

This meeting was convened by Acumen as part of the measure maintenance 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 members' discussions and recommendations. Section 2.1 describes workgroup member discussions and recommendations on defining the patient cohort. Section 2.2 outlines workgroup members' discussions and recommendations related to assigning clinically related services. Section 2.3 provides an overview of next steps for the measure comprehensive reevaluation process.

2.1 Defining the Patient Cohort

Acumen reviewed the methodology for constructing an episode-based cost measure, with a focus on defining the patient cohort by "triggering an episode," and further refining the patient cohort via measure-specific exclusions. Currently, a Routine Cataract Removal episode is triggered using Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code, CPT/HCPCS 66984³. The episode window encompasses the pre-trigger period (60 days prior to the episode trigger date) and a post-trigger period (90 days after the episode trigger date). Patients with significant ocular conditions impacting surgical complication rates and visual outcomes of surgery are excluded from the measure.

2.1.1 Adding Trigger Code

Acumen presented analyses to show the most frequently observed cataract removal service CPT/HCPCS codes, with the most frequent being CPT/HCPCS 66984. The workgroup then discussed whether the second most frequently observed cataract removal service CPT/HCPCS code, CPT/HCPCS 66982⁴, should be added to the trigger logic. CPT/HCPCS 66982⁴ represents a small number of cataract surgery procedures relative to CPT/HCPCS 66984. Other cataract removal service CPT/HCPCS codes are observed even less frequently. Workgroup members expressed concern that adding CPT/HCPCS 66982 would disadvantage providers with a small number of cases, as their cost performance could be skewed if these procedures are higher cost (e.g., if they require more interventions, given the greater clinical heterogeneity of the CPT/HCPCS 66982 population). Workgroup members didn't suggest adding any other CPT/HCPCS codes to the trigger logic.

2.1.2 Removing Exclusions

Acumen reviewed methods used to account for patient heterogeneity and to allow for meaningful clinical comparisons:

³* "Removal of cataract with insertion of prosthetic lens"

⁴* "Complex removal of cataract with insertion of prosthetic lens"

*AMA CPT Code Description Licensing. Codes and descriptions included are from the Current Procedural Terminology (CPT®) Copyright 2020 American Medical Association. All rights reserved.

- (i) risk adjustment⁵
- (ii) sub-grouping⁶
- (iii) exclusion⁷
- (iv) monitoring⁸

Exclusions are intended for small patient/case cohorts that demonstrate extreme variability due to clinical heterogeneity, aren't feasible for performance improvement, and can't be mitigated via risk adjustment or service assignment. The measure currently excludes all patients who have any diagnosis from a detailed list of ocular conditions identified during the 120 days prior to the trigger procedure. During the initial development of the Routine Cataract Removal measure, these diagnosis-based exclusions were adopted wholesale from the Physician Quality Reporting System (PQRS) predecessors to MIPS quality measure #191 *Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery* and #192 *Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*; MIPS quality measure #192 is no longer in use in MIPS.

Acumen presented analyses on current measure exclusions. Current exclusions for ocular conditions remove nearly half of all episodes. The excluded episodes have very similar observed cost profiles compared to other episodes. The complexity of excluded episodes measured through the number of Hierarchical Condition Categories (HCCs) is also very similar compared to other episodes. These considerations suggest that exclusion may not be an appropriate method to account for this large patient cohort.

The workgroup generally agreed the measure specifications should be updated to include patients with many of these conditions in the measure, based on little or no expected impact on the cost measure score. The workgroup advised retaining exclusions for rare conditions and conditions with greater clinical variability that introduces unpredictability in cataract surgery costs. Members suggested including patient with conditions that don't often require additional procedures and applying risk adjustment to account for patient heterogeneity. The workgroup discussed examples, including diabetic retinopathy, intraoperative floppy iris syndrome (IFIS), macular degeneration, and glaucoma. The workgroup expressed an interest in additional analyses to see how well the risk adjustment model effectively addresses clinical heterogeneity for each condition. Patients with "hypermetropia" and "other age-related cataract" were noted to warrant inclusion in the measure without any additional risk adjustment.

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

- Members recommended against adding an additional procedure code to the measure trigger logic.

⁵ Risk adjusting is a method to account for the case-mix of patients and other non-clinical characteristics that influence complexity. It's meant to be used for subpopulations that make up a large share of patients who have a characteristic that's outside of the attributed clinician's reasonable influence. Risk-adjusted cost measures compare observed episode spending to an expected episode spending (predicted by a risk adjustment model).

⁶ Subgrouping is a method that's intended for when we would want to compare episodes only with other similar episodes within the same subgroup. This approach is used when subgroups are very different from one another, and each subgroup requires its own risk adjustment model. Since each subgroup will have its own risk adjustment model, the size of each subgroup should be sufficiently large.

⁷ Excluding is a method in which we exclude certain patients or episodes to address issues with patient heterogeneity. This approach should be used when the subpopulation affects a small, unique set of patients in which risk adjustment wouldn't be sufficient to account for their differences in expected cost.

⁸ Monitoring is a method in which we gather additional data to see how best to account for factors resistant to the other methods specified above.

- Members generally agreed to include patients with many of the ocular conditions previously excluded from the measure, based on little or no expected impact on cataract surgery costs.
- Members advised retaining exclusions for rare conditions and conditions with greater clinical variability that introduces unpredictability in cataract surgery costs.
- The reevaluated version of the measure will be referred to as *Cataract Removal with Intraocular Lens (IOL) Implantation*.

2.2 Assigning Clinically Related Services

Acumen described the purpose of service assignment so that members could discuss whether any updates should be made to the measure specifications. The purpose of service assignment is to identify services occurring during the episode that are clinically related to the attributed clinician's role in managing patient care during an episode. 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 not related to the procedure or type of care being assessed.

The current service assignment rules for the Routine Cataract Removal measure include clinically related office-based procedures and testing, office visits and telehealth, returns to the operating room and other complications, and ancillary services, including anesthesia, medications, and injections.

Acumen presented a list of other potentially-related services occurring during the episode window:

- Pre-operative testing
- Additional telehealth services
- Durable medical equipment (DME)
- Emergency department (ED) visits for ocular complaints
- Eye care (e.g., examination of eye, microfluid analysis of tears)

The workgroup had a verbal consensus to add telehealth codes and postoperative DME to the measure. For ED visits, the workgroup generally agreed that the measure should include ED visits for ocular pain within 1 to 3 days postoperatively. Since preoperative testing sometimes depends on surgical centers' requirements instead of providers' choices, one member suggested not adding it to the measure, consistent with discussion in initial measure development. Other members noted preoperative testing can be a source of low-value care and should be included in the measure.

The workgroup also discussed assigning Part B medication costs to the measure. Acumen presented previous feedback from interested parties regarding the following clinically related Part B drugs which have separate payment statuses: Omidria, Dexycu, and Dextenza. Only Omidria is currently assigned to the episode; Dexycu and Dextenza weren't available when the measure was developed and aren't assigned to the measure. Members raised the following points in favor of continuing to include Omidria in the measure:

- Omidria is a very expensive medication and an important source of cost variation.

- Its potential effects may have greater potential benefit for complex cataract removal cases which are currently excluded from the measure (i.e., less common for routine cataract care).
- Opioids shouldn't be needed for routine cataract removal procedures so if this is an opioid alternative, it provides an important source of cost variation.
- Some practices reported being pressured to use this drug for profit.

Members raised the following points in favor of removing Omidria from the current set of assigned services:

- It's FDA-approved.
- There are peer-reviewed articles documenting its potential benefits.
- It reduces pain and improves pupillary dilation.
- It has a separate payment status as an opioid alternative (i.e., incentivized for use through the Hospital Outpatient Prospective Payment System [OPPS] program).

Some workgroup members also recommended that Part B medications with separate payment statuses should be considered collectively, i.e., the same service assignment rules should apply to any clinically-related Part B medications with separate payment statuses. Other workgroup members suggested that these and similar medications be considered on a case-by-case basis.

The discussion then turned to standardized Part D costs. Standardized Part D costs weren't available at the time of measure development but can now be considered for inclusion in the measure. Part D payment standardization allows drugs with the same ingredient, strength, dosage form, route of administration, and brand/generic status to have the same unit price to allow the price to be comparable across providers, regardless of the drug manufacturer, Part D plan, or dispensing pharmacy. Workgroup members noted that there are clinically-related Part D medications that could be considered for inclusion in the measure. However, the workgroup also discussed the importance of drug price transparency, which would allow providers to have more awareness of how much the drugs cost Medicare. Several members noted that drug choices could be out of the attributed clinicians' control and be dependent on surgical centers' preferences, and that regional pricing differences may be large in magnitude, change frequently, and not be known to clinicians.

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

- Members recommended assigning costs of ED visits for ocular pain within 1 to 3 days postoperatively and eye care services, but didn't reach consensus for postoperative DME, or additional telehealth services. The revised measure specifications for public feedback will include these service categories.
- Members recommend against assigning additional preoperative testing services.
- Members agreed that the same service assignment rules should apply to all clinically related Part B drugs with separate payment statuses, but didn't reach a consensus on whether the measure should include or exclude specific Part B drugs, including Omidria, Dexycu, and Dextenza. The revised measure specifications for public feedback will include these Part B drugs in the service assignment rules.
- Members didn't reach a consensus on whether to include standardized Part D costs in the measure and expressed a need for drug price transparency to allow clinicians to have more control over drug costs. The revised measure specifications for public feedback won't include Part D drugs in the service assignment rules.

2.3 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the Comprehensive Reevaluation Webinar Poll to gather input from members on the discussions held during the webinar. Acumen will operationalize input for the measure specifications based on the Comprehensive Reevaluation Webinar Poll results and follow up with workgroup members with more information about the next steps in the comprehensive reevaluation process. Additionally, the revised measure specifications will be made available for public feedback in early 2023.

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 comprehensive reevaluation 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 outlined the topics and process used for the webinar, including embedded empirical analysis results
- Measure specifications (Measure Information Form, Measure Codes List), which were a reference for the current measure specifications
- Investigation workbook, 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)

3.3 Overview of Cost Measure Comprehensive Reevaluation

At the beginning of the meeting, Acumen presented an introductory session on the following topics:

- The activities done to date for the comprehensive reevaluation of selected episode-based cost measures
- The goals of the meeting and timeline of activities for Wave 1 measures
- 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 information gathering findings, public comments, and analyses and data

Please contact **Acumen MACRA Clinical Committee Support** at 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.