

Prostate Cancer Service Assignment and Refinement (SAR) Webinar Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, October 4, 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").¹ 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, 2022.² 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

¹ 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>).

² 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>).

for a Service Assignment and Refinement (SAR) Webinar to revisit the specifications 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.

Prostate Cancer SAR Webinar, October 4, 2022

This meeting summary document outlines the purpose, discussion, and recommendations from the Prostate Cancer 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 Prostate Cancer SAR Webinar on October 4, 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 14 of the 17 workgroup members. The webinar was facilitated by an Acumen moderator, Heather Litvinoff. The Prostate Cancer workgroup chair was Join Luh, who also facilitated meeting discussions. Christina Butler and Martie Carnie 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.³

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.

³ 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 refining the measure scope, accounting for patient heterogeneity, 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 2 PFPs to gather input that would inform cost measure development for Prostate Cancer. During the webinar, 2 PFPs shared these findings and fielded questions from the workgroup members.

PFPs reported that initial services received for prostate cancer included prostate-specific antigen (PSA) tests and follow-ups with urologists. In some cases, they received follow-up PSA tests and imaging diagnostic services. However, PFPs reported that the process can be confusing and frustrating to manage, which can largely be attributable to poor communication. Treatment options can include surgery, radiation, chemical treatment, hormone therapy, or watchful waiting. PFPs reported that the treatment experience can also be frustrating because of the uncertainty in when to intervene. Some reported delayed treatment that led to metastasis and death.

PFPs also reported other complications, such as nerve damage, erectile dysfunction (ED), urinary incontinence, and impotency. They noted that these conditions, especially ED, had a lasting emotional impact on the patients, as they struggled with how these complications impacted their identities. Other less common complications include anemia (as a result of Radium-223 treatment) and fluid leak.

PFPs reported that barriers to quality care were common in treating prostate cancer. Communication was highlighted again as a barrier to effective, quality care for patients. One PFP also noted that familiarity, or lack thereof, with the healthcare system as a whole was a barrier to care. The PFP who works as a patient advocate in a health system shared that without her background, it would have been very difficult to find the information she needed to set appointments in a timely fashion. In this case, waiting 6 weeks for a magnetic resonance imaging (MRI) study didn't negatively impact the outcome, but it easily could in another case.

The workgroup appreciated the feedback from the PFPs and discussed how to improve based on their experiences. One member noted that MRIs aren't yet considered the standard of care for prostate cancer, which might explain why it was so difficult to get one. Another member noted that proper MRI usage requires radiologists and urologists who are familiar with it, potentially limiting its use to less resource-dense hospitals. The workgroup agreed that communication is a vital issue in prostate cancer care and directing patients toward the correct resources is essential.

2.2 Refinements to the Measure Scope

Acumen provided an overview of the episode-based cost measure framework and episode construction methodology. The scope of the measure is driven primarily by the trigger specifications, which aim to identify an ongoing patient-clinician relationship using 2 claims.

The International Classification of Diseases, 10th Revision (ICD-10) code R9720 (Elevated PSA) was suggested by the workgroup in the first webinar as a potential triggering claim (i.e., first service) to indicate a patient-clinician relationship. However, the workgroup believed that R9720 shouldn't be used as a confirming claim (i.e., second service). While it's technically possible to implement this algorithm, there may be some unintended consequences introduced when a diagnosis code can only trigger and not confirm a relationship.

Acumen presented preliminary results to highlight that adding the R9720 code as a trigger-only diagnosis may allow the measure to capture an additional 4 days of observation, on average, compared to using only the C61 diagnosis code alone. This period may capture some additional diagnostic cost to confirm prostate cancer, but it's applicable for only about 6% of episodes. On the other hand, it may make the patient population more heterogeneous because of the introduction of many very low-cost episodes that are either false positives or watchful waiting.

One workgroup member mentioned that eliminating the code seems acceptable, given the tiny portion of total episodes it would include. Several members noted that these low-cost episodes might be under "Active Surveillance" and so the follow-up visit might be more than 180 days after the confirming claim. Another workgroup member noted that "Active Surveillance" is a valid treatment for prostate cancer; therefore, excluding it would make the measure less comprehensive and representative of prostate cancer as a whole. One member highlighted that the underlying consideration is the scope of the measure, specifically whether the measure aims to capture all of prostate cancer or only the treatment portion. Other members also agreed that the consideration of the scope of the measure is central to this discussion.

Key Takeaways from Discussion and/or Polls for Refinements to the Draft Specifications:

- Members recommended removing the ICD-10 code R9720 from the triggering logic.

2.3 Accounting for Patient Heterogeneity

Acumen reviewed the following methods used to account for patient heterogeneity and allow for meaningful clinical comparisons: (i) risk adjustment⁴, (ii) sub-grouping⁵, (iii) exclusion⁶, and (iv) monitoring⁷.

⁴ 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 sub-populations 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).

⁵ Sub-grouping is a method that's intended for when we want to compare episodes only with other similar episodes within the same sub-group. This approach is used when sub-groups are very different from one another, and each sub-group requires its own risk adjustment model. Since each sub-group will have its own risk adjustment model, the size of each sub-group should be sufficiently large.

⁶ 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 sub-population affects a small, unique set of patients in which risk adjustment wouldn't be sufficient to account for their differences in expected cost.

⁷ 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.

After the workgroup webinar, the workgroup was in consensus that metastatic cancer often or always indicates high-intensity treatment. Acumen presented preliminary results that show how sub-grouping by metastatic cancer seems to adequately account for the variation in cost within the current patient cohort in conjunction with the risk adjustment model. Internal analyses by Acumen also confirmed that metastatic cancer was the most optimal variable to stratify episodes into 2 homogenous sub-groups by cost. Acumen also noted that updates can be made to sub-grouping or the risk adjustment model in the future if there are more granular diagnosis codes for prostate cancer.

Indicators of high-resource use recommended by the workgroup were also found to be strong predictors of episode cost. Testing results show that adding recent use of chemotherapy and immunotherapy as risk adjusters improved the risk adjustment model. Acumen opted to not include some other indicators suggested by the workgroup (e.g., recent combination of both prostatectomy and radiation, recent medical oncologist visit) because they didn't seem to improve the model beyond the current set of risk adjusters.

The testing results also revealed 2 sub-populations of patients whose cost weren't adequately adjusted:

- Patients without any claims related to prostate cancer in the previous year
- Patients enrolled in hospice

The workgroup discussed risk adjustment and exclusions. They supported excluding hospice care patients and risk adjusting new prostate cancer patients, noting that costs for such patients are often front-loaded and potentially indicative of a different cost structure. One member recommended treating new prostate cancer patients as a different group that needed to be analyzed separately. Acumen noted that if we removed R9720, we would be left with a definitive prostate cancer, which can help to limit the scope of the measure to ongoing prostate cancer. Additionally, results from the previous webinar showed that over 95% of patients aren't new cases.

Key Takeaways from Discussion and/or Polls for Accounting for Patient Heterogeneity:

- Members recommended risk adjusting for episodes without a prostate cancer encounter in the past year
- Members recommended excluding patients with hospice enrollment prior to the episode

2.4 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 not furnished for the management of prostate cancer.

Using prior input from public comments, as well as internal literature reviews and workgroup feedback from July 2022, Acumen drafted the following categories of clinically related services:

- Outpatient evaluation and management services

- Treatment services (i.e., chemotherapy, radiation, surgery, immunotherapy, and hormone therapy)
- Diagnostic services (i.e., biopsies, imaging, and lab tests)
- Part D medications

Members generally agreed that services for the consequences of treatment should be included. Some members noted that sepsis after chemotherapy is an uncommon outcome, which may be related to patient selection and it would be difficult to measure. Another member said that all consequences from cancer-treating drugs should be included, as should complications of radiation therapy (e.g., radiation cystitis, proctitis, strictures). A member suggested using post-treatment procedures as potential indicators of the consequences of treatment. For example, physical therapy for pelvic floor issues may indicate diarrhea and the presence of vacuum pumps may indicate erectile dysfunction. A member suggested additional consequences that patients might experience in the wake of treatment, such as skeletal events (e.g., bone metastases or osteoporosis). The workgroup generally agreed that pain management services should be included in the measure.

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

- Members recommended including the following consequences of treatment in service assignment:
 - Sepsis or other infections after chemotherapy
 - Adverse effects of Cabazitaxel, Docetaxel, Paclitaxel (e.g., peripheral neuropathy, nausea, vomiting)
 - Anemia
 - Neutropenia and febrile neutropenia
 - Urinary dysfunction (e.g., urethral stone, transurethral resection of the prostate)
 - Urinary tract infections
 - Procedures for erectile/urinary dysfunction
 - Erectile dysfunction
 - Bowel dysfunction (e.g., diarrhea, bowel dysmotility, constipation)
 - Surgical complications related to prostatectomy (e.g., cystocele, rectocele, fistulas, stricture)
 - Radiation complications (e.g., radiation cystitis, proctitis, strictures, colonoscopy to evaluate radiation proctitis, hyperbaric oxygen for cystitis or proctitis)
 - Durable medical equipment (penile implants, pumps for erectile dysfunction, Foley catheter)
 - Skeletal-related complications (e.g., fractures, osteoporosis)
 - Physical therapy or rehabilitation
 - Pain management
 - Psychologic or psychiatric services for depression or other disorders associated with cancer diagnosis or treatment

2.5 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 Hierarchical Condition Categories (HCCs) used in the base risk adjustment model
- Investigation workbooks sent prior to the meeting, which presented detailed findings from empirical analyses:
 - A Sub-Population Analysis, which provided data on the frequency and cost associated with a preliminary set of sub-populations informed by public comments received and deliberations among the Acumen clinical team
 - 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

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.