Prostate Cancer Workgroup Webinar Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, July 28, 2022
September 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 schedule. 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) Prostate Cancer, and (iii) Rheumatoid Arthritis.

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

[1] For information on measure development in Wave 4, refer to the Wave 4 Measure Development Process 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).

workgroup webinars from July 26 to 28, 2022. For Wave 5, all workgroup meetings will be held virtually. The workgroups will convene for a second and third meeting to continue measure specification and refinement discussions before and after a national field test, which is currently slated for early 2023.

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This meeting summary document outlines the purpose, discussion, and recommendations from the Prostate Cancer workgroup 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 workgroup webinar on July 28, 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 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. Martie Carnie and Joe Connell 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 will contain the full list of members, including names, professional roles, employers, and clinical specialties; it will be posted on the MACRA Feedback Page.[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 were 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.

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.

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

2. Summary of Sessions and Discussion

This section is organized based on meeting sessions and describes workgroup member discussions and recommendations. The first sub-section summarizes the PFP findings discussed during the webinar. The second sub-section describes discussions regarding the overview of the measure construction process. The remaining sub-sections describe workgroup member discussions and recommendations on defining the patient cohort, accounting for patient heterogeneity, and identifying clinically related services, respectively. The final sub-section provides an overview of next steps for the measure development process.

2.1 Person and Family Partner (PFP) Findings and Discussion

We conducted focus groups and interviews with 4 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 workgroup members.

PFPs noted that confirming a diagnosis for prostate cancer lasts several months and usually involves prostate specific antigen (PSA) testing, biopsy of the prostate gland, and diagnostic imaging (e.g. magnetic resonance imaging [MRI]). Annual PSA testing was a major driver to seeking further diagnostic testing for prostate cancer. PFPs indicated that primary care providers and urologists were the most involved in caring for patients with prostate cancer, especially in the early stages. PFPs also reported receiving care from nurse practitioners, radiation oncologists, hematologists, surgeons, and medical oncologists, who were more likely to lead the care team. There were several treatment options offered to patients with prostate cancer. According to the PFPs, routine treatment services included radiation therapy, surgery, chemotherapy, and androgen deprivation therapy (ADT).

PFPs identified the need for more education, especially for recently diagnosed prostate cancer patients, to facilitate informed decision-making on treatment choice. Most PFPs noted that treatment options and side effects were poorly explained. They also emphasized the importance of setting realistic expectations of outcomes for patients undergoing treatment for prostate cancer.

PFPs mentioned that open patient-provider communication and the ability of clinicians to listen to and consider patient priorities when discussing treatment options was central to quality care and improved patient outcomes and care experience. They also highlighted several opportunities for improvement, which included supporting quality of life decisions, improving pain management for prostate cancer patients undergoing treatments, and increasing mental health support in recognition of the psychological impact of prostate cancer.

2.2 Overview of the Measure Construction Process

Acumen provided a brief overview of the steps involved in constructing an episode-based cost measure, including the requirements for an effective cost measure. The Prostate Cancer measure seeks to capture the cost of caring for prostate cancer patients, including condition-related services and complications. Key steps involved in constructing an episode-based cost measure are listed below.

- Triggering, or starting an episode, to identify the start of a patient-clinician relationship
- Attributing an episode to a clinician group or clinician
- Assign the cost of clinically related services
- Applying measure exclusions
- Risk adjusting episode cost within each sub-group (if applicable)

- Calculating the measure score

2.3 Defining the Patient Cohort

Acumen discussed the framework for defining the patient cohort for the Prostate Cancer measure. The goals of this session were to define the scope of the measure and refine the service and diagnosis codes used to identify the presence of a care relationship. Additionally, we aimed to define the timing of the attribution window and attributed clinicians, and lastly, outline opportunities for alignment with MIPS quality measures and MIPS Value Pathways (MVPs). In terms of measure scope, Acumen proposed a method to identify potential patient-clinician relationships by looking for 2 services (i.e., trigger and confirming claim) with a prostate cancer diagnosis on different days within 180 days of each other. An episode of care for prostate cancer is triggered when an attributed clinician group (identified by their Tax Identification Number [TIN]) bills 2 claims with particular Current Procedural Terminology / Healthcare Common Procedure Coding System (CPT/HCPCS) codes within a defined period of time. Both of these claims must have an International Classification of Diseases 10th Edition (ICD-10) diagnosis code indicating prostate cancer. These CPT/HCPCS codes include the following:

- On a trigger claim, it's either an outpatient evaluation and management (E&M) code that includes clinician visits in the outpatient setting, clinician's office, nursing facility, or assisted living facility (intended to identify primary care) or a biopsy of the prostate gland, PSA test, or diagnostic imaging
- On a confirming claim, it's either another outpatient E&M, ADT, PSA test, or a condition-related CPT/HCPCS procedure code related to the treatment of prostate cancer

During the webinar, several workgroup members noted that the measure should capture patients with a confirmed diagnosis of prostate cancer as well as prostate cancer patients under active surveillance. In order to capture newly diagnosed prostate cancer patients, workgroup members recommended including the R9720 (elevated PSA) diagnosis code. Furthermore, there was consensus that the triggering logic should also account for differences in initiating a patient-clinician relationship by different medical specialties.

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

- Members recommended using both C61 (malignant neoplasm of prostate) and R9720 (elevated PSA) ICD-10 diagnosis codes with a condition-related CPT/ HCPCS code as the first service (trigger claim), which includes:
    - Outpatient E&M service with the C61 diagnosis code
    - PSA test, imaging, or biopsy of prostate with the R9720 diagnosis code
- For the second service (confirming claim), members recommended using another outpatient E&M service, PSA test, or ADT with a C61 diagnosis code

2.4 Accounting for Patient Heterogeneity

Acumen reviewed the different methods for accounting for heterogeneity in the patient cohort for an episode-based cost measure to allow for meaningful clinical comparisons. During the webinar, the workgroup reviewed the 3 options for addressing heterogeneity:

- Stratifying the patient population into mutually exclusive and exhaustive sub-groups to define more homogenous patient cohorts[4]
- Defining covariates in the risk adjustment model[5]
- Identifying measure exclusions[6]

Another option that was mentioned was monitoring for further testing later in the development process.

Acumen presented a proposal to stratify the prostate cancer patient population into sub-groups of low, medium, and high intensity of resource use based on prior service utilization.

The topic of how to stratify patient risk in absence of granular diagnosis codes within the C61 diagnosis code was a robust discussion among workgroup members. Several members highlighted the need to distinguish localized versus metastatic cancer and new versus existing prostate cancer. Another suggestion was to look for prior use of chemotherapy and ADT. One member highlighted that there may be too much variation in clinical practice to be able to reliably classify risk using the specialty of the clinician. Treatments, such as surgery only, radiation only, or combination of surgery and radiation, were also mentioned as potential indicators of risk.

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

- Members recommended to include the following sub-populations within the low intensity of resource use sub-group:
    - Services by urologists only
    - PSA testing only
- Members recommended to include the following sub-populations within the medium intensity of resource use sub-group:
    - Services by medical oncologists only
    - Services by radiation oncologists only
    - Services by surgical oncologists only
    - Radiation only
    - Surgery only
- Members recommended to include the following sub-populations as high intensity of resource use sub-groups:
    - Metastatic cancer
    - Chemotherapy
    - Immunotherapy
    - Surgery and radiation

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[4] Sub-grouping is a method that's intended for when we would 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.

[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 sub-populations that make 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] 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.

2.5 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 prostate cancer care.

The goal for this session was to identify clinically related services where the attributed clinician group or clinician can reasonably influence the occurrence, intensity, and frequency of those services. Acumen presented a preliminary list of services that included outpatient E&M services, Part D drugs, and services related to cancer treatment and diagnosis. There was verbal consensus among workgroup members to include the aforementioned prostate cancer-related treatment and diagnostic services (listed below), and workgroup members provided several more service categories to consider for this measure. Members also agreed to include Part D drugs in the measure, as it's an integral part of prostate cancer care.

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

- Members recommended to include the following drugs:
    - Drugs approved by the National Cancer Institute:
        - Abiraterone Acetate
        - Apalutamide
        - Bicalutamide
        - Cabazitaxel
        - Darolutamide
        - Degarelix
        - Docetaxel
        - Enzalutamide
        - Flutamide
        - Goserelin Acetate
        - Leuprolide Acetate
        - Lutetium Lu 177 Vipivotide Tetraxetan
        - Mitoxantrone Hydrochloride
        - Nilutamide
        - Olaparib
        - Radium 223 Dichloride
        - Relugolix
        - Rucaparib Camsylate
        - Sipuleucel-T
    - Additional drugs mentioned during the webinar:
        - Medications for anxiety and depression
        - Anti-nausea medication
        - Alendronate
        - Carboplatin
        - Cisplatin
        - Denosumab
        - Estrogen
        - Etoposide
        - Finasteride

        - Histrelin
        - Ibandronate
        - Ketoconazole
        - Methylprednisone
        - Pamidronate
        - Prednisone
        - Risedronate
        - Tamoxifen
        - Triptorelin
        - Zoledronic acid
- Members recommended including the following service categories:
    - Outpatient E&M services
    - Cancer treatment (chemotherapy, surgery, ADT, radiation, immunotherapy)
    - Diagnostic services (biopsy, MRI, positron emission tomography (PET) scan, computed tomography (CT) scan, nuclear medicine, bone scan, PSA testing, genetic testing)

2.6 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the Workgroup Webinar Poll to gather input from members on the discussions held during the webinar. In this poll, we also asked workgroup members for their availability for the second webinar in either late September or early October 2022. Acumen will operationalize input for the measure specifications based on workgroup webinar discussion and poll results and will 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 was sent prior to the meeting and outlined the topics and process used for the webinar, including embedded empirical analysis results
- A Welcome Packet of materials providing an overview of Wave 5 of cost measure development and information on the measure frameworks
- 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 and discussions with CMS.

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 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