# Depression Post-Field Test Refinement (PFTR) Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
PFTR Webinar, April 12, 2022
June 2022

Contents



## 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 4, instead of the typical Clinical Subcommittee (CS) process for episode group prioritization and selection, we obtained stakeholder input on candidate clinical areas and episode groups through a public comment period from December 16, 2020, to February 5, 2021.[2] This approach provided flexibility for a wider range of stakeholders 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), CS, and Clinician Expert Workgroups ("workgroups"). The following Wave 4 episode groups were finalized based on the prioritization criteria, public comments received, and discussions with CMS: (i) Emergency Medicine, (ii) Heart Failure, (iii) Low Back Pain, and (iv) Depression.

We held a nomination period for workgroup members between April 26, 2021, and May 21, 2021. The workgroups are composed of clinicians with expertise directly relevant to the selected episode groups. Workgroups (of about 15-20 members) were finalized in June 2021, and they provided detailed input on the development of the selected episode groups during their first workgroup webinars from June 21 to June 24, 2021. Acumen convened the workgroups again for a Service Assignment and Refinement (SAR) Webinar to revisit the specifications recommended during the workgroup webinar and refine the measures prior to national field testing. After the national field test from January 10, 2022, to March 25, 2022, Acumen

[1] For information on measure development in Waves 4, refer to the 2022 Episode-Based Cost Measures Field Testing 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 MACRA Episode-Based Cost Measures: Wave 4 Measure Development Public Comment Summary Report document (https://www.cms.gov/files/document/wave-4-public-comment-summary.pdf).

convened the workgroups for a third meeting to continue measure specification and refinement discussions in April 2022. For Wave 4, all workgroup meetings were held virtually.

# Depression PFTR Webinar, April 12, 2022

This meeting summary document outlines the purpose, discussion, and recommendations from the Depression PFTR Webinar. Section 1 provides an overview of the webinar goals and process. Section 2 summarizes the discussion and recommendations from the workgroup.

## 1. Overview

The goals of the Depression PFTR Webinar on April 12, 2022, were the following:

(i) Discuss field testing feedback
(ii) Review empirical analyses
(iii) Confirm refinements to finalize the measure prior to submitting for potential consideration in MIPS

The meeting was held online via webinar and attended by 8 of the 14 workgroup members. The webinar was facilitated by an Acumen moderator, Eugene Lin. The Depression workgroup chair was Naakesh (Nick) Dewan, who also facilitated meeting discussions. Libby Hoy from PFCCpartners presented findings from Person and Family Partners (PFPs). The MACRA Episode-Based Cost Measure Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties.[3]

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. 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 greater than 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.

## 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 in the webinar (Section 2.1). The remaining sub-sections describe workgroup member discussions and recommendations on defining the episode group (Section 2.2), accounting for patient heterogeneity (Section 2.3), and capturing variation in care through service assignment (Section 2.4). Section 2.5 describes the next steps.

[3] CMS, "MACRA Episode-Based Cost Measures: Wave 4 Clinician Expert Workgroup Composition (Membership) List" (https://www.cms.gov/files/document/wave-4-measure-specific-workgroup-composition-list.pdf).

## 2.1 Person and Family Partner (PFP) Findings and Discussion

A representative from PFCCpartners presented findings from the field testing survey in which 3 PFPs provided input prior to the meeting. PFPs provided feedback about the importance of care coordination and how barriers to care exacerbate issues with fragmented care.

PFPs noted that indicators of quality care include good coordination between primary and specialists (such as psychologists and psychiatrists), as well as inclusion of family caregivers. PFPs noted that primary care physicians or psychologists tend to be the first line of clinicians they interact with, and then they consult a psychiatrist if medication alterations are required. PFPs sought care for their condition for medication management and responses to environmental challenges to behavioral health.

PFPs highlighted barriers to access to consistent care, including lack of insurance coverage and lack of available psychologists and counselors. They also noted that inconsistent coordination between psychologists and psychiatrists created a barrier to receiving coordinated care. In many cases, primary care clinicians weren't equipped to recognize and refer PFPs to appropriate services, and may not be aware of the indication of some medications that can exacerbate depression.

In response, one workgroup member noted that cardiac medications could exacerbate depression, and clinicians who order cardiac medications should be aware of how this affects patients. Workgroup members acknowledged that there are complications that lead toward poor care coordination and noted that the Depression measure should incentivize higher prioritization of care coordination. One workgroup member mentioned the importance of using existing resources and tools that incentivize collaborative care and encourage care coordination. This can be done by promoting and fostering an environment that maximizes the involvement of primary care, where primary care clinicians are the first point of contact or intervention, and behavioral health professionals can treat the more severe cases of depression.

## 2.2 Defining the Episode Group

The workgroup revisited the scope of the cost measure based on the recap Acumen provided on the cost measure framework (Section 2.2.1). Workgroup members also engaged in discussions related to capturing chronic care in various settings (Section 2.2.2) and capturing patient-clinician relationships by different specialties (Section 2.2.3).

### *2.2.1 Defining the Scope of the Episode Group*

Acumen provided a recap of the cost measure framework and field testing results. Most notably, the measure demonstrates high reliability – the ability to consistently distinguish the performance of one clinician from another (i.e., 0.92 at the clinician group level and 0.87 at the clinician level for the 20-episode case minimum). Acumen also provided a recap of how to identify an ongoing patient-clinician relationship for managing depression; they noted that an episode of care is triggered when a clinician or clinician group bills at least 2 services (i.e., trigger and confirming claims) for a patient within 180 days with a related depression diagnosis. While reviewing the list of related diagnosis codes, a point was raised that the list of International Classification of Diseases, 10$^{th}$ revision (ICD-10) diagnosis codes describes the treatment of depression more broadly, and that only ICD-10 codes F32 (Major Depressive Disorder [MDD], single episode) and F33 (MDD, recurrent) are specific to MDD. The workgroup agreed to be more inclusive and keep this broader list of diagnosis codes to define the measure scope, but suggested to change the name of the measure to "Depression" instead of "Major Depressive Disorder" to better characterize the scope of this measure.

### *2.2.2 Capturing Care Relationships in Nursing Facilities*

One of the suggestions from field testing was to remove nursing facility evaluation and management (E&M) Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes (i.e., 99304 – 99310, 99315 – 99316, 99318) from the trigger logic, as they may capture patients not receiving ongoing management of depression. Acumen presented analyses showing how these nursing facility care codes are observed in low frequency as trigger codes. One workgroup member agreed with removing these codes from the trigger logic, noting that depression treatment in nursing homes is different than in ambulatory settings and that behavioral health staff in this setting mainly provide consultation services rather than managing the patient. One PFP representative noted that including nursing home claims might be important because patients with depression often end up in nursing facilities. Acumen noted that even if these codes were removed from the trigger logic, the measure would still include patients who end up in short-term nursing facilities if an episode is triggered through the other trigger codes.

### *2.2.3 Capturing Patient-Clinician Relationships among Clinical Psychologists*

Another comment from field testing was that few clinical psychologists are being attributed to the measure. Acumen noted the current trigger codes appear to capture many clinical psychologists (i.e., 23,927 attributed individual clinicians, identified by their unique Taxpayer Identification Number and National Provider Identifier pair, or TIN-NPI), but there are substantially fewer clinical psychologists being eligible after a case minimum of 20 episodes is applied (i.e., 1,804 TIN-NPIs). Acumen presented a list of existing trigger codes in the measure that capture clinical psychologists, as well as additional codes (related to psychological and neuropsychological testing) for the workgroup to consider adding to the trigger logic to potentially capture more clinical psychologists.

Workgroup members generally agreed with including the new codes for psychological and neuropsychological testing (CPT/HCPCS codes 96101, 96130, 96132, 96136) for consistency because 96118 was already included in the list of codes. One exception was CPT/HCPCS code 96137, which is an add-on code and must be billed in conjunction with other codes. One workgroup member noted we may be seeing less clinical psychologists because their practice differs from other specialties in that they usually see fewer patients than other clinicians. This member suggested that psychologists may not meet required case minimums for MIPS measures generally. This member also suggested including other psychological testing codes to improve consistency within the measure.

<u>Key Takeaways from Discussion and/or Polls for Defining the Episode Group</u>:

- Members agreed to change the measure name from “Major Depressive Disorder” to “Depression.”
- Members recommended removing the nursing facility E&M codes (99304 – 99310, 99315 – 99316, 99318) from the measure’s trigger logic.
- Members recommended adding additional codes related to psychological and neuropsychological testing (specifically CPT/HCPCS codes 96101, 96130, 96132, 96136) to trigger and confirm episodes, if a related diagnosis code is present, as a way to capture more clinical psychologists.
- Members didn’t recommend adding CPT/HCPCS code 96137 to trigger or confirm episodes.

## 2.3 Accounting for Patient Heterogeneity

Members engaged in a detailed discussion about some measure-specific risk adjustors (Sections 2.3.1 and 2.3.2) and exclusions (Section 2.3.3), based on field testing feedback.

Acumen also presented topics that covered other potential sources of variation, including social risk factors and specialty adjustment (Section 2.3.4).

### *2.3.1 Indicators of Treatment-Resistant Depression (TRD)*

Acumen presented potential additional indicators of TRD based on field testing feedback. Specifically, stakeholders suggested the following indicators for TRD:

- (A) Assisted living facility as place of residence (as these living situations can suggest the presence of TRD or lead to TRD)
- (B) Prior observation stays that may not be picked up as emergency department or inpatient admissions
- (C) Longer lookback for prior hospitalizations, electroconvulsive therapy (ECT), and transcranial magnetic stimulation (TMS)

(A) The PFP representative noted that patients living in assisted living facilities can have severe depression and should be accounted for in the measure. However, since assisted living facilities aren't covered by Medicare and aren't available via claims, this can't be implemented.

(B) The workgroup agreed to include observation stays as an indicator of TRD as they may indicate higher severity of illness (similar to inpatient care) and may predict patients needing more complicated care.

(C) Acumen's recommendation is to maintain the current, standard 1-year lookback period for the prior hospitalizations, ECT, and TMS sub-populations. They noted a longer lookback period: (i) increases data burden, (ii) will result in patients being excluded for data incompleteness, and (iii) may not always reflect the current clinical profile of patients (leading to more false positives). The workgroup agreed with this recommendation.

### *2.3.2 Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)*

Stakeholders suggested considering differences in treatment costs related to depression, specifically ECT and TMS. Acumen presented this feedback to the workgroup and confirmed that during the previous webinar in August 2021, the workgroup already voted to include ECT and TMS as risk adjustors in the measure. Therefore, no further action was needed.

### *2.3.3 Exclusions*

One commenter suggested excluding patients 75 years and older. Acumen presented results showing that these patients account for 39% of all depression episodes. Additionally, after implementing risk adjustment, the costs were comparable across age groups, even those 75 and older. Given that this measure is designed for the Medicare population and the results show no substantial difference in risk-adjusted costs across age groups, workgroup members agreed to keep this population in the measure.

### *2.3.4 Other Potential Sources of Variation*

Acumen presented results showing that adjusting for dual Medicare and Medicaid enrollment has minimal impact on the measure. The workgroup generally agreed that adjusting for dual enrollment status is a good step in the right direction, but they also mentioned that there are other social determinants of health that should be considered (e.g., social isolation, lack of family support, housing, food deserts, and isolation related to deafness or visual loss). Acumen noted that they'll continue with further testing to explore social risk factors.

Acumen also presented an overview of the specialty adjustment methodology and upcoming testing plan. The aim is to adjust for complexity of care that's potentially outside the control of the attributed clinician(s) or different practice patterns across specialties. The workgroup was generally supportive of this type of specialty adjustment to capture additional patient differences. Acumen welcomed the workgroup's thoughts and feedback on these 2 areas, but noted that ultimately CMS will make the final decision on whether and how to adjust for social risk factors and account for specialty adjustment.

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

- Members recommended to include a measure-specific risk adjustor variable for observation stays as an indicator of TRD.
- Members agreed to maintain the current, standard 1-year lookback period for current risk adjustors.
- Members agreed to keep patients 75 years and older in the measure.

## 2.4 Capturing Variation in Care through Service Assignment

Acumen described the purpose of service assignment so that members could continue discussing which services 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. The following sub-sections summarize discussions of service assignment, particularly the inclusion of Part D costs (Section 2.4.1), treatments for related comorbidities (Section 2.4.2), diagnosis restriction for assigned services (Section 2.4.3), and other suggestions from field testing (Section 2.4.4).

### *2.4.1 Inclusion of Part D Cost*

Acumen explained that some commenters expressed concern with the inclusion of Part D costs in the measure, noting that this: (i) would add further complexity to the measure, (ii) may exacerbate inequities; and (iii) might penalize clinicians if they're held accountable for differences in Part D plan benefit structure, something they can't control. If included, stakeholders commented that Part D costs should only be attributed to the prescribing clinician(s) and only include depression-related medications.

During the last meeting in August 2021, the workgroup had voted to include relevant Part D costs in the measure, given that medications are important in the treatment of depression and are often costly. During this meeting, Acumen presented results indicating that the risk-adjusted costs for sub-groups with and without Part D are similar. One workgroup member suggested that Part D costs be normalized (or standardized) such that clinicians aren't held accountable for differences in cost for the same drug due to differences in the benefit structure. Acumen clarified that Part D costs are standardized based on active ingredient, strength, route of administration, dosage form, and brand/generic description. In other words, differences in Part D plans among different patients are removed to ensure fair cost comparisons. The workgroup member (along with the rest of the workgroup) supported including Part D costs with this type of standardization and based on the results presented, particularly since Part D costs are a substantial part of care provision for depression.

Acumen also presented a list of Part D drug classes that are included in the measure. These classes of drugs included those used to treat depression and those that could treat adverse effects of some drugs used to treat depression. One commenter had concerns about the inclusion of some of these drug classes, noting that they may not be solely related to depression, are prescribed by other clinicians (e.g. for pain management), or aren't typically

prescribed. The workgroup specifically indicated that glucocorticosteroids should be removed from the list, and voted on whether to keep or remove other drug classes from the measure.

### *2.4.2 Treatments for Related Comorbidities*

Another field testing comment was that clinical psychologists rarely see patients presenting with only one psychiatric diagnosis (e.g. comorbid depression and substance use) and that the episode should account for other comorbidities. The workgroup didn't agree with including services for comorbidities, such as substance use, as substance use disorders substantially change the management of depression. Patients with depression and substance use disorders are materially different from those with only depression and are often treated by different professionals; also, coordination between the treatment of depression and substance use isn't possible in some areas (e.g., rural areas). Moreover, the workgroup agreed to not include services for other types of comorbidities.

### *2.4.3 Diagnosis Restriction for Assigned Services*

Acumen explained that the current service assignment rules indicate that services are only included if there are certain diagnosis codes associated with them. Some codes – including ICD-10 code G21 (secondary parkinsonism), G24 (dystonia), and G26 (extrapyramidal and movement disorder in diseases classified elsewhere) – were included in the measure because they may identify adverse effects of some drugs used to treat depression. The workgroup agreed to remove these 3 ICD-10 codes from the measure's service assignment rules because they are neurological codes and are rare to see in patients with depression. They also agreed to remove ICD-10 code F53 (psychotropic drugs, not elsewhere classified).

### *2.4.4 Other Suggestions from Field Testing*

Stakeholders suggested specific services to include in the measure, such as care in extended stay assisted living facilities, medication management, and emergency medications and treatments that are costly but effective. The workgroup agreed to not take further action on these measures for the following reasons. First, assisted living facilities are services not covered by Medicare. Second, medication management is already included in the measure. Third, no examples of emergency medications and treatment were provided; consequently, the workgroup agreed to not take any further action on these suggestions. Stakeholders also suggested to exclude transportation costs, but Acumen clarified that these are included only if there's a related diagnosis on the claim, which the workgroup agreed to keep in the measure.

<u>Key Takeaways from Discussion and/or Polls for Capturing Variation in Care through Service Assignment</u>:

- Members supported the inclusion of Part D costs in the measure.
- Members recommended removing the following drug classes from the measure:
    - Antihistamines – Piperidines Movement Disorder Drug Therapy
    - N-Methyl-D-aspartic acid (NMDA)
    - Vasomotor Symptom Agents
- Members recommended including costs of services for comorbidities but didn't recommend including them for substance use.
- Members agreed to remove ICD-10 codes G21, G24, G26, and F53 from the measure's service assignment rules.

## 2.5 Next Steps

In the last session, Acumen provided a quick summary of the measure's testing results, indicating that the measure is shown to be highly reliable, able to make a fair comparison across

episodes with and without Part D, and not sensitive to patients' social risk factors. Acumen also provided a wrap-up of the discussion and 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 about potential refinements. The poll also included a section for other general comments. Acumen will operationalize input for the measure specifications based on PFTR Webinar Poll results.

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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.