

Quality Payment PROGRAM

Questions for Field Testing Measure Specifications

Winter 2022 Field Testing



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1.0 Introduction

We are gathering input on the draft measure specifications for the 5 episode-based cost measures undergoing field testing. This document includes questions on each of the measures, and accompanies the draft specifications for each measure, comprising a Draft Measure Methodology document and Draft Measure Codes List file.¹

Stakeholders may submit feedback in response to the questions included in this document as well as on other aspects of the measures through this [online survey](#)² between January 10 and February 25, 2022. When submitting feedback through the survey, stakeholders can also attach a PDF or Word document with their comment. Stakeholders may submit comments anonymously.

Field testing is taking place from January 10 to February 25, 2022. It is part of the measure development process and is an opportunity for clinicians and other stakeholders to learn about episode-based cost measures and provide input on the draft specifications. During field testing, we will:

- Distribute Field Test Reports on the [Quality Payment Program website](#)³ for group practices and solo practitioners who meet the minimum number of cases for each measure.
- Post draft measure specifications (i.e., measure methodology and codes lists), and supplemental documentation, such as testing results, on the [MACRA Feedback Page](#).
- Collect stakeholder feedback on the draft specifications for each measure.

The feedback from field testing helps inform refinements to the measures before consideration of their potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS). Feedback on other aspects of field testing, such as the Field Test Report format, will be considered for future testing periods. Table 1 outlines the measures undergoing field testing.

Table 1. Cost Measures Undergoing Field Testing

Episode Group Type	Episode-Based Cost Measure
Emergency Medicine	Emergency Medicine
Chronic Condition	Heart Failure
Chronic Condition	Low Back Pain
Chronic Condition	Major Depressive Disorder
Acute Inpatient	Psychoses/Related Conditions

¹ The specifications are available on the MACRA Feedback Page: <https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program/Give-Feedback>

² The field testing online survey is available here: https://acumen.qualtrics.com/jfe/form/SV_7VByoPD9BPTdR3w

³ CMS, "Quality Payment Program Account," *Quality Payment Program*, <https://qpp.cms.gov/login>.

The cost measures were developed with extensive input from Clinician Expert Workgroups, comprising clinician experts with experience in the clinical area of the measures under development. Patient and family representatives, who have direct experience with the condition in question, participated in structured interviews and Clinician Expert Workgroup meetings to give their perspective. These workgroups provided detailed input on each component of the measure at 2 webinars, taking place in June and August of 2021. After field testing, the workgroups will refine the draft measure specifications based on the stakeholder feedback. The Wave 4 Measure Development Process document on the [MACRA Feedback Page](#) provides more information on the development process of these measures.

2.0 Feedback on the Episode-Based Cost Measures Draft Specifications

This section includes specific questions on components of each episode-based cost measure that we are interested in gathering stakeholder feedback on. In addition to the questions in this section, the online survey also includes a general question for each measure, where stakeholders can submit comments on other aspects of the measure specifications not directly covered in the targeted questions below.

2.1 Emergency Medicine Episode-Based Cost Measure

Defining Visit Types

1. The intention of the emergency medicine cost measure is to holistically capture all emergency department (ED) care. As such, the measure accounts for a diverse set of conditions, based on diagnosis codes from the visit, by stratifying them into 28 mutually exclusive sub-groups or “visit types”. Each episode is compared only with episodes of the same ED visit type; that is, the risk adjustment model is run separately within each ED visit type. Visit types are defined by the ICD-10 diagnosis codes found on ED Evaluation & Management (E&M) claims, and were developed by reviewing high-volume ED conditions and considering organ systems. The list of ED visit types, in order of observed cost, is:

1. Sepsis	8. Medical Complications	16. Non-Respiratory Chest Pain	23. Health Care Maintenance
2. Altered Mental State	9. Kidney and Urinary	17. Syncope	24. Non-fracture Musculoskeletal
3. Cancer	10. Respiratory	18. Fracture	25. Female Disorders
4. Hematologic and Immunologic	11. Neurologic	19. Abdominal Pain, Nausea, and Vomiting	26. Trauma: Minor or Unclear Severity
5. Stroke	12. Diabetes	20. Behavioral Health	27. Eye and Ear
6. Peripheral Vascular	13. Major Or Head Trauma	21. Poisoning	28. Pregnancy
7. Gastrointestinal or Liver Conditions	14. Other Cardiovascular	22. Oral, Nasal, and Skin	
	15. General Infection		

Are there visit types that are missing, can be combined, further stratified, or subsumed?

2. ED visit types use all diagnoses reported on the ED E&M claims to be defined. Since, there are many diagnoses across these claims data, it is possible for a single episode to be defined under more than one ED visit type definition. To assign each episode a single visit type for cost comparisons, a hierarchy is applied. The hierarchy used in field testing has been defined empirically to categorize episodes into their most expensive and resource-intensive potential visit type, so that providers are not penalized for furnishing high-cost, medically necessary services. Please see the list of visit types above, ranked by observed cost, for the hierarchy. More information on the codes used to define these types is available in the Emergency Medicine Draft Measure Methodology and Draft Codes List, posted on the [MACRA Feedback Page](#).

Does the current hierarchy appropriately sort ED visits by cost and resource use?
If no, please describe what changes should be made to the hierarchy.

3. In line with the measure intent to comprehensively assess ED care, the measure includes ED visits with an observation stay and accounts for the increased costs by risk adjusting for the presence of an observation stay. This means that the measure neutralizes the impact of additional costs associated with the use of an observation stay.

Is this approach of risk adjusting for ED visits with observation stays an appropriate way to ensure that the measure is accurately capturing this important aspect of ED care while also accounting for cost differences? Note that the measure includes all Parts A and B costs within 30 days of the ED visit, with certain exceptions listed in Question #5 below.

Accounting for Patient Heterogeneity

4. The cost measure currently includes a robust risk adjustment model that combines the CMS-HCC model with additional factors that affect the spending for patients receiving care in the ED. The base model includes adjustments for patient age and reason for enrollment, recent use of long-term care, and 79 indicator variables for clinical risk factors identified in the 120 days prior to the episode of care. Additionally, the risk adjustment model includes factors specific to ED care: transfer from IRF, LTCH, or SNF to the ED, whether there was an observation stay, and the MS-DRG if the ED visit ends in an inpatient admission. The detailed list of risk adjustors used in the risk adjustment model is available on the “RA” tab of the Emergency Medicine Measure Codes List file, available on the [MACRA Feedback Page](#).

Besides the variables in the current risk adjustment model, are there other factors outside of the reasonable influence of the clinician that should be accounted for in estimating the expected spending for episodes built around ED visits?

Considerations for additional variables include: the factor’s clinical/conceptual

relationship with cost, variation in the prevalence of the factor, whether the factor is present at the start of care, the factor should be not an indicator or characteristic of the care provided, the factor should be resistant to manipulation or gaming, and the factor contributes to unique variation in cost (i.e., is not redundant with other variables).

Assessing Costs for the Episode Group

5. As the measure intent is to comprehensively assess care in the ED for a short, defined period of time (30 days from the ED visit), the measure uses service exclusions rather than service inclusions. The service exclusions are defined to be specific to each ED visit type and generally exclude services that are: likely to be re-occurring, related to conditions present prior to the emergency medicine care, or outside the influence of the emergency medicine care team.

This approach to assessing costs of care reflects the role of ED clinicians where they can treat all visit types. This is a different role from that which the episode-based measures assess, as they are focused around the role of a clinician providing care for a particular condition or procedure. There are additional considerations unique to the ED setting related to using the service exclusion approach. First, the 30-day episode window represents a limited timeframe when costs are being assessed. Second, an exclusion rule strikes an appropriate balance between having easily understandable cost definitions and clinical specificity. Third, clinicians have a high volume of cases, mitigating concerns about performance being driven by rare, high-cost events.

The following general categories of services are excluded, however the rules differ slightly across visit types.

- Admissions for multiple trauma or transplants
- Hemodialysis
- Chemotherapy
- Post-discharge drug costs
- Nursing home visits
- Pathology services
- Physical therapy for a condition unrelated to ED visit
- Scheduled allergy shots
- Inpatient Rehabilitation Services (Post-Acute Care)
- Long-Term Care Hospitalizations (Post-Acute Care)
- Skilled Nursing Facility services (Post-Acute Care)

The complete list of service exclusions by ED visit type is provided in the Emergency Medicine Draft Measure Codes List file, available on the [MACRA Feedback Page](#).

Should other types of services be excluded from the measure? If so, please indicate the type of service, and whether it should be excluded for specific ED visit types or across all ED visit types.

2.2 Heart Failure Episode-Based Cost Measure

The Heart Failure measure uses the chronic condition cost measure framework, which generally holds providers accountable for cost over a longer time period than the acute inpatient and procedural measures do. Chronic condition measures require evidence of an ongoing patient-clinician relationship related to managing the chronic condition; more background information on the measures is available in the [Chronic Condition Cost Measure Framework Poster](#), posted on the [MACRA Feedback Page](#).

Defining the Episode Group

1. Stakeholders identified heart transplant and left ventricular assist device (LVAD) as being major events that fundamentally alter a patient's clinical characteristics and care trajectory in a way that means that they cannot be fairly compared with the overall patient cohort. To account for this, the measure excludes episodes with prior and/or recent heart transplant or LVAD from the measure. Episodes with concurrent/downstream heart transplant or LVAD will only be included if there is at least one year of data in the episode window. However, these episodes will end upon the occurrence of the heart transplant or LVAD; the episode does not include the cost of the procedures or any costs afterwards.

Is this approach appropriate for defining a clinically coherent patient population for the Heart Failure measure? Are there any other events that have a similar impact as heart transplant or LVAD that should be considered as events that end an episode?

Attributing Episodes to Clinicians

2. Currently, the Heart Failure cost measure is attributed to any clinician group (identified by Taxpayer Identification Number, or TIN) billing the trigger event (a pair of services [trigger and confirming claims] for the treatment or management of heart failure [e.g., outpatient services Evaluation & Management (E&M) codes] with a relevant heart failure diagnosis billed by the same TIN within 180 days), and to any clinician (identified by National Provider Identifier, or TIN-NPI) within that TIN that bills at least 30% of trigger or confirm claims with a heart failure diagnosis on Part B Physician/Supplier (Carrier) claim lines during the episode. Under the TIN-NPI attribution methodology, the following 5 clinician specialties are most frequently attributed the measure (by number of episodes): Cardiology (54% of episodes), Internal Medicine (15%), Cardiac Electrophysiology (8%), Interventional Cardiology (8%), and Family Practice (6%).

The scope of the measure is intended for both primary care physicians as well as specialists who manage heart failure. **Are these appropriate specialties for the measure to capture? Are there any specialties that provide ancillary care to these patients that should be attributed the measure?**

Accounting for Patient Heterogeneity

3. The cost measure currently includes a robust risk adjustment model that combines the Centers for Medicare & Medicaid Services Hierarchical Condition Category (CMS-HCC) model with additional factors that affect the spending for patients with heart failure. The base model includes adjustments for patient age and reason for enrollment, recent use of long-term care, and 79 indicator variables for clinical risk factors identified in the 120 days prior to the episode of care. Additionally, the risk adjustment model includes factors specific to heart failure: idiopathic heart failure, right heart failure, substance abuse/cardiomyopathy and coronary heart disease. The detailed list of risk adjustors used in the risk adjustment model is in the Heart Failure Draft Measure Codes List file, available on the MACRA Feedback Page.

Besides the variables in the current risk adjustment model, are there other factors outside the influence of the clinician that should be accounted for in estimating the expected spending for treating heart failure? Considerations for additional variables include: the factor's clinical/conceptual relationship with cost, variation in the prevalence of the factor, whether the factor is present at the start of care, the factor should not be an indicator or characteristic of the care provided, the factor should be resistant to manipulation or gaming, and the factor contributes to unique variation in cost (i.e., is not redundant with other variables).

4. Stakeholders have indicated the importance of differentiating between Heart Failure with Reduced Ejection Fraction (HFrEF) and Heart Failure with Preserved Ejection Fraction (HFpEF). To address the clinical and coding challenges of identifying HFrEF and HFpEF, we tested a variety of categorization methodologies based on the degree of agreement between diagnosis codes incorporating type of claim and specialty of billing clinician. Testing these categorizations against service information (e.g., implantable cardioverter defibrillator use) showed only very small differences in cost.

One draft method requires that a share of the patient's claims with heart failure diagnoses meet a threshold for either HFpEF or HFrEF, otherwise categorized as unknown. Then, it compares agreement of outcomes from multiple diagnosis sources, i.e., diagnoses from E&M claims or billed by cardiologists. Under this draft categorization, mean observed cost is \$14,028 and \$12,320 for HFrEF and HFpEF respectively, and mean observed cost for when an implantable cardioverter-defibrillators (ICDs) is observed is \$14,811 and \$14,796 for HFrEF and HFpEF, respectively.

What validation checks can be performed using claims data to confirm whether a classification methodology for HFrEF and HFpEF is accurately distinguishing between these types of heart failure?

5. **If the categorization methodology shows only a minor difference in expected cost, should the measure still use HFrEF and HFpEF as risk adjustors even if there is minimal impact?**

Assigning Costs to the Episode Group

6. The cost measure includes clinically related services that are within the reasonable influence of the attributed clinician. The measure uses standardized payment data that adjusts for geographic variation and other non-clinical sources of cost variation. The goals of service assignment are to capture clinically related costs and to distinguish between good and poor care, including where appropriate care for heart failure can decrease the likelihood or severity of another service. The measure currently captures costs that fall within the following clinical themes:
 - Cardiopulmonary procedures/interventions; blood transfusions and associated labs; services related to bleeding; cardiac medications (injections, infusions, other forms)
 - Diagnostic imaging; laboratory (panels, counts, smears, other analysis); outpatient visits; other hospitalizations (complications and adverse drug events)
 - Aftercare, rehab, ancillary services; durable medical equipment; patient transport; telehealth

The complete list of services that are assigned to the measure is provided in the Heart Failure Draft Measure Codes List file, available on the [MACRA Feedback Page](#).

Are there any additional types of services that are clinically related to an episode of care for heart failure that should be included in the measure to meaningfully assess clinician resource use? Considerations include: the clinical/conceptual relationship with cost, variation in the prevalence of the factor, present at the start of care, is not an indicator or characteristic of the care provided, is resistant to manipulation or gaming, and contributes to unique variation in cost (i.e., is not redundant with other variables).

7. The measure includes prescription drugs as they are an integral part of managing heart failure. To account for the fact that not all Medicare A/B beneficiaries are enrolled in Part D, the cost measures that include standardized Part D costs stratify episodes into cohorts with and without Part D enrollment to account for the differences in cost. The draft list of Part D medications included in the measure is available in the Heart Failure Draft Measure Codes List file, posted on the [MACRA Feedback Page](#).

Does this list of Part D medications accurately capture the drugs that are clinically related to the treatment or management of heart failure? Should there be any changes to this list, either to add or remove services?

2.3 Low Back Pain (LBP) Episode-Based Cost Measure

The Low Back Pain measure uses the chronic condition cost measure framework, which generally holds providers accountable for cost over a longer time period than the acute inpatient and procedural measures. Chronic condition measures require evidence of an ongoing patient-clinician relationship related to managing the chronic condition; more background information on the measures is available in the [Chronic Condition Cost Measure Framework Poster](#), posted on the [MACRA Feedback Page](#).

Attributing Episodes to Clinicians

1. Currently, LBP episodes are attributed to any clinician group (identified by Taxpayer Identification Number, or TIN) billing the trigger event (a pair of services [trigger and confirming claims] for the treatment or management of LBP [e.g., outpatient services Evaluation & Management or E&M, therapy evaluation, therapy and chiropractic services] with a relevant LBP diagnosis billed by the same TIN within 60 days), and to any clinician (identified by National Provider Identifier, or TIN-NPI) within that TIN that bills at least 30% of trigger and confirming claims. Under the TIN-NPI attribution methodology, the following 9 clinician specialties are most frequently attributed the measure (by number of episodes): Chiropractic (36% of episodes), Physical Therapy (9%), Physical Medicine and Rehabilitation (8%), Orthopedic Surgery (6%), Internal Medicine (6%), Pain Management (6%), Anesthesiology (5%), Interventional Pain Management (5%), and Family Practice (5%).

The scope of the measure is intended to reflect the role of a wide range of clinicians who provide care for patients to treat and manage LBP. **Based on the trigger code logic and list of currently attributed specialties, are there other codes that should be included or removed from the measure to ensure that we capture the appropriate specialties that provide care to this patient population?** The complete list of trigger codes is provided in the Low Back Pain Draft Measure Codes List file, available on the [MACRA Feedback Page](#).

Accounting for Patient Heterogeneity

2. The measure uses sub-groups, risk adjustment, and exclusions to account for patient heterogeneity and to ensure that episodes of care are comparable. By construction, episodes where the patient has a spinal surgery during the episode involve higher observed and risk-adjusted cost than the overall pool of LBP episodes. To avoid the potential to disincentivize necessary surgical care, the measure stratifies episodes into mutually exclusive and exhaustive sub-groups to account for cost variation in episodes with spinal surgery during the episode and patient history of complex LBP (radiculopathy, spinal stenosis, or spondylolisthesis). That means there are 4 sub-groups: (i) spinal surgery during the episode plus patient history of complex LBP, (ii) spinal surgery during the episode and the patient does not have a history of complex LBP, (iii) no spinal surgery during the episode but the patient has a history of complex LBP, and (iv) no spinal surgery during the episode and the patient does not have a history of complex LBP.

The rationale for these sub-groups are to account for major sources of patient heterogeneity where the characteristic is expected to interact differently with each risk adjustment variable. This allows the measure to capture spinal surgery - an important aspect of treating and managing LBP - while ensuring that the higher costs of episodes with spinal surgery are not compared with episodes where there is no spine surgery. The complex LBP diagnoses reflect a series of conditions where clinical input and empirical analyses suggest that this is a different patient cohort with higher care needs. For instance, expert review of testing results for a range of other conditions, including spondylolysis, spondylosis, and scoliosis and other spinal deformities, identified these conditions as being distinct from radiculopathy, spinal stenosis, and spondylolisthesis, so should not be lumped into the complex LBP group, but had some differences in cost profile that should be accounted for through risk adjustment.

Is the approach to stratify the measure into sub-groups for 2 major predictors of costs of LBP care (i.e., spine surgery during the episode and history of complex LBP) appropriate to account for patient heterogeneity? For instance, are there any other conditions that should be considered as part of the complex LBP sub-group alongside radiculopathy, spinal stenosis, and spondylolisthesis?

3. Each measure has its own risk adjustment model to control for variables that affect expected costs for that condition. The base model is the CMS-HCC Model, with adjustments for patient age and reason for enrollment, recent use of long-term care, and 79 indicator variables for clinical risk factors identified in the 120 days prior to the episode of care. Additionally, the LBP risk adjustment model includes factors specific to LBP, including spondylolysis, scoliosis and other spinal deformities, medical back problems hospitalization, depression, osteoarthritis, osteoporosis, and smoking.

The measure includes a history of spinal surgery in the risk adjustment model. However, there are data limitations in how far prior to the episode the measure can check for whether a patient received a spine surgery. As such, the risk adjustor for history of spinal surgery is defined with spinal surgery procedure codes (ICD-10-PCS and CPT/HCPCS codes) and diagnosis codes for spine fusion and postlaminectomy syndrome in the year prior the start of the episode. The full list of risk adjustment variables, including the codes used to identify prior spinal surgery, is available in the Low Back Pain Draft Measure Codes List file.

Are there other ways to identify whether a patient has received spinal surgery in the past? For instance, are there other diagnosis codes that clinicians might use to indicate a history of spinal surgery - even if it occurred years in the past - when treating a patient for LBP? Please list the codes and rationale.

4. **Should any other variables be added or removed from the LBP risk adjustment model?** Considerations for additional variables include: the factor's clinical/conceptual relationship with cost, variation in the prevalence of the factor, whether the factor is present at the start of care, the factor should not be an indicator or characteristic of the

care provided, the factor should be resistant to manipulation or gaming, and the factor contributes to unique variation in cost (i.e., is not redundant with other variables).

Assigning Costs to the Episode Group

5. The cost measure includes clinically related services that are within the reasonable influence of the attributed clinician. The measure uses standardized payment data that adjusts for geographic variation and other non-clinical sources of cost variation. The goals of service assignment are to capture clinically related costs and to distinguish between good and poor care, including where appropriate care for LBP can decrease the likelihood or severity of another service. The measure currently captures costs that fall within the following categories of services:

- Outpatient E & M claims with a LBP diagnosis
- Chiropractic and osteopathic manipulation
- Imaging
- Acupuncture
- Spinal injections and neuro-stimulators
- Related hospitalizations and emergency department visits
- Outpatient psychotherapy and depression screening
- Drug tests: Outpatient testing used for patients on opioids
- Walking aids: Durable Medical Equipment (DME) services such as wheelchairs, crutches, canes, walkers
- Related Part D drugs (full list in Question #8 below)

The full list of codes used to identify the services included in the measure is available in the Low Back Pain Draft Measure Codes List file.

What additional services should be assigned to the measure to reflect LBP care and to distinguish between good and poor clinician performance?

6. Patients with LBP may require post-acute care (PAC) services (i.e., home health services and care provided at inpatient rehabilitation facilities and long-term care hospitals), particularly following a surgery or hospitalization. Assigning PAC services to the episode group helps to provide a more complete picture of the costs of care associated with a LBP episode. All PAC services with a LBP diagnosis are currently included in the Low Back Pain measure. **Is the approach for including post-acute care services appropriate to account for the full scope of care that clinicians may provide during a LBP episode?**
7. Weight management can play a role in the treatment of LBP, and referral to a nutritionist and nutrition services could be useful for LBP management and treatment. However, Medicare only covers a limited range of nutritional services. On the one hand, including

these costs could help provide a more comprehensive assessment of LBP care. On the other hand, the limited services that we would be able to identify in Medicare claims data may only capture a small share of the broader picture of nutritional services.

Should nutritional services be included as cost related to LBP management and treatment?

8. The measure includes prescription drugs, as they are part of the care for LBP. To account for the fact that not all Medicare A/B beneficiaries are enrolled in Part D, the cost measures that include standardized Part D costs stratify episodes into cohorts with and without Part D enrollment to account for the differences in cost. The following types of Part D drugs are included in the measure:

- Glucocorticosteroids
- Serotonin Modulators
- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
- Tricyclic Agents
- Antidepressants - Misc.
- Antidepressant Combinations
- Opioid Agonists
- Opioid Partial Agonists
- Opioid Combinations
- Nonsteroidal Anti-inflammatory Agents (NSAIDs)
- Analgesics - Anti-inflammatory Combinations
- Central Muscle Relaxants

The full draft list of Part D medications included in the measure is available in the Low Back Pain Draft Measure Codes List file.

Does this list of Part D medications accurately capture the drugs that are clinically related to the treatment or management of LBP? Should there be any changes to this list, either to add or remove services?

2.4 Major Depressive Disorder (MDD) Episode-Based Cost Measure

The Major Depressive Disorder measure uses the chronic condition cost measure framework, which generally holds providers accountable for cost over a longer time period than the acute and procedural measures. Chronic condition measures require evidence of an ongoing patient-clinician relationship related to managing the chronic condition; more background information on the measures is available in the [Chronic Condition Cost Measure Framework Poster](#), posted on the [MACRA Feedback Page](#).

Attributing Episodes to Clinicians

1. Currently, Major Depressive Disorder episodes are attributed to any clinician group (identified by Taxpayer Identification Number, or TIN) billing the trigger event (a pair of services [trigger and confirming claims] for the treatment or management of MDD [e.g., outpatient services E&M or behavioral health visit codes] with a relevant MDD diagnosis billed by the same TIN within 180 days), and to any clinician (identified by National Provider Identifier, or TIN-NPI) within that TIN that bills at least 30% of trigger and confirming claims. Under the TIN-NPI attribution methodology, the following 5 clinician specialties are most frequently attributed the measure (by number of episodes): Internal Medicine (25% of episodes), Psychiatry (24%), Family Practice (20%), Nurse Practitioner (12%), and Clinical Psychologist (8%).

The scope of the measure is intended for both primary care physicians as well as specialists who manage the patient's MDD. **Based on the trigger code logic and list of currently attributed specialties, are there other codes that should be included or removed from the measure to ensure that we capture the appropriate specialties that provide care to this patient population?** The complete list of trigger codes is provided in the Major Depressive Disorder Draft Measure Codes List file, available on the [MACRA Feedback Page](#).

Accounting for Patient Heterogeneity

2. Stakeholders highlighted the need to account for treatment-resistant depression (TRD) as patients with TRD have different care needs. Since there are no diagnosis codes for TRD, the measure uses proxies in claims data that can indicate TRD. Specifically, the Major Depressive Disorder measure risk-adjusts for (i) 2 or more hospitalizations related to MDD, (ii) prior electroconvulsive therapy (ECT), (iii) prior transcranial magnetic stimulation (TMS), and (iv) esketamine services within the prior year.

Should there be any changes to this set of claims-based proxies to identify TRD? For example, are there other indicators of TRD that should be added? Are any of these current proxies too broad (i.e., is there a risk of misidentifying patients as having TRD)?

3. The cost measure uses a robust risk adjustment model that combines the CMS-HCC model with additional factors that affect the spending for patients with MDD. The base model includes adjustments for patient age and reason for enrollment, recent use of long-term care, and 79 indicator variables for clinical risk factors identified in the 120 days prior to the episode of care. Additionally, the risk adjustment model includes factors specific to MDD: history of memory loss, eating disorders, chronic pain, history of 2 or more MDD-related hospitalizations, history of suicide attempt or ideation, and use of ECT/TMS/esketamine. The detailed list of risk adjustors used in the risk adjustment model

is in the Major Depressive Disorder Draft Measure Codes List file, available on the [MACRA Feedback Page](#).

Besides the variables in the current risk adjustment model, are there other factors (that can be measured using claims data, e.g., service and diagnosis information) outside the influence of the clinician that should be accounted for in estimating the expected spending for treating MDD? Considerations for additional variables include: the factor's clinical/conceptual relationship with cost, variation in the prevalence of the factor, whether the factor is present at the start of care, the factor should not be an indicator or characteristic of the care provided, the factor should be resistant to manipulation or gaming, and the factor contributes to unique variation in cost (i.e., is not redundant with other variables).

4. **Are there upcoming updates in diagnosis classification** (such as DSM-5-TR or ICD-11) that should be considered for ensuring a fair comparison across the range of clinical severity? If so, **are there additional claim-based proxies of clinical severity that should be considered in this cost measure?**

Assigning Costs to the Episode Group

5. The cost measure includes clinically related services that are within the reasonable influence of the attributed clinician. The measure uses standardized payment data that adjusts for geographic variation and other non-clinical sources of cost variation. The goals of service assignment are to capture clinically related costs and to distinguish between good and poor care, including where appropriate care for MDD can decrease the likelihood or severity of another service. The measure currently captures costs that fall within the following categories of services:
 - Outpatient Evaluation & Management (E&M) claims
 - Part D medications (full list in Question #6)
 - Counseling services
 - Psychiatric emergencies and hospitalizations
 - ECT and TMS
 - Pre-operative and lab work prior to ECT
 - Medication monitoring and complications
 - Medical care after a suicide attempt
 - Collaborative care services
 - Outpatient occupational evaluation
 - Occupational therapy
 - Esketamine and ketamine infusion
 - Services for serotonin syndrome
 - Services treating tardive dyskinesia

The complete list of services that are assigned to the measure is provided in the Major Depressive Disorder Draft Measure Codes List file, available on the [MACRA Feedback Page](#).

Are there any additional types of services that are clinically related to an episode of care for MDD that should be included in the measure to meaningfully assess clinician resource use?

6. The nature of care for chronic conditions means that effective management could reduce the risk and/or severity of downstream patient outcomes. **Other than the services currently included to capture downstream consequences of care (e.g., psychiatric emergencies and hospitalizations), what are other consequences of care for MDD that are within the provider's reasonable influence and should be considered in the measure?**

7. The measure includes prescription drugs as they are an integral part of treating MDD. To account for the fact that not all Medicare A/B beneficiaries are enrolled in Part D, the cost measures that include standardized Part D costs stratify episodes into cohorts with and without Part D enrollment to account for the differences in cost. The draft list of Part D medications included in the measure is available in the Major Depressive Disorder Draft Measure Codes List file, and they fall into the following categories:
 - Glucocorticosteroids
 - Antihistamines - Piperidines
 - Benzodiazepines
 - Antianxiety Agents - Misc.
 - Alpha-2 Receptor Antagonists (Tetracyclics)
 - GABA Receptor Modulator - Neuroactive Steroid
 - Monoamine Oxidase Inhibitors (MAOIs)
 - N-Methyl-D-aspartic acid (NMDA) Receptor Antagonists
 - Serotonin Modulators
 - Selective Serotonin Reuptake Inhibitors (SSRIs)
 - Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
 - Tricyclic Agents
 - Antidepressants - Misc.
 - Antidepressant Combinations
 - Benzisoxazoles
 - Butyrophenones
 - Dibenzapines
 - Dihydroindolones
 - Quinolinone Derivatives

- Antipsychotics - Misc.
- Premenstrual Dysphoric Disorder (PMDD) Agents
- Vasomotor Symptom Agents
- Movement Disorder Drug Therapy
- Combination Psychotherapeutics

Does this list of Part D medications accurately capture the drugs that are clinically related to the treatment or management of MDD? Should there be any changes to this list, either to add or remove services?

2.5 Psychoses/Related Conditions Episode-Based Cost Measure

The Psychoses/Related Conditions episode-based cost measure focuses on the acute, inpatient management of severe mental illness episodes. This was identified as a priority because of the importance of assessing mental and behavioral health care in MIPS, the high costs of inpatient psychoses admissions, and opportunities for improvement. The measure was initially developed in 2019 and has undergone refinement since then, including re-convening a Clinician Expert Workgroup in 2021 to consider updates to the measure. Summaries of discussions about the measure, along with technical documentation and codes lists, are available on the [MACRA Feedback Page](#).

Assigning Costs to the Episode Group

1. The cost measure includes clinically related services that are within the reasonable influence of the attributed clinician. The measure uses standardized payment data that adjusts for geographic variation and other non-clinical sources of cost variation. The goals of service assignment are to capture clinically related costs and to distinguish between good and poor care, including where appropriate care for psychoses and related conditions can decrease the likelihood or severity of another service. The measure currently captures costs that fall within the following categories of services:
 - (Re)admissions/Emergency Department Visits
 - Outpatient Infusions, Laboratory, Imaging
 - Outpatient Services and Psychotherapy
 - Patient Transport
 - Post-Acute Care and Ancillary Services

The complete list of services that are assigned to the measure is provided in the Psychoses/Related Conditions Measure Codes List file, available on the [MACRA Feedback Page](#).

In addition to costs of readmissions or emergency room visits occurring post-discharge, are there other consequences of care that should be included in this measure?

2. Input from patients, families, and caregivers with lived experience of psychoses care highlighted discharge planning, care coordination, and post-discharge care as areas for improvement. As such, the measure includes downstream costs of care for 45 days post-admission. **Are there additional ways that this measure could be used to reflect and incentivize care coordination and discharge planning?**

3.0 Questions for the Patient and Caregiver Perspective

The Acumen team is committed to hearing from people with lived experience with the conditions. Patients and or family caregivers for patients experiencing the conditions and settings listed below are encouraged to respond. Your responses will inform future work on these measures. Please feel free to respond to however many as you wish.

Throughout the measure development process, Acumen has received input from patients and caregivers through structured interviews and participation of Person and Family Partners in clinician expert workgroup webinars. Summaries of the [guiding principles](#) of Patient and Family Engagement (PFE) and [PFE input from Wave 3](#) of cost measure development are available on the [MACRA Feedback Page](#), along with other informational materials on the measures.

3.1 Emergency Medicine

Diagnosis and Start of Treatment

1. What diagnosis was explained to you while in the emergency department? Did this diagnosis change after leaving the emergency department (e.g., in a subsequent hospitalization or through a follow-up with a doctor)?
2. Was the diagnosis you received in the emergency department related to a pre-existing condition?

Healthcare Providers and Care Team

3. What types of healthcare providers did you see when you were treated in the emergency department?
4. Were any of the clinicians who provided care in the emergency department part of your existing care team or part of the follow-up after you left the emergency department?

Services During and After Emergency Department Visit

5. What services did you receive while you were in the emergency department?

6. Once diagnosed and initially treated, which of your healthcare providers contributed to the decision of either staying for an observation stay, being discharged, or admitted to a hospital? Were you an active participant in deciding?
7. After you left the emergency department, what follow-up or related care did you receive, if any? For example, did you receive follow-up instructions or appointments?
8. What aspects of the care you experienced could be improved?

3.2 Heart Failure

Healthcare Providers and Care Team

1. What types of healthcare providers did you see when you first started having symptoms?
2. What types of clinicians do you consider as part of your care team? That is, which healthcare providers help you to stay as healthy as possible?
3. How often do you interact with the members of your care team?
4. What factors affect how often you get care and which clinician you see? For example, are there particular clinicians or specialists that you would see in particular cases (e.g., general cardiologist or advanced cardiologist)?
5. If you have multiple doctors in your healthcare team, do they coordinate with each other about your care? For example, if one clinician refers you to another clinician, does the second clinician know what care you have already received?
6. What types of medical care have you experienced for the diagnosis, treatment, or management of heart failure?
7. What types of medical care are the most effective or meaningful for helping to stay as healthy as possible?
8. Are there any events that changed the types of services you receive for managing your condition? If so, what events were those, and how did they change the types of services (e.g., heart transplant, LVAD)?
9. Does your care team communicate to you about whether you have heart failure with reduced ejection fraction or preserved ejection fraction (HFrEF or HFpEF)? Are there any particular services that you have received that your care team has said is specifically for HFrEF or HFpEF?
10. What aspects of the care you experienced could be improved? For example, have there been barriers to accessing care?

3.3 Low Back Pain

Healthcare Providers and Care Team

1. What types of healthcare providers did you see when you first started having symptoms?
2. What types of clinicians do you consider as part of your care team? That is, which healthcare providers help you to stay as healthy as possible?
3. How often do you interact with the members of your care team?
4. What factors affect the frequency of care and which clinician you see? For example, are there particular clinicians or specialists that you would see for more severe flare-ups of low back pain?
5. If you have multiple doctors in your healthcare team, do they coordinate with each other about your care? For example, if you received imaging services for your back, did all the members of your care team review the results from those scans?

Services Related to Treatment or Management

6. What types of medical care have you experienced for the diagnosis, treatment, or management of low back pain?
7. What types of medical care are the most effective or meaningful for helping to stay as healthy as possible?
8. Are there any types of care that you received that you believe were low value or ineffective in treating low back pain?
9. If you've had spinal surgery for low back pain, for how long did you receive care after surgery? Describe any differences and similarities between the types of services you received before and after surgery.
10. If you've received post-acute care services (e.g., home health services, treatment at an inpatient rehab facility or long-term care hospital) related to your low back pain, were those services helpful and necessary to your recovery? Please provide additional information about the types of services you received and their purpose.
11. What aspects of the care you experienced could be improved? For example, have there been barriers to accessing care?

3.4 Major Depressive Disorder

Healthcare Providers and Care Team

1. What types of clinicians are involved in your care team for the treatment/management of depression?
2. How often do you interact with the members of your care team?
3. What factors affect the frequency of care and which clinician you see? For example, are there particular clinicians or specialists that you would see for more severe depression?

4. If you have multiple doctors in your healthcare team, do they coordinate with each other about your care? For example, if one clinician refers you to another clinician, does the second clinician know what care you have already received? Or, if your psychiatrist changes your medication, is your primary care physician notified?

Services Related to Treatment or Management

5. What types of medical care have you experienced for the diagnosis, treatment, or management of depression?
6. What types of medical care are the most effective or meaningful for staying as healthy as possible?
7. If you have treatment-resistant depression, how was this diagnosed? After the diagnosis of treatment-resistant depression, how did the treatment change if at all?
8. What aspects of the care you experienced could be improved? For example, have there been barriers to accessing care when seeking treatment for/management of depression?

3.5 Psychoses/Related Conditions

Healthcare Providers and Care Team

1. Were there many clinicians who provided care while you were in the hospital? If there were multiple clinicians, did you feel as though they coordinated with each other to provide consistent care?
2. If you were receiving care for mental or behavioral health prior to your hospitalization (e.g., from a primary care doctor), did the inpatient care team notify them that you had been hospitalized?
3. What did your inpatient care team do to make your discharge or transition to another care setting easier?

Services Related to Treatment or Management

4. Did you receive services related to the inpatient hospitalization after you left? For example, were you readmitted or had to seek urgent care? If so, was there anything that your inpatient care team could have done to prevent this?
5. What aspects of the care you experienced could be improved?