Major Depressive Disorder Workgroup Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, June 21, 2021
June 2021

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. This approach will be revisited for future Waves of development. 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) Major Depressive Disorder.

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

[1] For information on measure development in Waves 3, refer to the 2020 Episode-Based Cost Measures Field Testing Wave 3 Measure Development Process document [PDF] (https://www.cms.gov/files/document/macra-cmft-ebcm-process-2020.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 [PDF] (https://www.cms.gov/files/document/wave-4-public-comment-summary.pdf).

provided detailed input on the development of the selected episode groups during their first workgroup webinars from June 21 to June 24, 2021. For Wave 4, 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, currently slated for late 2021.

Major Depressive Disorder Workgroup Webinar, June 21, 2021

This meeting summary document outlines the purpose, discussion, and recommendations from the Major Depressive Disorder 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 during the webinar as preparation for discussion on detailed measure specifications.

1. Overview

The goals of the Major Depressive Disorder workgroup webinar on June 21, 2021, 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 the measure's scope through identifying the episode group trigger codes, how to account for patient 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 via webinar and attended by 11 of the 14 workgroup members. The webinar was facilitated by an Acumen moderator, Eugene Lin. The Major Depressive Disorder workgroup chair was Naakesh Dewan, who also facilitated meeting discussions. Gaye Hyre was the PFP 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]

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 (see Section 3). After the webinar, workgroup members were sent a recording of the webinar and polled on their preferences to ensure the measures are developed based on well-documented 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.

[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).

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 during the first session of the webinar (Section 2.1). The following sub-sections describe workgroup member discussions and recommendations on defining the episode group (Section 2.2), addressing sub-populations of interest for meaningful clinical comparison (Section 2.3), and assigning services to the episode group (Section 2.4), respectively. Section 2.5 describes the next steps.

2.1 Person and Family Partner (PFP) Findings and Discussion

The attending PFP presented findings from focus groups and interviews with 4 PFPs conducted prior to the meeting. PFPs provided feedback about the initial diagnosis, the healthcare team and services furnished, and opportunities to improve care for managing the condition.

PFPs indicated that treatment for depression often begins after cases of self-harm, traumatic events, and major complications. They reported that depression is a component of other serious mental illnesses, such as bipolar disorder or post-traumatic stress disorder. For severe major depressive disorder cases, PFPs recommended that patients who visit the emergency department or are hospitalized are more clearly directed to the appropriate clinician. There was a question raised about whether the measure includes patients with mild major depressive disorder, who may not need the emergency services that the PFP mentioned. Acumen recommended to start with a broad scope for the episode group, which can be further refined during workgroup discussions.

PFPs listed out the different types of clinicians that are part of the care team for patients with major depressive disorder, including psychiatrists, general practitioners, counselors, licensed clinical social workers, psychiatric residents, and advanced practice registered nurses. PFPs noted that in addition to the usual clinicians within a patient's care team, other types of clinicians, such as pharmacists, are essential to streamline care.[4]

PFPs noted services that are important for the major depressive disorder condition. These include psychiatric care, inpatient hospital or emergency department visits, outpatient counseling services, antidepressants, group therapy sessions, counseling services that include tool building, and case management. PFPs noted that while telehealth is a useful platform, in-person counseling is more effective and less isolating for the patient. Workgroup members later discussed including telehealth codes in the trigger list (Section 2.2.2).

PFPs also highlighted indicators of high-quality depression care. They emphasized the importance of coordination and effective communication between the patient's care team. As an example, PFPs cited a positive experience of a care team consisting of a psychiatrist, registered nurses, and therapists that provided the patient a multi-hour intake procedure and coordinated with the patient's primary care clinician and pharmacist based on their needs. PFPs also noted

[4] Currently, pharmacists aren't eligible for MIPS.

medication coordination, peer connections, and personalized care characterized by comprehensive intake processes.

2.2 Defining the Episode Group

In this session, Acumen reviewed the chronic condition framework for defining an episode group. The goals during this session were to define the scope of the Major Depressive Disorder measure as well as refine the list of codes used to trigger a Major Depressive Disorder episode. In terms of scope, Acumen presented a list of International Classification of Diseases, 10th revision (ICD-10) diagnosis codes indicating major depressive disorder and discussed the benefits and tradeoffs of how broad the scope of the Major Depressive Disorder measure could be to capture the appropriate patient cohort. In terms of identifying an episode of care, a Major Depressive Disorder episode 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 ICD-10 diagnosis code indicating major depressive disorder. These CPT/HCPCS codes include the following:

- On a trigger claim, 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 that are intended to identify primary care, or an outpatient behavioral health visit code that includes psychiatric diagnostic evaluation and psychotherapy services
- On a confirming claim, either another outpatient E&M or behavioral health visit code or a condition-related CPT/HCPCS procedure code related to the treatment of major depressive disorder

Section 2.2.1 provides a summary of the workgroup's input on the measure scope and ICD-10 diagnosis codes used to identify major depressive disorder patients on trigger and confirming claims. Then, Section 2.2.2 provides workgroup members' input on the CPT/HCPCS codes used for trigger and confirming claims.

2.2.1 Discussion of ICD-10 Diagnosis Codes

Members discussed the types of diagnoses that should be considered relevant to the patient population to determine the measure's scope. Overall, members agreed on including the set of diagnosis codes for major depressive disorder. The workgroup discussed expanding the set of diagnosis codes to capture additional types of care, but some members were concerned that adding further diagnoses could increase the heterogeneity of an already heterogeneous patient cohort. Members agreed that cost measures should align with quality measures, and used this as a starting point to determine if the set of diagnosis codes should be expanded. They specifically looked at the Depression Remission at Twelve Months quality measure (Quality ID #370),[5] which includes dysthymia but excludes bipolar disorder and schizophrenia. As a result, the workgroup was generally in favor of including patients with dysthymia. They also recommended excluding certain comorbidities, such as bipolar and schizophrenia/schizoaffective disorders, if these diagnosis codes are present in addition to major depressive disorder at the start of the episode of care. Acumen will be conducting additional analyses on patients with major depressive disorder with comorbidities such as bipolar and schizophrenia disorders to present to the workgroup at the next meeting, particularly

[5] Measure specifications for the Depression Remission at Twelve Months quality measure (i.e., Quality ID #370) [PDF] can be found on the Quality Payment Program website (https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_370_MIPSCQM.pdf).

given that PFP findings indicated the onset of major depression as a component of serious mental illness diagnoses, including bipolar disorder. Workgroup members had mixed opinions about including adjustment disorder. One member noted that adjustment disorder isn't included in quality measures and should therefore be excluded. However, others were hesitant about excluding adjustment disorder because an adjustment disorder diagnosis could lead to a major depressive disorder diagnosis and improve the measure's ability to account for these patients.

Key Takeaways from Discussion and/or Polls for ICD-10 Diagnosis Codes:

- Inclusion Criteria:
  - Members agreed to include the set of diagnosis codes for major depressive disorder but didn't reach consensus on including the premenstrual dysphoric disorder ICD-10 code. This ICD-10 code is present in 0.03% of the episodes and will be kept in the preliminary list of ICD-10 diagnosis codes, given its small patient cohort size and no consensus reached.
  - Members recommended including diagnosis codes for dysthymia.
  - Members didn't reach consensus on including diagnosis codes for adjustment disorder. Acumen will present the prevalence and risk-adjusted costs of episodes with adjustment disorder in the next meeting.
- Exclusion Criteria:
  - Member recommended to exclude some comorbidities, including bipolar disorder and schizophrenia/schizoaffective disorders, if these diagnosis codes are present in addition to major depressive disorder at the start of the episode of care. Acumen will be conducting additional analyses on these patient cohorts to present to the workgroup at the next meeting.

2.2.2 Discussion of CPT/HCPCS Codes

When Acumen discussed the algorithm that's used to trigger episodes, they mentioned that the current chronic condition measures (Asthma / Chronic Obstructive Pulmonary Disease [COPD] and Diabetes) use a 180-day trigger window (i.e., the maximum window of time between the trigger and confirming claims) to capture clinician and patient relationships. In addition to other chronic condition measures using this timeframe, Acumen explained the benefits and drawbacks of having a shorter or longer trigger window, noting that a 180-day trigger window captures around 95% of all trigger events for the Major Depressive Disorder episode group.

The workgroup then discussed different types of CPT/HCPCS codes that could be used to trigger or confirm an episode and thus indicate the start of a care relationship for major depressive disorder. For trigger codes, the workgroup discussed outpatient E&M, outpatient behavioral health visit, collaborative care management, health and behavior assessment and intervention, telehealth, and consultation codes. For confirming codes, the workgroup discussed codes for treatment such as electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS).

Workgroup members were generally in agreement with the list of CPT/HCPCS codes presented that are used as trigger claims, which include outpatient E&M codes and outpatient behavioral health visit codes. Members also supported the use of telehealth service codes as trigger codes, particularly given the rise in telehealth during and potentially after the COVID-19 pandemic.

They suggested to broaden the list of trigger codes by including other types of services that could indicate the start of a care relationship for major depressive disorder, including collaborative care management codes and health and behavior assessment and intervention

codes. The workgroup recommended adding collaborative care management codes to recognize the role of the care team and integrated care in management of major depressive disorder, in an effort to incentivize low-cost, efficient care. They also suggested including health and behavior assessment and intervention codes to recognize the roles of other specialists (i.e., psychologists) and services that contribute to the management of major depressive disorder. Members agreed that these codes should be accompanied by a major depressive disorder diagnosis.

Members agreed that consult codes shouldn't be included, since they imply that the consulting clinician isn't not fully involved in the patient's care. In addition, Acumen mentioned that Medicare doesn't reimburse for consult codes.

Members agreed with the list of other condition-related CPT/HCPCS codes related to the treatment of major depressive disorder that could be used as confirming claims, including psychoanalysis, ECT, TMS treatment, pharmacologic management, and narcosynthesis for psychiatry diagnostic and therapeutic purposes. They suggested that these codes also be included as trigger claims, given that some specialties specializing in ECT and TMS could meet a patient for the first time during these procedures.

There was also discussion about whether different types of clinicians use billing codes differently. Acumen will present additional results on how to capture specialties that are involved in care for major depressive disorder.

<u>Key Takeaways from Discussion and/or Polls for CPT/HCPCS Codes</u>:

- The workgroup agreed to include outpatient E&M and behavioral health visit codes as trigger codes.
- The workgroup recommended expanding the list of trigger codes to include the following CPT/HCPCS codes:
    - Collaborative care management codes
    - Health and behavioral assessment and intervention codes
- The workgroup recommended that the following confirming claims also be included as trigger claims:
    - Psychoanalysis
    - ECT
    - TMS treatment
    - Pharmacologic management
    - Narcosynthesis for psychiatry diagnostic and therapeutic purposes

2.3 Addressing Sub-Populations for Meaningful Clinical Comparison

Members also engaged in a detailed discussion about how to account for patient cohort heterogeneity among various sub-populations within the Major Depressive Disorder episode group. Sub-populations refer to patient cohorts as defined by their pre-existing conditions and characteristics. Workgroup members discussed: (i) stratifying the patient population into mutually exclusive and exhaustive sub-groups to define more homogenous patient cohorts,[6] (ii) defining covariates in the risk adjustment model,[7] (iii) identifying measure exclusions,[8] and (iv) monitoring certain sub-populations for further testing.[9]

After Acumen provided a description of each method and presented analytic data on preliminary sub-populations (recommended or identified either through the literature scan, public comment, or Acumen clinical team), workgroup members discussed the patient sub-populations and their preferences for how to address them. Sections 2.3.1, 2.3.2, and 2.3.3 summarize the workgroup discussions and recommendations regarding patients with and without psychotic features, patients with treatment-resistant depression, and those in remission, respectively; Section 2.3.4 provides the discussions and recommendations regarding how to address other sub-populations of interest.

2.3.1 Patients With and Without Psychotic Features

The workgroup agreed to stratify the patient cohort into 2 sub-groups: (i) major depressive disorder with psychotic features, and (ii) major depressive disorder without psychotic features. The rationale for stratifying by the presence of psychotic features was that there may be different treatment plans required for these cases and there's a lower probability of error when a clinician bills for depression with psychotic features compared to other diagnoses. Based on data that showed the diagnosis rate of depression with psychotic features, Acumen estimated that there are enough episodes for potential sub-grouping. Acumen will present more empirical results at the next meeting to determine how these patient sub-populations are different than the typical major depressive disorder patient cohort.

Key Takeaways from Discussion and/or Polls for Patients With and Without Psychotic Features:

- Members recommended to create 2 sub-groups for: (i) major depressive disorder with psychotic features, and (ii) major depressive disorder without psychotic features. Acumen will present further data on these sub-populations during the next meeting to confirm how they should be accounted for.

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[6] 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.

[7] 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 adjust observed episode spending to an expected episode spending (predicted by a risk adjustment model).

[8] 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.

[9] Monitoring for further testing is an option for flagging certain sub-populations that the workgroup may revisit later during measure development upon review of further data. This approach is best used when the workgroup requests additional data or information on a sub-population to discuss the appropriate method for meaningful clinical comparison.

2.3.2 Patients with Treatment-Resistant Depression

The workgroup considered how to account for patients with treatment-resistant depression (TRD). The workgroup noted that the definition Acumen used of requiring 3 or more antidepressants within the prior year might be overly sensitive to very short prescriptions (e.g., 30 or fewer days). They suggested testing a stricter definition that only included longer prescriptions (e.g., 90 or more days). Additionally, members noted it may be difficult to implement this definition, given that around 20% of the initial patient cohort doesn't have Part D. The workgroup suggested using a proxy variable for TRD, such as prior hospitalizations. Acumen will conduct additional analyses to test how these patients can be identified and to examine differences in costs of care to help the workgroup determine how to account for this patient cohort, either through sub-grouping or risk adjustment.

Key Takeaways from Discussion and/or Polls for Patients with TRD:

- Members agreed to and requested additional analyses on identifying patients with TRD to determine how to account for this patient sub-population during the next meeting.

2.3.3 Patients in Remission

Workgroup members also discussed how to account for patients in remission and noted that they would like to see more data on this sub-population, including how frequently these episodes are reaffirmed (i.e., extend the attribution window when we observe services indicating that care is continuing). Most members agreed to include patients in remission in the measure. They pointed out that since major depressive disorder is chronic, remission is a phase of the chronic condition. Excluding patients in remission may incentivize clinicians to continue to bill for remission, even as the patient seeks treatment for depression. One member proposed either risk adjusting or sub-grouping for patients in remission, citing that coding for remission may not always be accurate. Acumen will also conduct additional analyses to test how these patients can be identified and to examine differences in costs of care.

Key Takeaways from Discussion and/or Polls for Patients in Remission:

- Members agreed to and requested additional analyses on identifying patients in remission to determine how to account for this patient sub-population during the next meeting.

2.3.4 Other Sub-Populations of Interest

There was some discussion about other sub-populations of interest. Several members supported risk adjusting for anxiety disorder and noted that anxiety often co-occurs and is a comorbid condition among patients with major depressive disorder. Additionally, a member recommended excluding patients with major depressive disorder and neurocognitive comorbidities (e.g., dementia) from the measure. Since patients with dementia are at higher risk and have limited memory capabilities, clinicians generally leave out routine major depressive disorder treatments, including psychotherapy and certain medications. However, the Acumen team noted that dementia patients constitute a considerable proportion of major depressive disorder patients and that the workgroup may want to consider accounting for these patients differently.

Key Takeaways from Discussion and/or Polls for Other Sub-Populations of Interest:

- Members didn't reach consensus regarding patients with anxiety disorder and other comorbidity sub-populations (i.e., coronary artery disease, prior suicide attempt, prior suicide ideation, post-traumatic stress disorder, sleeping disorder, eating disorder, and

chronic pain).These sub-populations may undergo further testing and will be discussed by the workgroup later on during measure development.

- Members recommended to exclude patients with dementia, but the Acumen team noted that the workgroup may want to reconsider how to account for these patients using sub-grouping or risk adjustment, given that they constitute a considerable portion of major depressive disorder patients. Acumen will present further data on this sub-population during the next meeting.

2.4 Assigning Services to the Episode Group

Prior to the meeting, workgroup members participated in a survey that asked them to provide preliminary input on the types of services to assign for the Major Depressive Disorder episode group. This input was intended to serve as the starting point for discussion during this session. Acumen presented this preliminary list of categories of services and asked for additional input from workgroup members. Members agreed to include services such as counseling services and psychiatric emergencies and hospitalizations. They suggested adding other services, including pre-operative and lab work prior to an ECT procedure, ECT and TMS, medication complications (such as serotine syndrome) and monitoring, medical care after a suicide attempt, outpatient occupational evaluation to support patients' routines and chronic condition management, and collaborative care services to incentivize coordination of care. Acumen clarified that workgroup members will be able to expand on this list of preliminary services during the next meeting.

Key Takeaways from Discussion and/or Polls for Assigning Services to the Episode Group:

- Members recommended to include the following services:
    - Counseling services
    - Psychiatric emergencies
    - Psychiatric hospitalizations
    - Pre-operative and lab work prior to ECT (i.e., lithium; monitor blood sugars)
    - ECT/TMS
    - Medication complications
    - Medication monitoring
    - Medical care after a suicide attempt
    - Outpatient occupational evaluation
    - Collaborative care services

2.5 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. The survey also consisted of open comment boxes to provide additional thoughts on topics for PFP input and a space to share additional comments. Acumen will operationalize input for the measure specifications based on Workgroup Webinar Poll results and will follow up with workgroup members with more information about the next steps in the measure development process (i.e., scheduling for the Service Assignment and Refinement Webinars in late August/early September 2021).

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 4 of cost measure development and information on the measure frameworks
- Investigation workbook sent prior to the meeting, which presented detailed findings from empirical analyses:
    - A Sub-Population Analysis Workbook, 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

The materials shared were based on analyses run on draft measure specifications that the Acumen clinical team created based on input from the Wave 4 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 4 measure development public comment period
- The goals of the meeting and timeline of activities for Wave 4
- 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