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2023 Measures Under Consideration Public Comment Summary

CLINICIAN COMMITTEE

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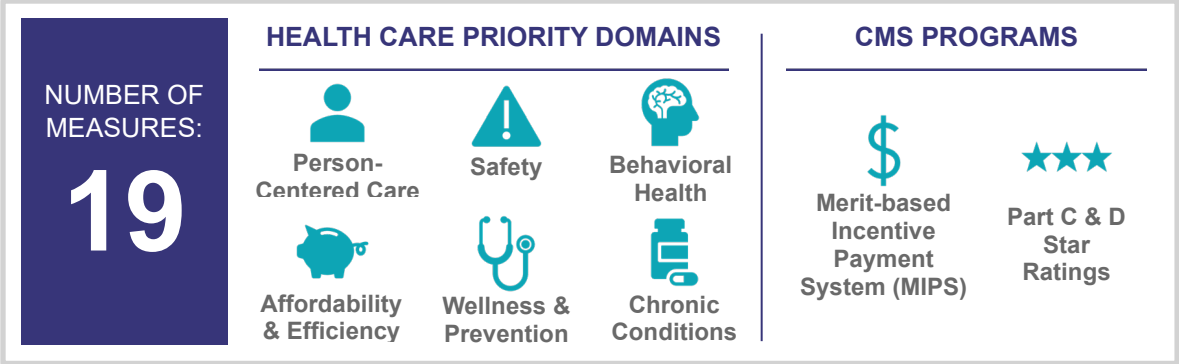
Public Comment Period Overview

Each Pre-Rulemaking Measure Review (PRMR) cycle begins with the publication of the Measures Under Consideration (MUC) list. The PRMR process engages a diverse group of interested parties in making consensus-based recommendations regarding the inclusion of considered measures. The 19 Clinician Committee measures for 2023 align with six health care priority domains and are under consideration for inclusion in the Merit-based Incentive Payment System (both cost and quality), as well as the Part C and D Star Ratings program.

Figure 1. Clinician Committee Measures Under Consideration



With the release of the MUC list on December 1, 2023, Battelle held a 21-day call for public comment along with a series of setting-specific listening sessions. Battelle received a total of 495 written comments from 147 professional organizations and 49 patients/patient representatives.

Figure 2. Public Comment Period Summary

Of the written comments submitted, 126 were submitted for measures assigned to the Clinician Committee. Additionally, the 2023 MUC List Clinician Measures Listening Session garnered verbal comments from 21 individuals encompassing a spectrum of perspectives, including patients and representatives from multiple professional organizations.

Alongside comments and feedback from the advisory and recommendation groups, insights from public comment will help identify areas of non-consensus to focus on during the Clinician Recommendation Group meeting and ensure that the voices of many interested parties are adequately represented in pre-rulemaking.

Measure-Specific Summary

The following brief summaries include themes and considerations gathered from both written and verbal comments provided during the comment period. Due to the didactic nature of the listening sessions that led to both comments and questions from the public, only the number of written comments is reported. While not counting towards the tally of total comments, themes and key points provided by listening session attendees are included in the summary tables for each measure.

All comments were assessed and categorized as “support”, “support with considerations” or “oppose”. A comment was considered “support with considerations” if it expressed support for measure intent or content while providing additional questions, requests for CMS to consider additional information, or discussed challenges to use of the measure in the selected program. For these summaries, duplicate comments submitted for the same measure were analyzed as one comment.

MUC2023-137 Initial Opioid Prescribing for Long Duration (IOP-LD)

Number of Written Comments: 7; Support (1); Support with Considerations (0); Oppose (6)

Reasons for Support
• Managing the use of opioid prescriptions may protect many against long-term opioid use. • May help to support non-pharmacological interventions for pain. • Adoption may help address the scope and speed of the opioid epidemic.
Reasons for Opposition
Specification: • Lack of measure exclusions for beneficiaries with medical need for extended use (e.g., frailty). • Lack of option for provider rationale for extended use. • Narrow patient population definitions • Patient Voice: Insufficient patient engagement in development. Validity: • Reflects 3-day and 7-day thresholds from the 2016 guidelines but not the removal of these thresholds in 2022 guidelines. • Concerns on evidence base supporting thresholds. • More validation requested at the attribution level. Usability & Feasibility: • May not align with current CMS program reporting guidelines & implementation.

- Current opioid management programs do not align with the 3-day supply standard nor CDC guidance.
- Should include denominator exclusions for beneficiaries who may be frail or include a risk adjustment and/or stratification for age or disability.

Patient & Provider Relationship:

- Decision should be between doctor and patient without external measurement.

MUC2023-141 Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy

Number of Written Comments: 2; Support (1); Support with Considerations (1); Oppose (0)

Reasons for Support
• Support for the measure intent, specification, and evidence base. • CMS is encouraged to consider the development and implementation of additional metrics that encourage evidence-based cancer care. • Will support alignment with National Comprehensive Cancer Network Oncology Guidelines.
Reasons for Opposition
• Appropriateness of measuring performance against an evolving and inexact standard should be reconsidered. • Concern that positive test results can vary based on clones and platforms used as well as interobserver reproducibility. • Consider revising to include consideration of PD-L1 testing regardless of platform or result.

MUC2023-161 Appropriate Germline Testing for Ovarian Cancer Patients

Number of Written Comments: 3; Support (2); Support with Considerations (1); Oppose

Reasons for Support
• Support for intent of measure and evidence base. • Potential for this measure to reduce patient suffering and health care costs while promoting effective treatments.
Reasons for Opposition
• Concern for the lack of Consensus Based Entity endorsement for this measure.

MUC2023-162 Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer

Number of Written Comments: 11; Support (9); Support with Considerations (2); Oppose (0)

Reasons for Support
• Patient-reported outcome measures are uniquely suitable for assessing cancer care. • Measure may help patients to assume a more active role in their care and help both providers and patients achieve the outcomes that matter for overall health, quality of life, recovery, and survivorship in cancer care. • Measure may improve patient-provider communication and data-driven care management plans, which in turn can lead to improved patient experience and health equity. • Support for improving accountability and value-based payment in cancer care.
Reasons for Opposition
• May not have broad applicability to oncology practices that have integrated other validated instruments into their practice. • Suggest that this measure be adapted over time to allow for submission of other validated patient-reported outcome measures (PROMs) beyond Patient-Reported Outcomes Measurement Information System (PROMIS) and flexibility to use PROMIS computer adaptive tests instead of the short forms.

MUC2023-164 Adult COVID-19 Vaccination Status

Number of Written Comments: 8; Support (3); Support with Considerations (1); Oppose (4)

Reasons for Support
• Support for intent of measure with emphasis on how vaccination will improve patient safety and prevent transmission. • Measure may encourage health plans and providers to promote uptake of COVID vaccination. • Measure was viewed as “vital” to the health and wellbeing of the community, particularly older adults and those at greater risk. • Viewed as an “important step” toward integrating the adult COVID-19 vaccination measure into the Adult Immunization Status (AIS) measure that has been included in the physician fee schedule quality reporting program.
Reasons for Opposition
• Concern that yearly updating of the definition of “up to date” may not be able to keep up with current guidelines and definitions. • Feasibility concerns related to cost, storage requirements, and administration of vaccines at practices with varying levels of resources. • Vaccine hesitancy, political divides, and regional variation are factors outside provider control and would potentially impact vaccination rates; “unfair” to hold providers accountable due to these factors. • It may be “premature” to develop and subsequently implement a performance measure addressing COVID vaccination rates.

- Measure lacks exclusions to account for regional variation, vaccine hesitancy and other external factors.
- Concern around how this measure may impact provider-patient relationship for populations with greater vaccine hesitancy.
- May negatively impact providers serving rural communities due to regional trends in vaccine hesitancy.

MUC2023-179 Initiation and Engagement of Substance Use Disorder Treatment (IET)

Number of Written Comments: 6; Support (1); Support with Considerations (1); Oppose (4)

Reasons for Support
• Measure will help address substance use disorder (SUD) and help plans gather data to provide education and outreach to improve access to care. • Fills gap in measurement that may lead to new approaches.
Reasons for Opposition

• More testing is needed on the current version with telehealth included.
• Several comments expressed concerns around data availability and interoperability.
  ○ State and federal regulations around confidentiality of SUD patient records may obstruct measure implementation.
  ○ Technology infrastructure needed for seamless sharing of records across providers is not uniformly available, posing a particular obstacle to rural and low-resource communities.
• The ability to provide treatment options to patients may be very dependent on the availability of services within a community or region, and the measure does not currently account for those instances.
• Patient disinterest and refusal remains a significant challenge in this population.

MUC2023-190 Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer

Number of Written Comments: 13; Support (11); Support with Considerations (1); Oppose (1)

Reasons for Support

• Robust support for the use of patient-reported outcome measures (PROMs) for cancer care.
  ○ PROMs viewed as an "essential element" in the new CMS Enhancing Oncology Model.
  ○ PROMS are able to represent and measure complexity of patient experience in cancer care.
  ○ PROMs should be considered the gold standard for understanding patients' experience of many symptoms that may be associated with the side effects of cancer treatment.
  ○ PROMs should result in better-managed side effects of treatment and increase the ability for patients to return to work and family roles.
• Measure may improve patient-provider communication and data-driven care management plans, which in turn can lead to improved patient experience and health equity.
• Commenters suggested that this measure should be recommended with the condition that it undergoes CBE endorsement.

Reasons for Opposition
• Feasibility is limited by the use of one tool and will therefore not have broad applicability to oncology practices that have integrated other validated instruments into their practices. • Important to allow flexibility in validated tools to measure fatigue. • More feasibility assessment and workflow analysis requested. • Suggest pathway forward as an "optional measure" to meet reporting requirements.

MUC2023-199 Connection to Community Service Provider

Number of Written Comments: 9; Support (2); Support with Considerations (2); Oppose (5)

Reasons for Support
• Support for measure intent and strong evidence base; commenters cited multiple sources of evidence in the literature of the impacts of social determinants of health (SDOH) on health outcomes for patients. • Measure has been validated for use in the Accountable Health Communities demonstration model, and in the Comprehensive Primary Care Plus model. Within validation set, a majority of practices were able to link patients with community-based resources. • A survey of clinicians found that a large majority wanted more tools to address SDOH in patients. • While current documentation of SDOH-related care is occurring, CMS has the opportunity to standardize measures that document this work, allow for reimbursement, and provide ongoing data that tracks the extent of these needs.

- While measure intent is supported, commenter suggested that this measure should be accompanied by efforts to ensure that communities have adequate resources to support referrals.
- Aligns with guidance Healthcare Information and Management Systems Society (HIMSS) provided for the collection of SDOH measure that came out in the 2022 IPPS/PFS rulemaking.

Reasons for Opposition

Evidence & Intent

- Inadequate evidence provided for the five social needs model and 60-day window for connection to community service providers (CSPs).

Feasibility & Usability

- More information should be provided regarding how contact with a CSP is tracked and which party is responsible.
- Concern that there is no verification or enforcement mechanism that would prevent entities from improper or dishonest tracking.
- Providers who serve a disproportionate number of patients with unmet social needs may be unfairly penalized, in part because they would require additional dedicated resources to implement the necessary interventions to improve performance.
- The related measure for screening for SDOH (#210) has never been included on the MUC list for the MSSP and it would be premature to consider a measure that would require the outcome of that screening measure.
- The measure should align with HL7 and USCDI standards.
- Community service providers (CSPs) do not all accept electronic referrals, often do not collection patient-level information or report information back to the referring clinician, and do not generate a claims record when a patient accesses services, impacting feasibility and increasing provider burden.
- Interoperability concerns raised suggest need for greater information technology investment in community service providers.

Validity & Reliability:

- The measure is currently limited to patients who have been discharged from the hospital, increasing its complexity for MSSP.
- The measure has not been tested for validity and reliability in ACOs.
- The performance score may not be able to distinguish between quality of care versus availability of resources.
- The measure had not undergone the rigorous consensus-based endorsement process.

Exclusions & Adjustment:

- Exclusions should be made for patients who contact a CSP but are ineligible for services, and locations with limited resources.
- Adjustment or exclusions should be considered to account for availability and capacity of community service providers to ensure that the measure can be implemented fairly.

CMS Program Suitability

- The measure does not align with CMS policy, which focuses on community health integration services, which cannot be initiated from the inpatient setting. It is suggested that CMS support development of a different measure that would focus on connection with a Primary Care Provider or other longitudinal source of care after discharge.

MUC2023-201 Cataract Removal with Intraocular Lens (IOL) Implantation

Number of Written Comments: 6; Support (0) Support with Considerations (2) Oppose (4)

Reasons for Support
• Commenter agreed with exclusion of complex cataract surgery, inclusion of costs for related services, exclusion of Part D drug costs, inclusion of all Part B drug costs, and removal of certain diagnoses from the exclusions and risk adjustment model. • Commenter suggested adding capsular glaucoma to the list of exclusions, and risk adjustment for health-related social needs (HRSNs) • Commenter recommended improvements in scoring and performance feedback to educate providers on the measure calculation and to add data fields in performance reports.
Reasons for Opposition
• The measure should be endorsed by a consensus-based entity. Validity & Reliability • Commenter recommended careful review by the clinical expert panel to resolve any inconsistencies in service attribution before the measure is applied for the 2023 performance year. • Commenter recommended improvements in scoring and performance feedback to educate providers on the measure calculation and to add data fields in performance reports. • The measure is not tested at the individual clinician level and may not be appropriate for MIPS. It is requested that the measure be tested using TIN-NPI data if the measure is intended for individual clinicians.[1] • Commenter encouraged CMS to explore different benchmarking approaches to manage the effects of outliers in cost. Exclusions & Risk Adjustment • The measure should have an appropriate risk adjustment model, exclusions, and attribution methodology. • While inclusion of Part D drug costs would be ideal, commenter noted that barriers such as providers' lack of information regarding cost and varying accessibility of drugs make this inadvisable. • Commenter recommended excluding Part B medication costs from the measure specifications to avoid disincentivizing use of alternatives that might better meet the needs of certain patients. • Commenter suggested adding capsular glaucoma to the list of exclusions, and risk adjustment for health-related social needs. Usability & Feasibility • A low reimbursement rate is already a disincentive for offering this procedure, and the measure may further incentivize providers to stop offering this procedure. • The measure risks attributing costs to the surgery provider that they have no control over, including costs that may have been improperly attributed.

[1] Note: Measures 201-209 are tested at the individual clinician and group level. CMS MERIT submission for 2023 only allowed selection of one level of testing in the submission form, which resulted in incomplete representation of testing in PRMR preliminary assessments (PAs) for these measures.

- Commenter suggested that 66984 is the only appropriate trigger code for the measure to ensure comparability of episodes and avoid penalizing low-volume providers or providers specializing in complex cases.
- Measure results may be difficult for providers to understand.

MUC2023-203 Chronic Kidney Disease

Number of Written Comments: 6; Support (0); Support with Considerations (2); Oppose (4)

Reasons for Support

- Commenter agreed with the decision to exclude SGLT2 inhibitor costs to avoid disincentivizing its use in appropriate patients and suggested developing a performance measure specifically for SGLT2 and other novel medications.
- Support for the value of measurement in reducing health care costs.

Reasons for Opposition

- The measure should be endorsed by a consensus-based entity.
- Nephrologists serving rural or economically disadvantaged populations may find it more challenging to implement the necessary clinical redesign or have scores impacted by lower patient volume and be penalized.

Validity & Reliability

- It is not sufficient to evaluate measure validity by correlating it with other cost measures, and validation studies should consider quality of care.
- Reliability is below the 0.6 threshold for 30 patients or fewer, and the measure should be restricted to higher patient thresholds.
- The measure has been tested at the clinician group level and not the individual clinician level[2]; however, the specifications state it can be applied to the individual clinician, which the commenter does not support.
- Reliability for patient thresholds under 30 is very low (i.e., 0.386 for 20 patients), and commenter suggested limiting reporting of the measure to a higher threshold of at least 30-50 patients.

Risk Adjustment & Exclusions

- Risk adjustment for social risk factors or complexity may be incomplete.
- The measure should have an appropriate risk adjustment model, exclusions, and attribution methodology.
- Commenter requested additional explanation for why patients with extremely low medical costs are excluded from the denominator.
- The risk adjustment model used is different from the model clinicians have been asked to use.

Feasibility & Usability

- Patients may have numerous comorbidities but these may not be available in billing codes, which limits ability to risk adjust in practice.
- A potential unintended consequence is that providers will select lower-risk patients or will not provide appropriate care due to cost concerns.
- A phased approach for implementation is suggested, beginning with pay for reporting.

[2] Note: Measures 201-209 are tested at the individual clinician and group level. CMS MERIT submission for 2023 only allowed selection of one level of testing in the submission form, which resulted in incomplete representation of testing in PRMR PAs for these measures.

- Clinicians may not easily understand how they are performing throughout the period and may lack visibility into costs of care.

MUC2023-204 End-Stage Renal Disease

Number of Written Comments: 6; Support (0); Support with Considerations (3); Oppose (3)

Reasons for Support

- Support for intent of measure and recognition of measure target importance to patient care and cost containment.
- There should be Fee-for-Service reimbursement for unique evidenced-based interventions that could enhance medication adherence or help manage adverse events and may include a broader range of team clinicians who can help support this.

Reasons for Opposition

- The measure includes the disclaimer that no evidence is provided explaining how clinician groups will achieve outcomes through cost containment.
- The measure should be endorsed by a consensus-based entity.

Exclusions

- Commenter requested additional explanation for why patients with extremely low cost are excluded from the denominator.
- Per the denominator exclusion, a better definition of "extremely low" treatment costs is needed.
- Commentor recommended removing Part D costs.

Risk Adjustment

- The risk adjustment model used is different from the model clinicians have been asked to use.
- The measure should have an appropriate risk adjustment model, exclusions, and attribution methodology.

Validity & Reliability

- The measure is not tested at the individual clinician level and may not be appropriate for MIPS. It is requested that the measure be tested using TIN-NPI data if the measure is intended for individual clinicians.[3]
- Commenter encourages CMS to explore different benchmarking approaches to manage the effects of outliers in cost.
- Minimum reliability at the TIN level with at least 20 episodes was 0.274, below the required minimum level of 0.7 for MIPS measures.
- It is not sufficient to evaluate measure validity by correlating it with other cost measures, and validation studies should consider quality of care.

Feasibility & Usability

- Patients may have numerous comorbidities but these may not be available in billing codes, which limits ability to risk adjust in practice.
- Clinicians cannot easily understand how they are performing throughout the period, they lack visibility into costs of care.
- A phased approach for implementation is suggested, beginning with pay for reporting.

[3] Note: Measures 201-209 are tested at the individual clinician and group level. CMS MERIT submission for 2023 only allowed selection of one level of testing in the submission form, which resulted in incomplete representation of testing in PRMR PAs for these measures.

Equity
- A potential unintended consequence is that providers will select lower-risk patients or will not provide appropriate care due to cost concerns.
- Measure should account for potential incomplete implementation of a new eGFR calculation that may result in delays in care for Black patients.
- In communities without access to a nephrologist, costs would likely be attributed to primary care physicians.
- There is a risk of stinting care or avoiding these patients because they may be more expensive.

MUC2023-205 Inpatient (IP) Percutaneous Coronary Intervention (PCI)

Number of Written Comments: 2; Support (0); Support with Considerations (1); Oppose (1)

Reasons for Support
- Support for intent of measure and recognition of measure target importance to patient care and cost containment.

Reasons for Opposition
- The measure should be endorsed by a consensus-based entity.
- Commentor recommended removing Part D costs.

Risk Adjustment
- The risk adjustment model used is different from the model clinicians have been asked to use.
- The measure should have an appropriate risk adjustment model, exclusions, and attribution methodology.

Validity & Reliability
- The measure is not tested at the individual clinician level and may not be appropriate for MIPS. It is requested that the measure be tested using TIN-NPI data if the measure is intended for individual clinicians.[4]
- Minimum reliability at the TIN level with at least 20 episodes was 0.315, below the required minimum level of 0.7 for MIPS measures.
- It is not sufficient to evaluate measure validity by correlating it with other cost measures, and validation studies should take account of quality of care.

[4] Note: Measures 201-209 are tested at the individual clinician and group level. CMS MERIT submission for 2023 only allowed selection of one level of testing in the submission form, which resulted in incomplete representation of testing in PRMR PAs for these measures.

MUC2023-206 Kidney Transplant Management

Number of Written Comments: 5; Support (0); Support with Considerations (3); Oppose (2)

Reasons for Support
• Support for intent of measure and recognition of measure target importance to patient care and cost containment. • There should be Fee-for-Service reimbursement for unique evidenced-based interventions that could enhance medication adherence or help manage adverse events and may include a broader range of team clinicians who can help support this.
Reasons for Opposition
• The measure includes the disclaimer that no evidence is provided explaining how clinician groups will achieve outcomes through cost containment. • The measure should be endorsed by a consensus-based entity. • Commenter requested more details on the data sources used for the measure. Exclusions • Commenter requested additional explanation for why patients with extremely low cost are excluded from the denominator. • Per the denominator exclusion, a better definition of "extremely low" treatment costs is needed. • Part D costs for insulin and other diabetes medications, and potentially immunosuppressants, should be excluded to avoid disincentivizing their use. Validity & Reliability • The measure is not tested at the individual clinician level and may not be appropriate for MIPS. It is requested that the measure be tested using TIN-NPI data if the measure is intended for individual clinicians.[5] • Commenter encouraged CMS to explore different benchmarking approaches to manage the effects of outliers in cost. • Minimum reliability at the TIN level with at least 20 episodes was 0.117, below the required minimum level of 0.7 for MIPS measures. • Measure does not meet the minimum reliability of 0.6. • It is not sufficient to evaluate measure validity by correlating it with other cost measures, and validation studies should consider quality of care. • Commenter calls for higher patient thresholds due to low reliability. Risk Adjustment • While patients who receive a "low-quality" kidney have improved outcomes and lower costs overall, they are likely to require more care than other kidney recipients, as are older patients with more comorbidities. • Commenter recommended working with HRSA or the Organ Procurement and Transplant Network (OPTN) to obtain the necessary data to adequately risk adjust the measure. Feasibility & Usability • Patients may have numerous comorbidities but these may not be available in billing codes, which limits ability to risk adjust in practice.

[5] Note: Measures 201-209 are tested at the individual clinician and group level. CMS MERIT submission for 2023 only allowed selection of one level of testing in the submission form, which resulted in incomplete representation of testing in PRMR PAs for these measures.

- Clinicians cannot easily understand how they are performing throughout the period, so they lack visibility into costs of care.
- A phased approach for implementation is suggested, beginning with pay for reporting.
- A potential unintended consequence is that providers will select lower-risk patients or will not provide appropriate care due to cost concerns.

MUC2023-207 Prostate Cancer

Number of Written Comments: 4; Support (0); Support with Considerations (2); Oppose (2)

Reasons for Support

- Support for intent of measure and recognition of measure target importance to patient care and cost containment.

Reasons for Opposition

- The measure should be endorsed by a consensus-based entity.
- The measure should have an appropriate risk adjustment model, exclusions, and attribution methodology.

Exclusions

- Commentor recommended removing Part D costs.

Feasibility & Usability

- Information about clinical stage (metastatic vs. non-metastatic disease) is not available in claims, and the risk adjustment model cannot control for the higher expected costs of providing appropriate care for patients with metastatic disease.
- Some costs may be outside the control of the provider who triggers the care episode and to whom costs are attributed, e.g., costs related to care provided by a radiation oncologist.
- Cost measures should be paired with measures that capture related outcomes. No measure currently evaluates prostate cancer outcomes in MIPS.
- The timeframe of the measure cannot capture cost savings that may result from a higher cost up front.
- Costs are evaluated without accounting for the quality of care or outcomes ("value") and may result in stinting of care.

Validity & Reliability

- The measure is not tested at the individual clinician level and may not be appropriate for MIPS. It is requested that the measure be tested using TIN-NPI data if the measure is intended for individual clinicians.[6]
- Minimum reliability at the TIN level with at least 20 episodes was 0.365, below the required minimum level of 0.7 for MIPS measures.
- It is not sufficient to evaluate measure validity by correlating it with other cost measures, and validation studies should consider quality of care.

[6] Note: Measures 201-209 are tested at the individual clinician and group level. CMS MERIT submission for 2023 only allowed selection of one level of testing in the submission form, which resulted in incomplete representation of testing in PRMR PAs for these measures.

Equity
- Black men experience higher incidence, higher mortality, and later diagnosis with prostate cancer, and delays in care can lead to worse outcomes and higher costs; providers may be incentivized to avoid these patients. Commenter suggested stratifying the measure.

MUC2023-208 Respiratory Infection Hospitalization

Number of Written Comments: 4; Support (0); Support with Considerations (2); Oppose (2)

Reasons for Support
- Support for intent of measure and recognition of measure target importance to patient care and cost containment.
- Commenter supported the measure concept in other programs.

Reasons for Opposition
- The measure should be endorsed by a consensus-based entity.
- The measure should have an appropriate risk adjustment model, exclusions, and attribution methodology.
- Commentor recommended removing Part D costs.

Evidence
- The complexity and variation in respiratory infections is a challenge for interpretating the meaning of this cost measure.
- Evidence on the effectiveness of procalcitonin is mixed.
- Diagnostic tests other than procalcitonin are becoming more available and should be considered.

Validity & Reliability
- Minimum reliability at the TIN level with at least 20 episodes was 0.536, below the required minimum level of 0.7 for MIPS measures.
- It is not sufficient to evaluate measure validity by correlating it with other cost measures, and validation studies should consider quality of care.
- The measure is not tested at the individual clinician level and may not be appropriate for MIPS. It is requested that the measure be tested using TIN-NPI data if the measure is intended for individual clinicians.[6]

Usability & Feasibility
- Hospitals will have cases attributed to them, but they have little ability to influence cost for an episode of case because the hospital portion of the cost is relatively fixed.

MUC2023-209 Rheumatoid Arthritis

Number of Written Comments: 6; Support (0); Support with Considerations (2); Oppose (4)

Reasons for Support
• Support for intent of measure and recognition of measure target importance to patient care and cost containment.
Reasons for Opposition
• An appropriate resource use measure for rheumatologists is lacking. • Commentor recommended removing Part D costs. • Cost measures should be paired with measures that capture related outcomes. • The cost measure does not appear to include a cost-effectiveness component. The evidence provided in support of the measure reflects better clinical outcomes. Feasibility & Usability • The measure would hold rheumatologists accountable for costs outside their control. • Costs are evaluated without accounting for the quality of care or outcomes ("value") and may result in stinting of care. • The measure does not provide actionable results for rheumatologists. • CMS payment and coverage policies restrict the medications rheumatologists can prescribe (e.g., step therapy requirements, the self-administered drug exclusion list) and can result in delays in patients receiving the most appropriate care. • The timeframe of the measure cannot capture cost savings that may result from a higher cost up front. Equity • Disparities in need for pain medication and therapies may lead to higher costs, and the measure should take this into account. Risk Adjustment • The risk adjustment model should be clarified; it is important to adjust for social risk factors, biological factors, and comorbidities. • The measure should have an appropriate risk adjustment model, exclusions, and attribution methodology. Validity & Reliability • Minimum reliability at the TIN level with at least 20 episodes was 0.489, below the required minimum level of 0.7 for MIPS measures. • The measure does not differentiate between patients being treated for rheumatoid arthritis vs. another diagnosis. • It is not sufficient to evaluate measure validity by correlating it with other cost measures, and validation studies should consider quality of care. • Commenter expressed support for the measure at the group practice level only and does not support attribution of the same costs to multiple clinicians.

MUC2023-210 Resolution of At Least 1 Health-Related Social Need

Number of Written Comments: 10; Support (3); Support with Considerations (2); Oppose (5)

Reasons for Support
• Social needs can impact daily functioning and are important to consider in health care delivery. • Occupational therapy providers address social drivers of health in both assessments and client interventions. Suggestion to include occupational therapy codes and screening tools in this measure. • The measure could help improve food access, which has been shown to benefit patients and lower health care costs. • While current documentation of SDOH-related care is occurring, CMS has the opportunity to standardize measures that document this work, allow for reimbursement, and provide ongoing data tracking the extent of these needs. • Measure has been validated for use in the Accountable Health Communities demonstration model, and in the Comprehensive Primary Care Plus model a majority of practices were able to link patients with community-based resources. • A survey of clinicians found that a large majority wanted more tools to address SDOH in patients.
Reasons for Opposition
• The measure has not undergone the rigorous consensus-based endorsement process. Evidence & Intent • Evidence provided related to five social needs is insufficient, and the 12-month timeframe after discharge is not justified. • More information should be provided regarding how accurate tracking of resolution of an HRSN is assured and the responsible party for recording the outcome. Feasibility & Usability • Concern that there is no verification or enforcement mechanism that would prevent entities from improper or dishonest tracking. • It is unclear how the measure defines an HRSN as resolved; SDOHs are often persistent, and resolution should be defined so that it is within the provider's locus of control. • Providers who serve a disproportionate number of patients with unmet social needs may be unfairly penalized, in part because they would require additional dedicated resources to implement the necessary interventions to improve performance. • Feasibility issues include limitations in the current IT infrastructure and likely increased burden on clinicians for reporting. • Clinicians may not be able to impact this measure due to the lack of community resources to address health related social needs. Specification • The measure should align with HL7 and USCDI standards. • Lack of clarity on patient population and suitability for MSSP. Validity & Reliability • The measure has not been tested for validity and reliability in ACOs. • The performance score may not be able to distinguish between quality of care versus availability of resources.

- Different screening instruments may be selected, and psychometric data to evaluate validity and reliability of these instruments is limited.
- The related measure for screening for SDOH has not been proposed for MSSP, and it would be inappropriate to consider an outcome measure prior to the process measure.

MUC2023-211 Melanoma: Tracking and Evaluation of Recurrence

Number of Written Comments: 1; Support (1); Support with Considerations (0); Oppose (0)

Reasons for Support
• Commenter expressed support for the addition of this measure.
Reasons for Opposition
• N/A

MUC2023-212 Level I Denials Upheld Rate Measure

Number of Written Comments: 11; Support (8); Support with Considerations (1); Oppose (2)

Reasons for Support

Improve Quality of Care

- The measure will improve quality of care by reducing unnecessary delays in care related to coverage denials by a Medicare Advantage (MA) plan that are upheld by the MA on appeal and will help consumers differentiate between MA plans on their ability to provide timely access to care.
- The measure will help beneficiaries receive occupational therapy care.

Improve Transparency

- The measure will increase transparency around denials of coverage and help ensure timely access to care.
- Commenting organization's members have reported an increasing level of inappropriate denials recently, a high overturn rate of initial denials, and multiple rounds of review to collect claims payments.
- The measure would help hold MA plans accountable for executing contractual commitments.
- Managing health care utilization serves an important function but can create barriers to care by delaying the start or continuation of medical care, which for some conditions can result in disease progression, and increased morbidity, hospitalizations, and mortality.

Feasibility

- The measure would likely reduce provider burden through fewer denials, will reduce beneficiary frustration, and does not appear to increase burden for health plans.

Use in Program

- The measure complements the Level 2 measure currently in use in Star Ratings (it is not duplicative).

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Reasons for Opposition

- Consider looking at service-specific data on prior authorizations to allow beneficiaries to understand the items and services for which MA denials are more likely to be overturned.
- Suggestion that CMS consider additional measures related to MA plan denials and delays.
- Some proper initial denials may be overturned after receiving new information, and the measure does not capture situations like these.

Use in Program

- Reducing the number of measures used in programs and increasing alignment across programs is a CMS priority.
- The measure is duplicative of an existing measure that evaluates Level 2 appeals decisions and would not bring additional value to the Star Ratings.


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