MUC2024-101 Parkinson's Syndromes, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) Episode-Based Cost Measure

American Academy of Family Physicians (AAFP) comments

Recommendation: Do not support

While we recognize the importance of working to improve affordability and efficiency, as well as the statutory requirement for cost measurement, the proposed cost measures for the MIPS program continue to concern the AAFP as they are currently designed. Before this or any other cost measure is implemented, we believe they should go through a rigorous endorsement process and further testing and refinement. Given the continuous and comprehensive nature of care delivered by family physicians, the AAFP does not believe that episode-based measurement adds value or improves patient outcomes in a primary care context.

We continue to reiterate concerns previously communicated to CMS by the AAFP, as well as many other physician specialty societies. Those include but are not limited to the following:

- The current and proposed episode-based cost measures make the unfounded assumption that lower cost is commensurate with higher quality. While in some cases that may be true, the support for this argument is superficial and among other things, does not account for patient preferences, case mix, and other significant factors that are beyond the measured clinician's control.
- They lack transparency. The inability of clinicians to improve their performance on cost-related measures because of the lack of visibility into the cost of care outside their direct care setting, as well as many cost-related factors fall outside their sphere of control.
    - The lack of interoperability and transparency across care settings makes these measures difficult for clinicians to impact. Eligible clinicians have no way of knowing how they are performing throughout the performance period, and that hinders their ability to maximize their performance.
    - Therefore, these measures do not lend themselves to improvement.
- Risk adjustment methodologies that do not fully recognize the social and economic context of the patient are insufficient to reflect the variance in cost that can result.
- Evidence-based cost measures (EBCMs) are likely to consider the impact of specific condition-related costs at least twice (and sometimes more) in multiple EBCMs. We are concerned this may have a bigger impact on primary care. Given the breadth of care provided by primary care physicians, they are likely to be attributed multiple episode-based cost measures.

Concerns specific to this proposed measure include but are not limited to the following:

- The lumping of conditions that are uniformly fatal (ALS) with those that are much more variable (MS) adds substantial room for variation. There is significant doubt that the measure specifications can adequately control for case mix and differences in denominator populations.

    - Consider a primary care physician that has 20 patients that fall into this measure. Of those, 4 have ALS. A comparator physician also has 20 patients that fall into this measure, but zero of them have ALS. There is no clear assessment of value.
- The developer did not assess alignment with United States Core Data for Interoperability (USCDI)/USCDI+ quality guidelines. Aligning with USCDI standards for data elements can promote interoperability and improve feasibility.
- This measure adjusts for dual-eligibility. However, Medicaid coverage and therefore dual-eligibility status varies by state which could affect risk adjustment. Many patients have high social needs, but do not qualify for Medicaid, especially in states that have not expanded Medicaid.
- Reliability is low compared to other measures. In testing, only 50% of TINS had a reliability of >0.6.
- Usability: Six weeks of field testing may not be sufficient to assume generalizability.
- The Preliminary Assessment states that referral to PT/OT/speech/language has been shown to increase costs. Some communities may not have those supports either in-office or home provided services. Therefore, patients may not have those services and therefore have lower costs. However, PT/OT/speech language therapy can significantly improve quality of life, length of independence and decrease falls. This is quality improvement, but it can also increase costs.

One possible solution could be a slow, phased implementation of this cost measure. This could entail pay-for-reporting at the outset (or perhaps a zero percent weight) for a few years until the measure has been more thoroughly tested, the specifications have been further refined, and the measure as gained endorsement from a CBE.