apma
Advancing foot and ankle medicine and surgery

December 23, 2024

Partnership for Quality Measurement
Pre-Rulemaking Measure Review Committee

Submitted Electronically via https://p4qm.org/media/3166

Re: MUC2024-100 Non-Pressure Ulcers Episode-Based Cost Measure Pre-Rulemaking Measure Review (PRMR) 2024 Measures Under Consideration (MUC) List Comments

Dear Partnerships for Quality Measurement (PQM; Powered by Battelle) and Centers for Medicare and Medicaid Services (CMS) Pre-Rulemaking Measure Review Committee:

On behalf of the American Podiatric Medical Association (APMA), the premier professional organization representing the vast majority of the nation's estimated 15,000 doctors of podiatric medicine, also known as podiatrists or podiatric physicians and surgeons, we appreciate the opportunity to provide continued input on the Non-Pressure Ulcers episode-based cost measure currently under development. We've provided feedback throughout the measure's development process, including representation on the Clinician Expert Workgroup. Given our clinical focus, we had hoped our feedback would inform refinements to the measure before it was considered for potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS). **However, we do not think that the measure can accurately distinguish between good and poor performance among clinicians in terms of cost efficiency as it is currently specified.**

While APMA strongly supports the development of an episode-based cost measure for non-pressure ulcers, we **do not** support the measure in its current form. Despite having representation on the Clinician Expert Workgroup that developed this measure, we still have questions and concerns about the measure's construct, and the way feedback about the measure is handled, which are outlined below. **As such, we do not support the Non-Pressure Ulcers Episode-Based Cost Measure as is currently specified, and we recommend that it be removed from further consideration until additional testing takes place and the results of such testing are clearly and transparently provided to the Clinician Expert Workgroup for consideration and deliberation.**

Chronic conditions pose specific challenges in terms of accounting for complex disease interactions, changes in severity over long durations, and changes in a clinician's role in disease treatment over time. APMA provides the following feedback for consideration to ensure the comparisons being made are meaningful, appropriate, and accurate.

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APMA provides the following feedback for consideration:

Reasonable Influence

APMA is deeply concerned about the definition of and/or practicality of what constitutes a clinician's ability to "…reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient." APMA remains concerned, in general, about the extent to which the actions of one clinician can impact another clinician outside the same TIN and especially when these interactions are between different specialties.

APMA is concerned, upon review of Field Testing Reports, about patients who received care in facilities where clinicians of the TIN do not have privileges and patients who received care in other communities/regions/states. In these situations, it is unreasonable to expect a clinician to have any influence over other clinicians' frequency, intensity, or occurrence of providing clinically related services. And in some instances, attributed clinicians may have zero knowledge of the patient's whereabouts at the time of these services being rendered in other facilities by other clinicians. It would be unrealistic to believe a clinician has any influence in such a circumstance.

There were also instances where the individuals listed outside of the TIN are completely unknown to or unheard of by the attributed clinician/TIN. In one example, the care was provided in a facility across the state as that is where the patient sought care. In these examples, the clinician billing the trigger and confirming code is not the "care coordinator" and thus should not be attributed costs to which they have no reasonable realistic or practical influence. In other examples, clinicians are being attributed costs associated with care being provided if a patient is transferred to or travels out of the state or region, if the patient goes doctor shopping, or if home care is being provided by an independent entity. **APMA is particularly concerned about the impact of the assumptions related to "reasonable influence."**

As non-pressure ulcers often require a multi-disciplinary approach, as evidenced by the number of NPIs rendering care, it is possible that referrals and/or care coordination efforts are being led by a clinician who is different from the clinician/TIN being attributed the costs. An example would be if a patient sees a podiatrist for a non-pressure ulcer and an attribution window is opened with trigger and confirming codes billed by the podiatrist. But the patient's primary care provider is referring the patient to other, potentially costly clinicians for clinically related services. In this example, costs will be attributed to the podiatrist when they cannot reasonably influence the frequency, intensity, or occurrence of clinically related services.

The Person and Family Partner findings highlighted the importance of care coordination. We agree wholeheartedly that care coordination is imperative. However, **we urge CMS to re-evaluate whether clinicians who are being attributed these costs are in fact the one's coordinating such care and thus more closely influencing the frequency, intensity, or occurrence of the clinically related services provided to a patient with non-pressure ulcers**. We strongly believe you will

find that those being attributed the costs are NOT always the clinician responsible for coordinating the clinically related care.

As such, APMA remains **significantly concerned** about how our clinicians reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a patient by other providers, especially those outside the same TIN and especially those between different specialties or within other communities. As highlighted earlier in this letter, in Field Test Report examples, there are clinicians being attributed patients under this measure despite only being responsible for 4% of the cost. The remaining 96% of the cost was generated by one surgeon, entirely out of the realm of reasonable influence.

A stated aim of the measure is to identify a longitudinal patient-clinician relationship. **We urge you to re-evaluate the definition of and/or practicality of what constitutes a clinician's ability to reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient.** CMS should **not** move ahead with this measure until it can figure out how to more accurately identify the role of the clinician in the episode (for example, patient relationship codes; PRCs).

Service Category

APMA requests clarity on whether "joint injections" and "speech and language pathology therapy" remain listed as clinically related services. This is an example of a recommendation we made earlier in the process that was not clearly/transparently addressed or responded to.

Accounting for Patient Heterogeneity

It appears ulcer type is a fair indicator of patient heterogeneity and resource use in caring for patients with *lower extremity* non-pressure ulcers. The standards of care and clinical guidelines differ based on ulcer type and thus the care path and costs associated with each ulcer type will be different. As such, APMA believes that these different ulcer types should not be compared to one another.

In the Post-Field Test Refinements, it appears as though changes were made to subgrouping. The non-specific ulcer subgroup decreased in overall percentage while increases were noted in arterial, diabetic, and multiple ulcer types. However, it is still not clear whether, **based on the changes made, the goal of moving diabetic- and arterial-type ulcers out of the non-specific subgroup into their respective subgroups was met. We would still like to see data on how many ulcers remain in the non-specific ulcer type subgroup that should be categorized in one of the other subgroups.** To support the measure's goals of comparing clinical homogenous cohorts, and providing meaningful clinical comparisons, **we urge Acumen to re-evaluate how ulcers are falling into the subgroups to ensure they are in the correct subgroups prior to CMS proposing this measure for implementation.**

APMA is also concerned that patients who experience multiple ulcers, even if of the same type, over the course of the episode, will receive a score indicative of the cost of caring for one ulcer, even though there may be multiple ulcers concurrently or consecutively during the episode window. An example would be if a patient with a diabetic type ulcer is treated and almost healed when a second diabetic type ulcer appears. The first ulcer heals, but now the clinician is back at the beginning of treatment for the new ulcer. The episode window continues, and costs continue to accrue, but for a new, separate ulcer. The costs associated with the full window are not indicative of the true cost of the episode for a single non-pressure ulcer that triggered attribution, but for the costs associated with any/all of the non-pressure ulcers presenting during the episode window. They also potentially inappropriately reflect the cost of other pressure ulcers since the debridement codes are used for certain square centimeters of debridement and not number or type of ulcers being debrided. In the previous example, if the second ulcer to appear is diagnosed as an arterial or venous ulcer, it is not clear whether the episode switches to a "multiple ulcer type" episode mid-episode or if a new episode for the same patient would be triggered as an arterial or venous ulcer, separate from the already triggered diabetic ulcer type episode window. **APMA has not received clarity on these issues from the measure developer and requests that significant consideration be given to these real-world scenarios before this measure is considered for adoption.**

In one of the reports, it states, "The 90th percentile of score is over triple the 10th percentile at both the TIN and TIN-NPI levels. The results highlight an opportunity for improvement by closing the gap between the most and least efficient providers." **However, as we express throughout this letter, it remains unclear where these results are a result of efficiencies controlled or influenced by the attributed clinician—** especially if we do not know how many ulcers are being cared for per patient during the episode window.

It is imperative that the measure developer provide the public with a clearer explanation of how whether and how it evaluates if this cost measure distinguishes between good and poor performance among clinicians in terms of cost efficiency. In the example related to having multiple ulcers during the episode window, it may be possible to distinguish between high- and low-cost providers, but when the measure is unable to determine how many ulcers were cared for during the episode window, it cannot accurately determine whether high or low costs are associated with good or poor performance. Two providers could have similar costs, but care for a completely different number of non-pressure ulcers on a given patient during the episode window.

Patient Exclusions

As we have expressed in past comments, APMA believes that the following patients should be excluded from this measure due to the unique nature of the mechanism of action of the injury: patients with animal bites, human bites, puncture wounds, burns, and gunshot wounds. This is another example of a recommendation we made earlier that was not addressed or responded to. It is critical that Acumen employ transparent processes throughout the measure development process so that the public understands the decision-making that informed the final measure specifications.

Quality Measure Alignment

APMA appreciates the notion that cost measures are not to be evaluated or interpreted in a vacuum and that one reason the non-pressure ulcers topic was selected for measure development was to align with quality measures. However, APMA is concerned about the extent to which existing MIPS quality measures align with the Non-Pressure Ulcer cost measure, as well as the ongoing lack of meaningful and practical measures available to podiatrists.

APMA stewards two MIPS Clinical Quality Measures (CQMs):

- QID 126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation (CQM)
- QID 127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear (CQM)

CMS recently demonstrated interest in tying the Non-Pressure Ulcer cost measure to these quality measures, as well as other US Wound Registry (USWR) QCDR measures, through its candidate Podiatry MIPS Value Pathways (MVP):

- USWR 22: Nutritional screening of all patients with chronic wounds and ulcers
- USWR 30: Arterial assessment of all patients with a lower extremity wound or ulcer
- USWR 32: Compression of VLUs at every visit
- USWR 33: DFU Healing or closure (risk stratified by the Wound Healing Index- WHI)
- USWR 34: Venous Leg Ulcer healing or closure (risk stratified by the WHI)
- USWR 35: Off-loading of DFUs at every visit

However, we have multiple concerns about CMS' assumption that these measures, together, produce an accurate picture of quality. In regards to the APMA stewarded measures, not all patients with a Non-Pressure Ulcer episode have diabetes. Additionally, we are concerned that these measures may not be available in the near future of MIPS Performance Years as a result of their topped-out status. Regarding the USWR QCDR measures, we reiterate our concerns about current barriers related to measure uptake by electronic health records (EHR)s. These QCDR measures are not currently available/accessible to podiatrists widely due to a lack of EHR vendor interest in adding these measures to their platforms.

As a result of these issues, we are concerned that quality-cost alignment here is weak and will not produce a clear or accurate picture of value. **We urge the measure developer to further evaluate the relevancy and accessibility of existing quality measures, and whether they are suitable to produce an accurate assessment of value in connection with this cost measure, before proposing this cost measure for implementation.**

Patient Relationship Codes

APMA looks forward to hearing additional information regarding how PRCs may be helpful for attribution methodology and how they may be used in the cost performance category of MIPS. We are eager to understand if PRCs may be a way to identify clinicians who should most appropriately be attributed cost and identify clinicians who may not have reasonable influence over other clinicians. **We urge CMS to delay implementation of this measure as it evaluates ways to improve the accuracy of attribution under its cost measures**— particularly those measuring chronic episodes.

Journal Submission

Section 101(c)(1) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in the Merit-based Incentive Payment System (MIPS). Since podiatry is listed as the single most applicable area of specialty most likely to report this measure, we suggest you submit the new measure for publication to the *Journal of the American Podiatric Medical Association* (JAPMA).

Conclusion

Given the significant concerns and lack of clarity outlined throughout this letter and the fact that podiatrists are the top specialty attributed this measure under its current methodology, APMA would like to see additional testing and evaluation of the results with the Clinician Expert Workgroup before the Non-Pressure Ulcers Episode-Based Cost Measure is considered any further.

Thank you for the opportunity to provide feedback on the Non-Pressure Ulcers episode-based cost measure. If you require additional information, please contact Dyane Tower, DPM, MPH, MS, CAE, Vice President, Clinical Affairs and Medical Director at dtower@apma.org or 301-581-9250. Thank you for your time and consideration.

Sincerely,

Lawrence Santi, DPM
President