MUC2024-100 Non-Pressure Ulcers 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:

- This measure lumps many different etiologies into one measure, which creates substantial room for variation. There is significant doubt that the measure specifications can adequately control for case mix and differences in denominator populations.
- Clinical documentation and diagnosis and coding of ulcers is inconsistent.
    - There may be unspecified or inaccurate diagnoses, which may not be discretely linked to USCDI elements.

- It is stated that imaging is often a driver for increased costs. MRIs or other imaging modalities are often necessary to rule out osteomyelitis in a wound. This can drive up costs but are often necessary for correct diagnosis and treatment which lead to better outcomes.
- The Preliminary Assessment states that, "for this ratio measure, a lower score indicates better quality of care." We highly disagree with this. A lower score simply indicates lower costs. Lower costs may actually be associated with lower quality of care. Higher costs are sometimes correlated with higher quality of care. The two are not the same.
- 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.
- Major costs include costs of drugs and even hyperbaric oxygen treatment. Clinicians cannot control the costs of drugs. Some expensive drugs and treatments can produce excellent clinical outcomes, but costs increase.
- Reliability: The Preliminary Assessment states that "...20% of [measured] entities have a higher risk of misclassification," which is concerning.
- Usability: Six weeks of field testing may not be sufficient to assume generalizability.

- This measure needs further testing, as well as an analysis of time-to-value realization. Improved performance (i.e. lower costs) does not equal better patient outcomes in many cases. We are concerned that efforts to reduce costs could lead to poorer outcomes for patients.

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.