2024 Field Testing Feedback Summary Report for 2 Episode-Based Cost Measures:

- Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)
- Non-Pressure Ulcers

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1.0 Introduction

1.1 Project Title

MACRA Episode-Based Cost Measures: 2024 Cost Measures Field Testing

1.2 Project Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program (QPP). QPP incentivizes clinicians to provide high-quality, high-value care through Advanced Alternative Payment Models (APMs) or the Merit-based Incentive Payment System (MIPS). MIPS-eligible clinicians will receive a performance-based adjustment to their Medicare payments based on a MIPS final score that assesses evidence-based and practice-specific data in four performance categories: (i) quality, (ii) cost, (iii) improvement activities, and (iv) Promoting Interoperability.

CMS has contracted with Acumen, LLC, to develop new episode-based cost measures for potential use in the Cost performance category of MIPS. This work is under the contract, “Physician Cost Measures and Patient Relationship Codes (PCMP)” (contract number 75FCMC18D0015, Task Order 75FCMC19F0004). Acumen has implemented a measure development process that relies on input from several interested parties, including multiple groups of clinicians affiliated with a broad range of professional societies and Person and Family Partners (PFP), to develop clinically appropriate and transparent measures that provide actionable information to clinicians.

This document summarizes the feedback from interested parties on the two episode-based cost measures that were field tested as part of the measure development process from February 1 to March 14, 2024. Section 1.0 provides background on the measure development process and the two episode-based cost measures being developed. Section 2.0 summarizes the general feedback Acumen received on the episode-based cost measures and the field testing process. Section 3.0 provides more detailed feedback on each of the two episode-based cost measures that underwent field testing. Section 4.0 outlines the next steps for potential measure refinement based on field testing feedback.

1.3 Measure Development and Field Testing Overview

The Wave 6 episode-based cost measure development process started in 2023 (when Acumen gathered input from interested parties to help inform which measures to develop). This process continued through 2024, gathering input on measure specifications. Clinician Expert Workgroups that convened beginning in June 2023 provided clinical specifications for the episode-based cost measures.

After this, Acumen continued to develop the measures in Wave 6 by reconvening the Clinician Expert Workgroup in October 2023 to review the measures and provide input on potential refinements to the current specifications. For more detailed information on field testing and the episode-based cost measure development process, please refer to the QPP Cost Measure Information Page.

Once the two episode-based cost measures were specified through clinician input, person and family engagement (PFE), public input, and empirical analyses, CMS and Acumen conducted field testing on the draft measures from February 1 to March 14, 2024. Field testing is a crucial part of the measure development process. It allows clinicians and other interested parties to learn about episode-based cost measures and provide input on the draft specifications.

During field testing, clinicians and clinician groups had the opportunity to view a Field Test Report on the QPP website with information about their performance. Field Test Reports were available to clinicians and clinician groups who had 20 or more episodes for at least one of the Wave 6 episode-based cost measures during the measurement period (1/1/2022 - 12/31/2022). The two episode-based measures undergoing field testing focus on the outpatient treatment and management of particular chronic conditions:

- Movement Disorders: Parkinson’s and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)
- Non-Pressure Ulcers

Specifically, 280 clinicians and clinician groups downloaded a Field Test Report from the QPP website during field testing. 263 clinician groups (identified by Tax Identification Number or TIN) downloaded a report and 17 clinicians (identified by TIN-National Provider Identifier or TIN-NPI) downloaded a report.

For the duration of field testing, all interested parties were invited to provide feedback on the measures by completing an online survey or submitting a comment letter,[1] regardless of whether they received a report. Acumen and CMS made several materials publicly available for interested parties’ review: (i) draft measure specifications, (ii) mock Field Test Reports, and (iii) supplemental documentation.[2] Acumen and CMS also hosted the MACRA 2024 Cost Measures Field Testing Webinar at the start of the field testing period to provide interested parties with details regarding the field testing process and draft measure specifications.[3]

Acumen also held 2 specialty society office hours before and during field testing to provide information about Field Test Reports and allow interested parties, including specialty societies who represent clinicians likely to be attributed the measures, to ask questions about field testing and the measure specifications.

Acumen received:

- A total of 38 comments through the 2024 Measure-Specific Cost Measure Field Testing survey, including 7 letters that were attached to a survey response.
- A total of 20 comments through the PFE Cost Measures Field Testing survey.
- A total of 3 comments submitted via email.

The list of commenters who submitted feedback during the field testing period is provided in Appendix A. The feedback about each measure was shared with the

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[1] The survey was previously available online at the 2024 Cost Measures Field Testing Feedback Survey.

[2] Field testing materials are available for download on the QPP Cost Measure Information Page.

[3] MACRA 2024 Cost Measures Field Testing Webinar materials are available on the Quality Payment Program Webinar Library.

Clinician Expert Workgroups to help inform measure refinement recommendations after field testing. Acumen and CMS will also evaluate the general feedback on measure specifications, the measure development process, and field testing, and consider ways to improve future episode-based cost measure development processes.

2.0 General Feedback Summary

This section summarizes general feedback received on the episode-based cost measures. Section 2.1 provides feedback on the field testing engagement approach. Section 2.2 summarizes feedback on the use of measures in MIPS.

2.1 Field Testing Engagement Approach

- Commenters expressed appreciation for the opportunity to provide feedback on the draft episode-based cost measures. Some commenters found a wide variety of the materials helpful, such as the measure specifications, mock field test reports, FAQ, and measure testing forms.
- Several commenters expressed concern that the field test reports and measure specification documents were complicated to interpret for a typical physician so they can make actionable changes, and suggested that CMS produce a plain language version of the field test report.
- Several commenters requested clarification regarding the metrics provided in field test reports (e.g., Histogram of National Cost Measure Scores, National Average Cost Measure Score, Service Categories, winsorization, specialty adjustment).
- One commenter suggested that CMS add dummy data to the mock field test report and related materials so that clinicians without field test reports can more easily provide field testing feedback.
- A few commenters requested clarification on clinicians labeled as “Within Your TIN” and “Outside Your TIN,” as well as “Attributing NPI” and “Non-Attributing NPI” in the field test report.
- A couple commenters suggested that state-level comparisons, comparisons among rural and urban providers, or comparisons by ZIP Code should be listed in clinicians’ field test reports to better compare geographically similar providers.
- One commenter suggested that CMS display observed vs. expected cost ratios by specialty or provider type on field test reports.
- A few commenters suggested that CMS present clearer information about risk score, risk bracket, and how this differs from HCC scoring. A couple commenters also suggested that CMS present risk information as an average and a range.
- One commenter requested that CMS provide more information on Restructured BETOS Classification.

2.2 Measure Reporting and/or Use in MIPS

- One commenter noted that the field test reports are too lengthy for clinicians to review more than once per year.
- A couple commenters requested further information on MIPS eligibility and the clinicians included in field testing.

3.0 Measure-Specific Field Testing Feedback

This section includes the measure-specific feedback received on the two episode-based cost measures during the field testing period. The feedback was shared with the Clinician Expert Workgroups prior to the Post-Field Test Refinement (PFTR) webinars in March 2024 for their review as they considered potential refinements to the measures.

Each section provides detailed feedback on the Wave 6 episode-based cost measures. Section 3.1 summarizes feedback on the Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) measure. Section 3.2 summarizes feedback on the Non-Pressure Ulcers measure.

3.1 Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)

3.1.1 Definition of an Episode Group

3.1.1.1 Subgroups

- One commenter was satisfied with the three subgroups contained in current measure specifications.
- One commenter noted that Lewy Body Dementia should be considered as an additional condition in the measure, as it presents like Parkinson's Disease at times.
- One commenter expressed concerns with the inclusion of Other Degenerative Diseases of Basal Ganglia in the Parkinson's and Related Disorders subgroup, due to the infrequent occurrence and heterogeneity of the diseases such as Pantothenate Kinase-Associated Neurodegeneration (PKAN), Progressive Supranuclear Palsy (PSP), Multiple System Atrophy (MSA), Fahr's Syndrome, Shy-Drager Disease, and other basal ganglia abnormalities.
- One commenter recommended further subgrouping the measure by surgical and non-surgical care.
- One commenter suggested to include quadriplegia and paraplegia as sub-groups, given that these conditions have differing impacts on patients with Amyotrophic Lateral Sclerosis (ALS) compared to other patient cohorts included in the measure.

3.1.1.2 Episode Triggering Logic

- A couple commenters were satisfied with the inclusion of rehabilitative services as a trigger code.
    - However, one commenter noted that if non-prescribing clinicians were attributed episodes, rehabilitative codes should be removed from trigger codes.
- One commenter indicated that only certain occupational and physical therapy evaluation codes should be included as trigger services, while Physical Medicine and Rehabilitation Therapeutic Procedures codes should only be included as confirming services.
- One commenter was satisfied with the current trigger diagnoses included in the measure.
- One PFE commenter recommended adding idiopathic peripheral neuropathy to the list of trigger diagnoses.

3.1.1.3 Measure Name

- Several commenters and PFE commenters agreed with the proposed new name "Progressive Neurological Disorders Affecting Movement".
- One commenter found that the proposed name was too broad and could suggest that the

measure captures conditions such as spinal muscular atrophy, hereditary ataxias and dystonia, among others.

  - Instead, they recommended titling the measure “Parkinson's Disease, Multiple Sclerosis and Amyotrophic Lateral Sclerosis.”
- One commenter recommended “Progressive Neurological Disorders of Movement”.

3.1.2 Attribution of the Episode Group to Clinicians

- Several commenters agreed that episodes should be attributed to non-prescribing clinicians, such as physical therapists, occupational therapists, and speech language pathologists for the following reasons:
  - Attribution ensures that effective rehabilitation is completed
  - These providers make up the majority of billing for this patient population
  - It is important to ensure the measure is capturing all appropriate patients
  - Patients note that physical and occupation therapy is most helpful
  - Rehabilitation professionals may be the only current provider involved in a patient’s care
  - It allows for greater clinician participation in the measure
  - It holds rehabilitation clinicians accountable for costs of care
- Several PFE commenters identified a wide range of clinicians involved in their care team including: family practice, internal medicine, nurse practitioner, neurologist, physical therapist, physician assistant, and cardiologist.
  - Other identified practitioners include psychiatrist, nutritionist, and occupational therapist.
  - Some comments noted that the most frequently seen practitioners are: family practitioners, physical therapists, cardiologists, and neurologists.
  - One PFE comment mentioned that care team coordination was mostly led by neurologists and primary care physicians.
  - One PFE noted internal medicine as the least helpful specialty, as they lack specialized care for Multiple Sclerosis (MS) diagnoses.
  - PFEs noted varying frequency for visiting these clinicians, ranging from multiple times per month for (e.g., recurring physically therapy) to monthly or at least annually (e.g., visits with neurologists).
- A few comments disagreed that episodes should be attributed to non-prescribing clinicians for the following reasons:
  - They do not certify the treatment plan
  - They have little control over cost or quality of care, such as the patient’s medical and pharmacologic management; the prescribing clinician is the one who generally manages this patient population
  - They do not have enough understanding of the disease process
- One commenter expressed concerns with the low attribution of the measure to neurosurgeons and recommended that attribution was limited to non-surgical specialties.

3.1.3 Assignment of Costs to the Episode Group

- A few PFE commenters noted massage and physical therapy as the most helpful services.

- A couple of PFE comments noted the recurring use of Durable Medical Equipment (DME).
- Several PFE commenters noted pain management as part of the care they received.
- A couple commenters were satisfied with the services currently included in the measure.
- One PFE commenter noted hospice care as a useful service to maintain their lifestyle in the case of exacerbation of ALS, and also noted they expect post-acute care services and long-term services and support to occur as part of end-of-life care.
- One PFE comment indicated infusions as an effective treatment.
- One PFE comment mentioned hospitalizations and long-term care as results of a condition flare up.
- One PFE comment specified injections as common services.
- One commenter expressed concerns with the inclusion of the following services:
    - Decompression of peripheral nerve, as it is not relevant to these conditions.
    - Other or therapeutic nervous system procedure, as it is not specific enough on the services it represents.
    - Hospitalizations for craniotomy with major device implant and craniotomy endovascular intracranial procedures, as they both may be the result of poor outpatient management.
    - Deep Brain Stimulation (DBS) and other neurosurgical treatments as it could disincentivize utilization for many patients; the commenter noted these services can have high up-front costs that may not result in savings during the episode window.
- A couple of commenters received chiropractic and massage therapy care, which may be covered Medicare services.

3.1.4 Risk Adjustment

- One commenter noted that, combined with sub-grouping, risk adjustment can help address concerns about potential disincentives to provide surgical care to patients with movement disorders.
- One commenter suggested including risk adjustors for social determinants of health.
- One commenter expressed concern with the use of Hierarchical Condition Category (HCC) codes as risk adjustors without careful consideration of each sub-group’s clinical circumstances (e.g., certain HCC variables may have different impacts on patients with Parkinson’s compared to MS or ALS).
- One commenter recommended the following changes to the risk adjustment model:
    - Including DBS or pump placement.
    - Including pre-existing presence of an implanted intrathecal pump and recent complications related to the pump.
    - Including stereotactic radiosurgery, rhizotomy, craniotomy, and microvascular decompression, which are used to treat facial pain in patients with MS.
    - Not including spinal cord stimulator (SCS) and peripheral nerve stimulator (PNS) implants.
- One commenter noted the following about the “past use of deep brain stimulators” risk adjustor:
    - The commenter found the lookback period too short to identify patients using

    - DBS, and recommended renaming it to "history of DBS with recent complication".
    - They also suggested splitting the risk adjustor into two: history of DBS with recent complication and history of DBS without recent complication.
    - They also noted the need to account for maintenance costs for DBS, which may not be identified via the current risk adjustment model.
- One PFE commenter agreed with the current set of risk adjustment variables.

3.1.5 Exclusions

- One commenter suggested excluding patients receiving palliative and hospice care.
- One commenter suggested excluding patients with Lewy Body Dementia.
- One commenter recommended exclusion of spinal cord injury patients.

3.1.6 Alignment of Cost with Quality

3.1.6.1 Quality Measures

- One commenter pointed to potential future quality measure concepts to help assess the value of care provided to patients with movement disorders:
    - Fall reduction
    - Functional outcomes
    - Maintaining independence
    - Aspiration pneumonia, pressure ulcers, and subsequent complications (sepsis, intubation, etc.)
    - Reducing non-elective hospital admissions
    - Prolonging life with a good quality of life
- One commenter listed specific MIPS quality measures as most relevant to the Movement Disorders cost measure.
- One commenter suggested development of measures that include clinical data sources to better assess value (quality and cost) of care.

3.1.6.2 Quality of Care

- Several PFE comments identified important outcomes, such as maintaining independence.
- Several PFE comments noted a lack of care coordination amongst clinicians and reported having to rely on family to coordinate services.
- Several PFE comments identified services with high out-of-pocket costs: self-administered medications, massage therapy, physical therapy, exercise classes, chiropractor, acupuncture, DME, supplements, clinicians that do not accept Medicare (i.e., naturopathic doctors).
    - A couple of commenters expressed the need for more frequent Medicare coverage of DME, as items get worn out and break after repetitive use
    - One PFE commenter reported significant difficulties getting medications in hospitals and skilled nursing facilities
- Some PFE comments indicated various barriers to care, such as:
    - Insurance,

    - Transportation costs,
    - Difficulties in getting referrals,
    - Difficulties in accessing complementary care not covered by Medicare, and
    - Difficulties accessing non-procedural care.
- Some PFE comments highlighted home health and physical, occupational, and speech therapy as important services to ensure quality care.
    - Some PFE comments noted difficulty in accessing home health services and timely physical, occupational, and speech therapy.
    - One PFE comment also noted their dissatisfaction with home health services due to a lack of part-time employees and training with Parkinson's and fall risk patients.
    - One PFE comment emphasized the benefits of home and community-based services compared to institutional care for patient safety, long-term care, and reduced costs.
- Some PFE comments noted the importance of information provided by insurance companies on pain management and long-term care options and alternatives.
- Two PFE commenters noted that their clinical practices offered bilingual services.
- One PFE commenter noted concerns with a late DBS replacement after infection set in, which compromised the patient's quality of life and care.

3.2 Non-Pressure Ulcers

3.2.1 Definition of an Episode Group

3.2.1.1 Episode Window

- Multiple commenters noted that the length of the episode window for the Non-Pressure Ulcers measure may be too long as an attributed clinician may only care for a patient in the first few days of an episode.

3.2.1.2 Episode Triggering Logic

- Several commenters expressed support for the draft trigger specifications for this episode group. They noted that the trigger codes appropriately capture the patient cohort that reflects the measure's intent to assess costs related to managing and treating patients with non-pressure ulcers.
    - A couple of commenters supported including rehabilitative services in the triggering logic as wound care may be initiated or continued by physical/occupational therapists (PT/OTs) and allows for increased participation of these providers in the measure.
    - Another commenter noted that the trigger codes are comprehensive and the combination of evaluation and management (E/M) and diagnosis codes capture the patient population they treat and manage in vascular and wound practices.
- A few commenters expressed concerns that the trigger specifications are not capturing the intended patient population for this episode group.
    - A couple of commenters suggested expanding the confirming services to include diagnostic radiology testing (e.g., vascular ultrasound and other non-invasive vascular testing with indications for "ulcers", "tissue loss" or "gangrene"), multilayered dressings, placement of Unna boot,

  biopsy of ulceration, and hyperbaric oxygen therapy (HBOT).
  - One commenter expressed that rehabilitation services should be removed from the confirming services, and should instead include application of skin substitutes.
  - One commenter stated that non-specialty or primary care services should not be used to trigger a Non-Pressure Ulcers episode in cases where a patient is referred to a specialist. They explained that early non-specialty care may not be relevant for future treatment as chronic wounds are defined as persisting for 3 months or more.
  - One commenter recommended pairing the chronic non-pressure ulcer codes with relevant diagnosis codes for comorbid conditions to further specify the type of wound being treated.
  - One commenter explained that while the current trigger codes capture a portion of the patient population, the trigger diagnosis codes should be expanded to include diabetes, lymphedema/phlebolymphedema, and varicosities. Another commenter noted that patients with venous leg ulcers tend to have associated venous hypertension and lymphedema, and clinicians are likely to use the presence of phlebolymphedema or CEAP classifications of severity of varicose veins to recognize venous ulcers.

3.2.1.3 Episode Triggering Logic

- A commenter found the trigger codes to be straightforward.

3.2.2 Attribution of the Episode Group to Clinicians

- Survey respondents emphasized the role of primary care providers (PCPs) and PT/OTs in the ongoing management of patients with non-pressure ulcers. Furthermore, they highlighted the collaborative nature of non-pressure ulcers care involving multiple specialties, including venous/lymphatic medicine, vascular/general surgery, undersea and hyperbaric medicine, interventional radiology/cardiology, dermatologists, podiatrists, and phlebologists.
  - PFE commenters also reported receiving wound/ulcer-related care from multiple specialties and practitioners including PCPs, nurse practitioners, PT/OTs, licensed practical nurses, and personal care attendants.
- Several commenters emphasized that attributing Non-Pressure Ulcers episodes to clinicians and clinician groups may be challenging due to the lack of designated taxonomy codes for wound care specialists (i.e., specialty designations cannot be used to support attribution).
- One commenter made several suggestions for attributing Non-Pressure Ulcers episodes. These include evaluating the level of influence of the individual clinician within the same specialty or group practice, and assessing the involvement of the individual clinician in treating and developing care plan for the patient.
- One commenter recommended the use of patient relationship codes (PRCs) to attribute clinicians to a Non-Pressure Ulcers episode.
- One commenter stated that case minimums should be applied for this episode group.

3.2.3 Accounting for Patient Heterogeneity

3.2.3.1 Sub-groups

- A couple of commenters noted that while ulcer type is a good indicator of patient heterogeneity and resource use, additional considerations should be given to place/site of service, location of the ulcer/wound, and size of the ulcer/wound at the time of diagnosis.
    - Several commenters expressed concerns that physicians practicing at hospital outpatient departments (HOPDs) may have different costs compared to office-based physicians due to differences in patient complexities and billing policies at these settings. Commenters highlighted specific services affected by these differences such as hyperbaric oxygen therapy and cellular tissue products.
    - Another commenter cited that rural, urban, and teaching hospitals also may have varying costs of services.
- Several commenters expressed concerns about using ulcer type as an indicator of resource use for this episode group, citing potential for misdiagnosing and under-diagnosing ulcer types.
    - They noted that the draft measure sub-groups do not adequately account for patients with mixed ulcer etiologies (i.e., more than one ulcer type present), multiple counts of ulcers, or those with variable presentations due to comorbidities. They explained that patients with mixed etiologies tend to be more complex. They also stated that patients with multiple counts of ulcers may be classified as only having one ulcer under the current draft measure specifications.
    - Another commenter explained that certain sites of service may misclassify pressure versus non-pressure etiologies, especially in care settings where pressure injury incidence and prevalence are used as quality metrics for skin safety practices.
    - Some commenters expressed concerns that ICD-10 coding specifically presents challenges for identifying ulcer types.
        - A few commenters stated that the current ICD-10 diagnosis codes are inadequate for identify ulcer types, noting that there are no ICD-10 diagnosis codes specific to arterial or diabetic foot ulcers, which are often coded as non-specific ulcerations.
        - A few commenters noted that a pair of codes are required to identify ulcer types, with the exception of venous ulcers, and the codes used may vary depending on the payer or provider. The variations in use of dual code sets among providers may lead to different classifications of ulcer type for the same patient.
        - Another commenter stated that a large group of ulcers may not fit into the current sub-groups as the available ICD-10 diagnosis codes do not account for transformations from acute to chronic ulcer.
    - A few commenters offered solutions to resolve issues with sub-grouping by ulcer type such as stratifying the “Multiple Ulcer Types” and “Non-specific Ulcer Types” sub-groups into smaller groups (e.g., “venous and arterial”) as well as using certain services and site of services to identify ulcer types (e.g., venous ablation procedures and vein care clinics to identify venous ulcers).
- A few commenters recommended renaming certain sub-groups. These included renaming the “Multiple Ulcer Types” sub-group to “Mixed Ulcer Types” to better indicate the presence of more than one ulcer type as well as renaming the “Diabetic Ulcer Type” sub-group to “Neuropathic Ulcer Type” to be more encompassing of the etiology of ulcers in this group.

- Multiple commenters recommended additional subgroups by ulcer type for consideration. These included malignant ulcers, dermatologic ulcers (i.e., ulcers resulting from conditions such as Pyoderma gangrenosum and scleroderma), lymphedema ulcers, and ulcers secondary to vasculitis.

3.2.3.2 Risk Adjustment

- Several commenters supported the current risk adjustment model and had no concerns regarding the risk adjustors for this episode group.
- Several commenters proposed refinements to the current risk adjustors for this episode group. These include:
    - Incorporating a more comprehensive frailty assessment
    - Expanding the smoking indicator to include history or intensity
    - Accounting for social determinants of health (e.g., health literacy indicators, food security, access to transportation, access to telemedicine, rural vs urban)
    - Adjusting for additional risk factors, including:
        - Frequency/intensity of visit
        - Size of the ulcer at the time of diagnosis, as larger circumferential wounds take longer to heal and are more resource intensive
        - Location and number of ulcers present
        - Site/place of service
        - Time to healing
        - Degree of underlying venous disease
        - Nutritional status
        - Patient functional status
        - Rates of recurrence/recidivism
        - Patients with obesity
        - Patients with lymphedema/lipedema and other lymphatic etiologies
        - Patients with peripheral vascular disease (i.e., venous and arterial insufficiency)
        - End-Stage Renal Disease
        - Diabetes Mellitus
        - Malignancies
        - Dermatologic ulcers
        - Ulcers secondary to vasculitis
        - Hospitalization rate
- Two commenters cited concerns with risk scores being reported as a lower score despite having a higher perceived patient complexity.
- One commenter expressed concerns about the measure not adjusting for part-time employment status of attributed clinicians.

3.2.3.3 Exclusions

- Commenters proposed additional patient sub-populations for exclusion from the episode group due to increased complexity. These include:
    - Lymphedema patients (including patients with lymphatic ulcers/skin breakdowns)
    - Patients with autoimmune diseases (such as Reynaud’s disease ulcers, Berger’s

    disease, Sjogren’s Syndrome, lupus, rheumatoid arthritis) that may impact wound healing. They note that these patients are likely to have underlying skin pathology that are difficult to treat and may use biologics that diminish wound healing capacity.
  - Cancer patients (i.e., melanoma, Merkel cell, angiosarcoma, malignant ulcers)
  - Patients with atheroembolization to the extremities
  - Patients with arterial disease
  - Ulcers associated with fistulae
  - Late effects of radiation
  - Calcinosis Cutis (i.e., dystrophic, metastatic, idiopathic, iatrogenic, and calciphylaxis)
  - Traumatic wounds (e.g., animal/human bites, gunshot wounds, puncture wounds, and burns) that transform into chronic wounds
  - Patients with Hidradenitis Suppurativa (HS)
  - Patients with tropical infectious ulcerations
  - Patients with Stevens-Johnson Syndrome (SJS)
  - Necrotizing fasciitis
- One commenter stated that the current list of excluded episodes for the Non-Pressure Ulcers measure should be included in the measure.

3.2.5 Assignment of Costs to the Episode Group

- Several commenters had concerns that the measure is inappropriately attributing clinicians. The majority of these commenters noted that clinicians within an attributed TIN are being held accountable for care provided outside the TIN.
  - Several commenters expressed concerns with an attributed clinician’s ability to reasonably influence care provided by non-attributed clinicians that they did not refer patients to. A few of these commenters were also concerned that non-attributed clinicians could be located in different states and/or could be a laboratory.
  - Additionally, multiple commenters discussed challenges regarding episodes in which patients receive duplicative care or seek care that the attributed clinician would typically not recommend for the management of a non-pressure ulcer.
  - Other commenters noted concerns with being attributed services that are unrelated to the type of care being assessed (i.e., treatment for patient’s comorbidities).
- Commenters recommended including additional services in this episode group. These include:
  - Imaging services (i.e., duplex/reflux scans, CT/MR angiography, lymphoscintigraphy, intravenous ultrasound, ultraviolet C, pulsed ultrasound, MIST therapy)
  - Procedures (i.e., biopsy of ulceration, application of cellular tissue products/skin substitutes, arteriography with angioplasty, bypass grafting of the lower extremity, venous ablation procedures, phlebectomy of varicose veins, ultrasound guided sclerotherapy)
  - Outpatient wound debridement and chemical wound debridement

  - Negative pressure wound therapy
  - Manual lymphatic drainage
  - Intermittent pneumatic compression (IPC) devices
  - Chemotherapy/radiation for ulceration
  - Vascular laboratory testing and other lab testing procedures to help identify markers of autoimmune diseases and infections
  - Collagen induction therapy
  - Shock wave therapy
  - Total contact casting
  - Consultation services as wound care consultants contribute to the management and care planning for non-pressure ulcers
- A couple of commenters had concerns about the draft service categories included in the measure. They noted that multilayered dressing should not be bundled with wound debridement as either can be performed independently. Furthermore, they stated that the "skin graft" service category includes vascular graft procedures (i.e., surgical bypass operations), which should not be included in the measure as they are not clinically-related to non-pressure ulcer care. A few commenters also noted that they felt that skin substitutes were not correctly included in the measure.
- A couple of commenters also clarified that most ulcer care is done in office-based/outpatient settings, and therefore, recommended that the list of assigned services be refined to include office-based diagnostic testing and wound care procedures performed in these care settings. One of the commenters also recommend that the durable medical equipment (DME) service category should be expanded to include pneumatic compression pumps and 20 mmHg or higher compression garments, including short-stretch self-applied Velcro wraps.
- A few commenters stated that speech and language pathology, PT, OT, joint injections, and skilled nursing facility services should not be included in the measures as they are not clinically related to the wound/skin ulcers. A few commenters recommended including PT services only if they are related to the non-pressure ulcer treatment. In contrast, one commenter noted their support to include OT/PT services.
- A PFE commenter noted that a follow-up ultrasound and anti-inflammatory medications after their hernia was removed could have improved their care.
- Another PFE commenter reported that their family member had a foot/leg ulcer that resulted in an amputation and subsequent mood disorder (i.e., depression). They also stated that assistance with low self-esteem and pain management would have improved their care experience and outcomes after amputation.

3.2.6 Alignment of Cost with Quality

- Survey respondents recognized the limited quality measures applicable to non-pressure ulcers. They noted several metrics that could indicate quality of care for non-pressure ulcers. These include:
  - Recurrence rate
  - Social Determinants of Health screening
  - Hemoglobin A1C (HbA1C) testing
  - Time to healing
  - Patient Safety (i.e., measures focused on patient safety, ensuring that care practices align with standards to prevent complications, infections, and adverse

  - events in the context of non-pressure ulcer management)
  - Functional Outcome (i.e., measures assessing the functional outcomes of patients undergoing non-pressure ulcer care, considering improvements in mobility, activities of daily living, and overall quality of life)
  - Patient Experience and Communication (i.e., measures capturing patient experience and communication, evaluating the effectiveness of clinician-patient interactions, education, and shared decision-making related to non-pressure ulcer care)
  - Care Coordination (i.e., measures assessing the coordination of care among healthcare providers involved in non-pressure ulcer management, ensuring a collaborative and integrated approach to patient care).
  - Use of Services for Non-Pressure Ulcers Types (i.e., measures assessing the appropriate use of services (e.g., diagnostic imaging studies, compression therapy) to accurately diagnose, treat, and manage a specific non-pressure ulcer type).
- Commenters also noted some Merit-Based Incentive Payment System (MIPS) quality and Qualified Clinical Data Registry (QCDR) measures that may be relevant for this episode group.

4.0 Next Steps for Measure Specification Refinements

This section outlines the discussion topics and subsequent questions that Acumen brought to the Clinician Expert Workgroups during the Post-Field Test Refinement webinars. Acumen identified these topics for discussion largely based on commenters' feedback gathered during field testing and subsequent empirical analyses. The Clinician Expert Workgroups' discussions about these questions directly help to inform refinements to the measures' specifications.

4.1 Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)

The following discussion topics were brought to the Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) workgroup:

- Defining the episode group
    - Inclusion of other degenerative diseases of basal ganglia
    - Attribution of the measure to non-prescribing clinicians
- Accounting for patient heterogeneity
    - Inclusion of measure-specific exclusions
    - Refining the risk adjustment model
- Service assignment
    - Inclusion of high-cost services
- Renaming the measure

4.2 Non-Pressure Ulcers

The following discussion topics were brought to the Non-Pressure Ulcers workgroup:

- Expanding confirming services
- Accounting for patient heterogeneity through risk adjustment
    - Adjusting for social risk factors
    - Additional sub-population for risk adjustment
- Identifying additional clinically related services

Appendix A: List of Commenters

This appendix provides an index of interested parties who submitted a comment during field testing. Though commenters who provided feedback and didn't include their name or organization aren't included in this table, their input has been included in the report.

Table A1. Commenters Providing Feedback on 2024 Field Testing

Name	Individual or Representative	Organization
Malaysha Pennix	Individual	-
Nicolle Samuels	Individual	-
Helen Gelly	Individual	-
Edward Gibson Bowron	Individual	-
Andrea Shark	Individual	-
Dorothy Winningham	Individual	-
Cherie Binns	Individual	-
Alan Coker	Individual	-
Ting Pun	Individual	-
Danny van Leeuwen	Individual	-
Diane	Individual	-
Phil Posner	Individual	-
Barbara Burdett	Individual	-
Michelle Edith Rosser	Individual	-
Eurith Brown	Individual	-
Danielle Gomez	Individual	-
Patricia Chavez	Individual	-
Lois Bence	Individual	-
Leslie Page Moch	Individual	-
Darnell Blackmon	Individual	-
Sarah Jacob	Individual	-
Joyce Ann Matula	Individual	-
Matthew Mark Melin	Individual	-
Zoe Deol	Individual	-
John Blebea	Individual	-
Michael M. Di Iorio	Individual	-
Keith Moore	Individual	-
Brian Loder	Individual	-
Mariah Todd	Individual	-
Stephen Franklin Daugherty	Individual	-
Kristen Sherwood	Individual	-
Louis Prevosti	Individual	-
Connie Montgomery	Individual	-
Caroline Fife	Individual	-
Emily Greenstein	Individual	-
Dominique Bolds	Individual	-
Keisha Payton	Individual	-
Stephanie Woelfel	Individual	-
Kara Couch	Individual	-
Aamir Siddiqui	Representative	American Society of Plastic Surgeons
Brad Goshorn	Representative	Adams Health Network
Traci A Kimball	Representative	The WISH Clinic
Michael Reed	Representative	Wyoming Wound Care Center
Sarah Warren	Representative	American Speech-Language-Hearing Association

Name	Individual or Representative	Organization
Elizabeth Milligan	Representative	Vein Specialists of the South, LLC
Larry Santi; Dyane Tower	Representative	American Podiatric Medical Association
Kim Karr	Representative	American Occupational Therapy Association
Alice Bell	Representative	American Physical Therapy Association
Rachel Groman	Representative	American Association of Neurological Surgeons
Rachel Groman	Representative	Congress of Neurological Surgeons
Michelle McEvoy	Representative	United Vein & Vascular Centers
Marcia Nusgart	Representative	Alliance of Wound Care Stakeholders
Samantha Shugarman	Representative	American College of Radiology

Appendix B: List of Verbatim Comments

This appendix includes the verbatim comments received during field testing through the 2024 Measure-Specific Cost Measure Field Testing survey, the PFE Cost Measures Field Testing survey, and via comment letter. Please note that certain information has been redacted where it may be considered confidential or sensitive information for the commenter, a clinical practice, or a patient.

Comment Number 1

- **Date:** 2/3/2024
- **Submitter Name, Credentials, and Organization:** Malaysha Pennix, Individual
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Movement Disorders

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports, Draft measure specifications, Field testing FAQ, CSV with patient-level information, Measure Testing Forms

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Measure construction methodology, Quick reference specifications, Measure flowcharts, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Saw on the CMS MACRA website

Comment Number 2

- **Date:** 2/5/2024

- **Submitter Name, Credentials, and Organization:** Nicolle Samuels, MSPT, CLT-LANA, CWS, Individual

- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

First of all, PT/OT/ST should be able to practice without a referral and plan of care or oversight from physicians. Patients should be able to access our services immediately and without barriers (similar to chiropractors) and be able to see us when they have an issue that needs to be addressed without 'discharging'. Wound care has an extremely high recurrence rate and continuing to monitor patients throughout their life journey with high risk integumentary conditions will save money, time, and lives.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

First of all, PT/OT/ST should be able to practice without a referral and plan of care or oversight from physicians. Patients should be able to access our services immediately and without barriers (similar to chiropractors) and be able to see us when they have an issue that needs to be addressed without 'discharging'. Wound care has an extremely high recurrence rate and continuing to monitor patients throughout their life journey with high risk integumentary conditions will save money, time, and lives. The biggest reason for failure in the wound care world is physician driven plan of care that is carried out by nursing or other disciplines. This current model eliminates ongoing evaluation of the patient and wound at every encounter with a current lack of critical thinking by the wound care provider.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

There should also be a category for mixed etiology. It could be one ulcer, but have a diabetic AND arterial component to the barrier to healing for example. Many wounds also have a mixed vascular etiology such as arterial and venous. Additionally, 'Neuropathic' would be more indicative and encompassing instead of 'Diabetic'.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Modalities: ultraviolet C, electrical stimulation, negative pressure wound therapy, total contact casting, pneumatic compression, pulsed ultrasound, etc.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Social determinates of health
Recurrence

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Lymphedema

[**Q157. 2.** 2. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

We should have intense intervention as soon as possible to decrease chronicity of wounds. Increase spend/cost initially to decrease long term and higher priced interventions. Example: refer to wound care physical therapist immediately for all wound types instead of 'wait and see' or 'failure first model to access hyperbarics, pneumatic compression, negative pressure wound therapy, skin grafts and surgery, cellular based tissue products that cost the system extreme amounts of money'.

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Was notified by specialty society / professional association

Comment Number 3a

- **Date:** 2/29/2024
- **Submitter Name, Credentials, and Organization:** Helen Gelly, MD, CWS, Regenerative and Hyperbaric Medicine, Individual
- **Comment Text:**

February 28, 2024

To Whom It May Concern,

I am a practicing hyperbaric and wound care physician who has 5 full-time physicians in our practice, [practice information redacted]. At the present time, we cannot support the measure as constructed. There are many issues that have not been addressed and are inconsistent with the way wound care/ulcer care is practiced.

I have been examining the Results of our report and have some concerns.

1. Our risk scores and our average HCC scores:

Considering that the typical internist has an average HCC score of about 1, and the nephrologists have scores in the mid 4s, it appears that our complex patients (of which there are many) and

because of their complexity, get admitted more frequently and consume more health care resources, but these are all out of our control. Yet, we would be the most frequently utilized provider due to the weekly nature of typical wound care treatment protocols and would be the clinicians that code the diagnoses that trigger the episode. The inpatient admissions attributed to us are actually for the pat ient 's comorbid conditions or complications. As an example, Patient [redacted] was admitted for knee pain in 2022 during our episode because he had chronic osteomyelitis that he was getting IV antibiotics for, and the suspicion was that he had a septic knee. That admission HAD NOTHING TO DO with his ulcer. How am I responsible for the admission cost?
2. How am I responsible for care given in another state? One of our patients was admitted in Florida. Our practice is in Georgia. Or for inpatient admissions in hospitals where I do not have Medical Staff privileges? Or for lab tests that are ordered, such as wound cultures? Are we being incentivized NOT to do cultures?

3. Table 4. What can I say? The NPIs Within Your TIN and the NPIs Outside your TIN have 3 out of the 5 listed on both sides of the table. We cannot be both inside and outside our TIN.

4. No one has addressed the issue of cellular tissue products (CTP), more commonly referred to as Skin Substitutes. They vary in cost from $800 to over $100,000 for one piece. I do not see them represented as a line item in the costs. And if they are applied in the HOPD, they are a bundled cost . So, an off ice-based physician would have much higher costs because the cost of the CTP is on the HCFA 1500 form and should be attributable.

5. The cost attributed to the physician is not congruent with clinical practice . Some wound care patients are seen for 16 weeks (on average) for simple non-healing issues. The vast majority of chronic patients are seen weekly for seven months. The HOPD office visit reimbursement is about $3500 for the G0463 code (office visit in HOPD without procedure) alone, so how can the national average be under $1000? Office-based physicians get paid differently than HOPD physicians, and if you care about comparing the two, it is apples to oranges.

6. We are a hyperbaric practice, so more patients referred to us have already been pre-screened for suitability for hyperbaric oxygen therapy, for example, for a Wagner Grade 3 or above ulcer. Our hyperbaric utilization will be higher than the average wound care physician because we provide it in our office and most do not or just supervise in the HOPD. The wound care might be done by podiatry. If the podiatrist is the practitioner who initiated the episode, are they responsible for the hyperbaric oxygen therapy that we provide? Conversely, if the podiatrist is doing the wound care on the ulcer, and we are the "initiating" physician, are we responsible for the surgical debridements in the OR, or the multiple CTPS applications?

7. Since over 87% of the HBOT is provided in the HOPD, the cost stated as the national average is about $13,000, divided by $630 = 20 treatments. If you take our number [redacted]. So, we are dead on in the national average but have been placed as an outlier because of how the data is collected. In this case, we are more expensive than HOPD, but if you look at the debridement codes (millions of claims vs. 350,000 for the HBOT in the latest dataset), office 11042 is [dollar amount redacted] more expensive for the same procedure per encounter. How do you judge minor procedures (including debridements 11042 and 97897?)? We should be under the average by a large margin, but we are not . The data does not reflect the actual practice of wound care, as most patients get at least six debridements.

8. What is a "skin procedure"? What is considered major vs minor?

9. How does my TIN get allocated costs for services that I cannot provide, X-rays? Ultrasound? But more importantly, if I refer a patient to interventional cardiology/radiology/vascular for a peripheral

arterial stent (which should be standard of care), will I have the $16,000 procedure that is performed in the office-based lab attributed to me? If the other physician has a cost measure in place, do we have reciprocal costs reflected in our episode? Does the interventionalist have all the ulcer costs attributed to them?

We would be happy to participate in discussions surrounding these questions and we feel that although a cost measure is appropriate for this condition, the current format of the episode is flawed and does not represent the actual practice of wound care in these very complex and costly patients.

Comment Number 3b

- **Date:** 2/5/2024

- **Submitter Name, Credentials, and Organization:** Helen Gelly, MD, CWS, Regenerative and Hyperbaric Medicine, Individual

- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

This is very challenging because there is no designated taxonomy code for wound care specialists, and most practitioners have other primary specialties, like Family medicine, surgery, or emergency medicine. The most overlap would be with Undersea and Hyperbaric Medicine, and most HBO physicians also do wound care.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

The problem is that there is a huge population that has ulcers/wounds that do not fit into these categories, that morph into an ulcer, for example, the door of the dishwasher lower extremity injury that results in a full thickness wound, that does not heal because the patient is elderly with venous insufficiency. It is not a "venous ulcer" by the strictest definition, but this traumatic wound will not heal unless it is addressed as if it is venous and requires compression, etc. Coding this becomes a nightmare. ICD-10 does not address this transformation from acute to chronic, wound to ulcer.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

All the skin manifestations of autoimmune diseases present a problem for healing; for example, a psoriasis patient with a lesion within the area of a psoriatic plaque will have a more challenging time healing, Raynaud's disease ulcers, Buerger's disease, etc. All of these need to be excluded because of the complexity of healing them with the underlying skin pathology as well as the common use of biologics that diminish wound healing capacity.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

The ones Medicare removed if i remember correctly , compression for venous disease, etc

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

Table 5 cannot be; the least expense cannot be less than an initial consultation for the ulcer...

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

They are meaningless as presented because most of the names within the NPI outside your TIN are actually within our group...is it because we were using facility designation for hyperbaric oxygen?

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Since this is the first pass, it was confusing, but the issue is what are the ramifications of where you land in the risk bracket?

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Draft measure specifications

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Quick reference specifications

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received Acumen email notification, Was notified by specialty society / professional association

Comment Number 4

- **Date:** 2/5/2024
- **Submitter Name, Credentials, and Organization:** Aamir Siddiqui, MD, American Society of Plastic Surgeons

- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

a primary care provider should not be the trigger event if patient is sent to a specialist. a chronic wound is defined as 3 months. the early non-speciality care is not relevant to future treatment

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

they should be a minimal volume criteria for example 4 cases/ 6 months.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

anti-coagulation, malignancy, autoimmune

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

report both
most useful category is debridement

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports, Draft measure specifications, Measure Testing Forms

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Measure construction methodology, Measure flowcharts, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received CMS email notification, Received Acumen email notification

Comment Number 5

- **Date:** 2/8/2024
- **Submitter Name, Credentials, and Organization:** Brad Goshorn, FACHE ACMPE, Adams Health Network
- **Comment Text:**

[**Q138. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

Yes because it ensures that effective rehab is completed

[**Q140. 3.** Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson’s and fit the measure’s intent?]

Looks Good as is

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson’s and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

No

[**Q142. 5.** Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?]

Yes

[**Q143. 6.** Are there any changes that should be made to the current risk adjustors, such as to add or remove variables? Are there measure-specific variables that should have their specifications updated?]

No

[**Q144. 7.** Should any patient cohorts be considered for exclusion from the measure? How might such patients be identified using Medicare claims data?]

Palliative and Hospice

[**Q145. 8.** Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are the other indicators of quality that are not currently captured in a MIPS quality measure?]

Lower cost that does not utilize recommended pathways of care should not be viewed as higher value of care. Equation should adjust for avoidance of best practice services to truly evaluate value rather than just low costs

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

The lack of a visit from Primary Care would indicate poorer care by not addressing the cause. There should be some tie back to Primary Care providers to ensure the cause of the wound is addressed. If a podiatrist or wound specialist is treating the wound there is no assurance that the patient has been seeing primary care for their chronic condition cause. Effective measure would be like the ER measures for vaccines and follow up visits or apply a risk penalty for lack of meeting that condition.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Yes

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

No

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Lack of Primary Care Visit during episode of care should be penalized

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

no

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

A1C <9
SDH Screening

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

No

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Useful

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Excellent if it looks like the mobility study (Did not recieve the Ulcer Report)

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports, Draft measure specifications, Field testing FAQ

[**Q162. 5**. What other feedback do you have about the field test reports?]

Great to introduce and trouble shoot continuum of care with Physicians

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Measure construction methodology, Quick reference specifications, Measure flowcharts, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received CMS email notification

Comment Number 6

- **Date:** 2/8/2024
- **Submitter Name, Credentials, and Organization:** Traci A Kimball, MD MBA CWSP, The WISH Clinic

- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcer

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

It would be wise to use a dual or triple trigger code sets for non-pressure ulcers - the L code plus the most pertinent co morbid condition codes associated inside the episode to enhance the specificity of the wound being treated inside the episode

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Assign the measure to specific taxonomic groups: NPPs, DOs, DPMs and MDs with credentials and specialty training related to wound management (not necessarily from a fellowship but validated by a national certifying BOARD, ie ABWM or others ABWMS or ASWHS- exclude all other rendering professionals. Create a specific NPPES taxonomic group for WOUND MEDICINE AND SURGERY and grandfather all current Board certified HCPs holding valid and active credentials without h/o PLI loss.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

This can get tricky when HCPs managing wounds misclassify pressure vs non-pressure etiologies in certain POS settings where pressure injury incidence and prevalence is seen as a quality measure and indicator of skin safe practice. I do think looking at resource use for things like RPM with images for all types , NIRS for arterial and mixed etiology wounds, pressure RTM for venous ulcerd and thermo mapping for diabetic ulcers would further codify the heterogeneity and complexity of the cohorts. To be a venous ulcer the provider can’t just call it so but actually treat and monitor it as a venous ulcer etc.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Yes adjunctive services like MIST, ECSWT, Cold Plasma Plasma 4 VaporOx, collagen induction microneedling therapy and chemical dessication debridement should also be services consider for the wound episode toolbox - these have proven safety and efficacy a few are still investigational.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Yes social determinants of health inclusive of food insecurity, access to transportation, PHQ-9, frailty scores, access to broadband and smart devices for telemedicine- wound care should be added to the risk adjustment capture…increase the weight of certain HCC links to ICD-10 like vascular codes including arterial insufficiency, venous insufficiency and lymphedema - morbid obesity is a major MCC for many reasons body habits and metabolism will influence what the patient can and cannot tolerate or do for themselves - as an example.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

There is bias here as these etiologies are highly n misdiagnosed and under diagnosed- you left off Hidradentiis suppurativa and tropical infectious ulcerations. I personally do not believe these should be excluded but incentivize by allowances and premiums for deployment of accurate diagnosis and Theragnostics when managing these wound types.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Assuredly in an at risk model where these measures are used to assess value we need to A:capture the most accurate risk description and save on utilization. Some other measures most relevant to NPUs are quality of comorbidity management, deployment of care navigation, reduction in acute care/urgent/emergent low value care utilization, use of high value cost efficient best practice protocols for each type of wound.

Comment Number 7

- **Date:** 2/5/2024
- **Submitter Name, Credentials, and Organization:** Edward Gibson Bowron, PT, DPT, Individual
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

The trigger codes capture a portion of the patient population in question. Other codes that are noteworthy include ICD-10 dx codes for diabetes and lymphedema codes such as I89.0 or varicosities such as I83.212. Non pressure ulcers are only half of the picture and identify the ulcer present but does not include the source of the ulcer itself. The integumentary system is only a reflection of the health of other systems and BOTH the integumentary system and vascular system most be treated for successful recoveries. They are dependent on each other but also treated separately in daily practice.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

This is a mute point and not relevant. Focusing on who signs an order is not important to a patient's success but rather the treating provider is the one who knows the patient's limitations, struggles, complications, etc better than the provider who simply signs an order to continue care. This is one of the most frustrating things in our current medical model. Those with little to no patient contact decide frequency of care simply because of titles and archaic practices that no longer are relevant and further, actually hinder good patient care.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Yes, I have identified those additional identifiers within question number 1.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

No, I believe you have captured the medical complexity of patients with (non healing) Non-Pressure Ulcers.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

No. Again, these patients are typically very medically complex and there are many factors that impact success. However, it is important to not place too much emphasis on risk factors as a good clinician is already aware of these and works to set the patient up for success regardless of these.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Possibly patients with active cancer.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

patient satisfaction

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

This is very helpful as it ensures cost savings between settings and providers is easily identified however I am not sure how success is being measured. For example, if a plastic surgeon places a skin flap on a patient and an ulcer is considered "closed" with a flap vs a patient who requires 20 visits to reach closure for a similar case within an outpatient clinic, are these instances compared as equal? Are skin flap failures taken into account? What are the long term outcomes for these two different examples and more importantly, what are the long term costs associated with these two examples I have provided.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

I believe this is very important as there are many procedures and tests and measures ordered that are trivial and very expensive.

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

n/a

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports

[**Q162. 5**. What other feedback do you have about the field test reports?]

None

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Quick reference specifications, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Was notified by clinical practice

Comment Number 8

- **Date:** 2/14/2024
- **Submitter Name, Credentials, and Organization:** Michael Reed, M.S.P.T., Certified Wound Specialist, Wyoming Wound Care Center
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Direct access to the Physical Therapist who is board certified in wound care and has more wound care training when they came out of any physical therapy program than most every physician coming out of school.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

yes,

Cancer ulcer

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Board Certified Wound Care Specialist should be separate on the list so who is getting a higher level of service can be tracked.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

no

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

How long an ulcer stays closed.

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Was notified by specialty society / professional association

Comment Number 9

- **Date:** 2/23/2024

- **Submitter Name, Credentials, and Organization:** Darnell Blackmon, MD, Individual
- **Comment Text:**

[**Q138. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

No. They don't certify the treatment plan.

[**Q140. 3.** Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson's and fit the measure's intent?]

No

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson's and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

Yes it does

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Should be linked directly to the provider who directs the care of the patient

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

It is not a good indicator as some ulcers have more than one etiology which can vary intervention. Also patients have variable presentations based on comorbid conditions

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Multilayer compression should not be bundled with wound debridement as either can be performed independently but performing both requires more time, additional supply cost and ancillary support for pressure measurements

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

MIPS makes no sense since indicators change over time and are often unrelated to the diagnosis and treatment of the patient. It merely provides a path for clawback and does not improve patient care or outcomes

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Yes. They should all be included based on the definition of a non-pressure ulcer. How can you have it both ways. If that is concerning then the terminology should be changed

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

None. No patient is the same. By this implementation you handicap the physician and outcomes will dwindle

Comment Number 10

- **Date:** 2/24/2024
- **Submitter Name, Credentials, and Organization:** Sarah Jacob, RN, BSN, CWON, CHRN, Individual
- **Comment Text:**

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

Yes, as it can be difficult to evaluate and work with patients with a movement disorder in any setting. Also, these providers are going to make up the majority of billing for this patient population.

[**Q140. 3.** Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson’s and fit the measure’s intent?]

Unsure

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson’s and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

Yes, the new proposed name is clearer.

Comment Number 11

- **Date:** 2/27/2024
- **Submitter Name, Credentials, and Organization:** Matthew Mark Melin, MD FACS, Individual
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Need to add phlebolymphedema as ICD 10 code as all venous leg ulcers have associated venous hypertension, lymphedema; phlebolymphedema and a CEAP "C" status 6 are the most commonly used terms to recognize a venous leg ulcer; if terminology not congruent with CMS and or acting clinicians, true data will never be obtained for accurate measures

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Appropriate logical coding
Appropriate accurate size measurement and response to therapies
Compression medical grade must be used consistently and good wound biofilm management

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Accurate diagnosis mandated, all lower extremity wounds demand an ABI given mixed venous PAD ulcers with rise of diabetes, treating a venous ulcer with underlying PAD and missing PAD does harm. Diagnostic testing must be supported and followed based on Societal guidelines

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Mandated compression in VLU, phlebolymphedema

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Nutritional factors

Tobacco use
Size of wound at start of treatment, larger circumferential wounds take longer and more effort to heal
The lymphedema aspect must be treated for VIU to heal patients

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Appropriate but the correct diagnosis of these conditions often not made, a biopsy with Derm pathology must be done in suspicious wounds
Cancers also should be listed that are associated with wounds; basal, squamous, Merkel cell, melanoma, angiosarcoma

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Getting wound diagnosis correct
Following societal guidelines based on published data
Wound decreases in size 29-40% every 4 weeks
Low recidivism rates by using goid skin care and compression

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Was notified by specialty society / professional association

Comment Number 12

- **Date:** 2/27/2024
- **Submitter Name, Credentials, and Organization:** Zoe Deol, MD, FACS, Individual
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

It is not clear what a "Measure-specific EM" is.
Trigger claim should include diagnostic radiologic testing such as vascular ultrasound.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Since 70% of lower extremity ulcers are secondary to underlying venous disease, the number one specialty would be a VLM specialist (Venous and Lymphatic Medicine). This is an evolving subspecialty composed of physicians from a wide variety of primary specialties, who received additional training and board certification in venous and lymphatic medicine (American Board of Venous and Lymphatic Medicine or ABVLM)
Other specialties that treat/manage non-pressure ulcers are: vascular surgery, general surgery, interventional radiology, and interventional cardiology. However, those specialties do not have VLM focused training as a VLM specialist does.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

"Multiple Ulcer" term (indicating more than one ulcer in number) should be changed to "Mixed Ulcer" (indicating more than one ulcer subgroup type)
Should also add the following ulcer types: Dermatologic ulcer (from conditions such as Pyoderma gangrenosuim, scleroderma, etc...) and lymphedema ulcer due to chronic lymphedema

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Since most ulcers are managed as outpatient, those services should be refined to include: offices based lab diagnostic testing (ultrasound) and wound care procedures. This definitely needs to include treatment of the underlying cause of most lower extremity ulcers....chronic venous disease. These procedures are performed more efficiently, cost-effective, safely in office based settings. Durable medical equipment also needs to specifically include 20-30mmHg or higher compression garments, including short-stretch self applied Velcro wraps to allow the patient to manage their own dressings at home daily. Also needs to include pneumatic compression pumps.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Morbid obesity with a BMI of 46 and higher imparts significant co-morbidity to ulcer healing due to decreased outcomes from procedures, decreased mobility, increased inflammatory markers, increased associated lymphedema, and more.
Associated Lymphedema and Lipedema also imparts significant comorbidity due to same reasons as above.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

1. Effective and prompt management of underlying venous disease and annual venous exams to monitor recurrence (EVRA Trial by Manji Gohel et. al. and LUPA Study by Stephen Black et. al. effectively report faster ulcer healing and decreased ulcer recurrence with prompt management of venous disease.)

2. Compliance with compression garments for venous ulcers
3. Outcomes measurements reported with CEAP, rVCSS, and a QOL measure (VVSymQ)

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

Truthfully, these reports are far too busy/complicated to decipher for the average physician with a busy work week, therefore they are useless feedback. There is no mock report available in the link provided for non-pressure ulcers, so there is no way to answer the questions in this section.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Again.....few to no physicians would review these in the current format, so they will have little effect on quality outcomes.

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Far too cumbersome and labor intensive for physicians to review and therefore institute change in their own practice.

[**Q162. 5**. What other feedback do you have about the field test reports?]

None of the above.

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Was notified by specialty society / professional association

Comment Number 13

- **Date:** 2/28/2024
- **Submitter Name, Credentials, and Organization:** John Blebea, MD MBA, Individual
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Would also include Non-Invasive Vascular Testing, Arterial and Venous, with indications for the procedures being "ulcers" or "tissue loss" or "gangrene"

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

By listing those specific specialties and certifications that take care of such patients...this would include vascular surgeons for ulcers with an arterial etiology and, for ulcers with venous etiology: venous and lymphatic specialists, phlebologists, vascular surgeons.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Ulcers with a lymphatic etiology should also be listed.
Rather than categorizing them by a "multiple" description, the actual combinations should be described in a more specific manner, such "arterial and venous" or "arterial and diabetic". These descriptions would be far more useful than simply multiple. For example, "venous and diabetic" is much less severe combination than "arterial and diabetic" and would require very different magnitude of care and resources...as well as being associate with a very different severity of outcome.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Imaging services should include and specify both arterial Duplex and physiological vascular laboratory testing of the extremities for arterial disease and venous Duplex reflux studies for venous ulcers.
Procedures should include venous ablation procedures.
Supplies should include compression devices and wrappings.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Chronic venous insufficiency and lymphedema should be added.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Patients with atheroembolization to the extremities

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Decreases in size of the ulcer over time, ulcer healing, time for ulcer healing to occur

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

Yes, useful to have both.
Comparisons should be more than personal and national as there can be major geographic differences (therefore, compare also to state level) and also between urban and rural practitioners.
Vascular procedures should be subdivided to venous and arterial as they are very different
Supplies should include Compression therapy/garments as "orthotic" may not necessarily be understood to include them

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

NPIs alone are not useful as clinicians will not take the time to investigate them - specific name and specialty identification would be more useful

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

As noted on prior page, include comparisons not just at the national level but in-state and among rural/urban practitioners.

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports

[**Q162. 5**. What other feedback do you have about the field test reports?]

At 15 pages, it is too long if to be sent more than once a year

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Quick reference specifications, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received CMS email notification, Was notified by specialty society / professional association

Comment Number 14

- **Date:** 2/28/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Movement Disorders

[**Q138. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

I don't think all people can be measured by the same codes. This should be changed to an individual basis.

I have a hereditary movement disorder and it keeps getting worse. I cannot afford $25.00 for each PT session. So, I will wind up in a wheel chair. I don't think this is fair at all.

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

Yes. The PT/OT helps me the most.

[**Q140. 3.** Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson's and fit the measure's intent?]

Yes. Idiopathic Peripheral Neuropathy

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson's and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

Yes

[**Q142. 5.** Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?]

Without having these services myself, I cannot answer this question

[**Q143. 6.** Are there any changes that should be made to the current risk adjustors, such as to add or remove variables? Are there measure-specific variables that should have their specifications updated?]

I feel you have the right stats here.

[**Q144. 7.** Should any patient cohorts be considered for exclusion from the measure? How might such patients be identified using Medicare claims data?]

No

[**Q145. 8.** Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are the other indicators of quality that are not currently captured in a MIPS quality measure?]

Being able to be mobile

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

Yes it was very important to have the Field Test Reports

[**Q157. 2.** 2. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

I do not know

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Well presented

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Field testing FAQ

[**Q162. 5**. What other feedback do you have about the field test reports?]
None

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Measure construction methodology

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received CMS email notification

Comment Number 15

- **Date:** 2/28/2024
- **Submitter Name, Credentials, and Organization:** Michael M. Di Iorio, MD, Individual
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Some ulcers are more common than others for example 80% of non-pressure lower extremity ulcers are venous ulcers

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Imaging services should be refined: venous imaging: duplex ultrasound, venogram, intravenous ultrasound etc.
Arterial: ultrasound, ankle brachial index, CT angiogram, catheter based angiogram etc.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

time to ulcer healing and rate of ulcer reocerrance

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports, Field testing FAQ

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Quick reference specifications

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Was notified by specialty society / professional association

Comment Number 16

- **Date:** 2/29/2024
- **Submitter Name, Credentials, and Organization:** Keith Moore, MD, Individual
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

I would like to submit feedback on both measures.

[**Q138. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

No. Not enough understanding of the disease process

[**Q140. 3.** Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson’s and fit the measure’s intent?]

Unsure

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson’s and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

Appears appropriate

[**Q142. 5.** Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?]

No

[**Q143. 6.** Are there any changes that should be made to the current risk adjustors, such as to add or remove variables? Are there measure-specific variables that should have their specifications updated?]

No

[**Q144. 7.** Should any patient cohorts be considered for exclusion from the measure? How might such patients be identified using Medicare claims data?]

No

[**Q145. 8.** Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are the other indicators of quality that are not currently captured in a MIPS quality measure?]

Reversability

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Gear it toward positive clinical outcomes

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Yes

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]
No

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

No

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

No

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Ulcer healing

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

No

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Duration/improved clinical outcomes

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Very good

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Measure Testing Forms

[**Q162. 5**. What other feedback do you have about the field test reports?]

None

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list.]

Quick reference specifications

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Attended field testing webinar

Comment Number 17

- **Date:** 2/1/2024
- **Submitter Name, Credentials, and Organization:** Elizabeth Milligan, RN, Vein Specialists of the South, LLC.

- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

This should include occupational and physical therapy codes as wound care may be initiated or continued in those services.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

This should include occupational and physical therapy codes as wound care may be initiated or continued in those services.
Lymphedema related ulcers and skin breakdown should also be included.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Size and co-morbidities should be included.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

This should include occupational and physical therapy codes as wound care may be initiated or continued in those services. Often times, the lymphedema therapist will perform skin care our wound care when treating patient with manual lymphatic massage therapy.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Notation of time to healing and percentage healed should be included.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Add lymphatic skin breakdown and ulcers to management list.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Important quality measures should have venous disease addressed or treated in addition to providing wound care.

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

N/A

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Specialty for treating providers should include but not be limited to: general surgeon, vascular, cardiovascular, PT, OT, nurse, phlebologist. All venous ulcers need vein disease addressed after presentation and if treated can improve wound healing and longevity of healing.

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received Acumen email notification

Comment Number 18

- **Date:** 2/29/2024
- **Submitter Name, Credentials, and Organization:** Mariah Todd, Individual
- **Comment Text:**

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

I feel the field test reports are more cost effective seeing as it gives you more specifics and a wider range of options where as the betos only hive commonly used to techniques.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

it's helpful because it has everything layed out for you in charts snd tables which it feels more organized

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

I'm not too sure I understand well enough to give a good answer

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports

[**Q162. 5**. What other feedback do you have about the field test reports?]

None

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Measure flowcharts

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received CMS email notification

Comment Number 19

- **Date:** 2/29/2024
- **Submitter Name, Credentials, and Organization:** Larry Santi, DPM, American Podiatric Medical Association
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

The trigger codes, at this stage, appear to appropriately identify a patient cohort that reflects the measure's intent.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

I am concerned about the definition of and/or practicality of what constitutes "…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 clinicians reasonably influence other clinicians, especially those outside their own TIN and especially those within other specialties. For example, a provider's Field Testing Report showed that an episode was attributed to their TIN. Only 4% of the cost associated with that episode were a direct result of one of the providers within the TIN. The other 96% of costs were from a specialist outside the reasonable influence of the TIN.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

I believe that ulcer type is a good indicator of patient heterogeneity and resource use in caring for patients with 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. These different ulcer types should not be compared to one another.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

I noted that post-acute care services are listed in the service categories. On the Service_Assignment_AB tab of the measure specification file, are there any skilled nursing facility or long-term care hospital details?

How we are to interpret the Service_Assignment_D details when the High Level Code Description reads "No NDC description available."

Does consideration need to be given to drugs that may be part of the treatment plan for arterial ulcers like pentoxifylline or cilostazol? If such a medication is being prescribed for an underlying condition, namely intermittent claudication in this example, do such medications need to be considered?

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

I appreciate that the testing and risk-adjustment aims to navigate the tension between ensuring fairness for clinicians treating higher caseloads of vulnerable patients and the possibility of masking poor performance and perpetuating disparity if clinicians are held to different standards. We would like to see more analysis related to social risk factors.

I would like to hear Acumen's feedback regarding the effectiveness of risk adjustment for certain populations. For example, how do you know risk adjustment for a certain population is sufficient (i.e., patients on dialysis, patients with peripheral artery disease)?

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

I believe that consideration for exclusion should be given to a few additional conditions:

a. Sjögren's syndrome is a chronic autoimmune disease that is commonly manifested by immune attack on the exocrine glands with resultant dry eyes and dry mouth. Sjögren's syndrome patients also have disease in other organs. One of the most common extraglandular manifestations is vasculitis. Skin vasculitis, with palpable purpura clinically and leukocytoclastic vasculitis on pathological examination, is common.
b. Calcinosis cutis is a condition in which calcium salts are deposited in the skin and subcutaneous tissue. It is classified into five main types: dystrophic, metastatic, idiopathic, iatrogenic, and calciphylaxis. Dystrophic calcification is the most common cause of calcinosis cutis and is associated with normal laboratory values of calcium and phosphorus. There is an underlying disease, systemic sclerosis, dermatomyositis, mixed connective tissue disease, or lupus, that induces tissue damage and creates a nidus for calcification.
c. Ulcers associated with fistulae
d. Late effects of radiation
e. Lupus

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

I appreciate 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. APMA, as expressed to CMS in other ways and through other avenues, remains concerned regarding the lack of meaningful measures for podiatrists, including a lack of meaningful quality measures to link with the proposed non-pressure ulcer episode-based cost measure. I would like to hear what quality measures Acumen/CMS considered with the non-pressure ulcers episode-based cost measure.

It is likely that meaningful measures to evaluate the quality of non-pressure ulcer care haven't yet been developed and/or that there could be qualified clinical data registry (QCDR) measures in use that could be evaluated for alignment.

There are some broad quality measures that could be considered, such as, HbA1c for patients with diabetes or the smoking cessation measure.

We appreciate that the Clinician Expert Workgroup will have an opportunity to review feedback on the quality measures through a lens of quality alignment and suggest relevant refinements to the non-pressure ulcers episode-based cost measure specifications.

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

While field testing aims to ensure that clinicians will understand the episode-based cost measure and what actions they could take to improve their performance on the measures, we do not believe this information is digestible for our practicing clinician members. The amount of documentation regarding the measure methodology and the measure specifications document aren’t easily interpreted.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

It would be interesting to see the observed versus expected ratios of cost by specialty or provider type, but we also recognize that wound care isn’t a specialty. Are there any other ways to review/analyze the data to group by type?

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

We can see within the report that Figure 1 shows provider-level scores, and Figure 2 shows episode-level costs but what is the clinician supposed to take away from those histograms? What is the clinician supposed to interpret from each of those histograms?

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Mock field test reports, Draft measure specifications, Field testing FAQ

[**Q162. 5**. What other feedback do you have about the field test reports?]

The report includes information on risk score and risk brackets. We ask that this section be clearer about the risk score, risk bracket, how this risk score is different from HCC scoring, and X. The report indicates that an average risk score is calculated and it is the average of the risk scores for all episodes. Can’t find average risk score. Please present as average and range.

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Measure construction methodology, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Saw on the CMS MACRA website

Comment Number 20

- **Date:** 2/29/2024
- **Submitter Name, Credentials, and Organization:** Stephen Franklin Daugherty, MD, FACS, Individual

- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

Look at physician specialty such as vascular surgery, general surgery, venous medicine, vascular medicine

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

"Multiple ulcers" is too broad a category. Look at arterial and venous, arterial and diabetic, venous and diabetic, venous and lymphatic, arterial and lymphatic, diabetic and lymphatic.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Physician office services

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

Severity of obesity
Lymphatic dysfunction
Socioeconomic
Rural versus urban/suburban
Zip code

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

No

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Early venous reflux testing with duplex ultrasound to evaluate for treatable venous reflux
Early arterial physiologic testing to evaluate arterial blood flow
Early treatment of significant venous reflux for venous leg ulcers
Time to healing
Ulcer recurrence within 90 days

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

Rural versus suburban versus urban
Zip code
State

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Time to wound healing

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Draft measure specifications

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Was notified by specialty society / professional association

Comment Number 21

- **Date:** 3/1/2024
- **Submitter Name, Credentials, and Organization:** Kristen Sherwood, Individual
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

I believe that after an ulcer has been detected and removed another ultrasound should be required within 30 days to ensure in the patients mind that no regrowth has occurred. I had an hernia detected upon removal the biopsy showed hernia genes in ulcer fluid. I would have loved anti- inflammatory prescriptions and a second ultrasound by my primary care.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Yes and then no for part two.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Appointment setting. When setting up an appointment at your primary care convenient at the primary cares, office had access to the surgeon schedule schedule so you could book your appointment that day and get authorization through insurance quicker. That will cause for less rupture because people would be in surgery sooner than later.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

No everything is covered here.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

No

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Precise cutting and coiled extraction. Although in Coil is extraction, you may receive an additional coil of pressure or swelling. It will go down in the long-term results are guaranteed to look better. There is no icing or heat necessary.

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

I received a cost performance before my surgery, and I didn’t have any questions about any insurance coverage or non-coverage. Luckily for me, my insurance carriers covered 100% of the cost and I did not even have a co-pay.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Statistical graphing between men and women of different races, creeds and colors may be helpful in the future to find out reasons why these ulcers occur.

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

I read all the sections before answering the questions and the survey was put together quite well. I’m impressed.

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Field testing FAQ, Measure Testing Forms

[**Q162. 5**. What other feedback do you have about the field test reports?]

None I like their statistics.

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Measure construction methodology, Quick reference specifications, Measure flowcharts, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received CMS email notification, Received Acumen email notification, Was notified by specialty society / professional association, Was notified by clinical practice

Comment Number 22

- **Date:** 3/1/2024
- **Submitter Name, Credentials, and Organization:** Kim Karr, OTR/L, CPHQ, RAC-CT, American Occupational Therapy Association
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Movement Disorders

[**Q138. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

We appreciate the inclusion of rehabilitative services codes within the measure. We believe that will allow for increased participation in this measure by rehabilitative professionals.

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

Yes-we believe that inclusion of rehab professionals who cannot prescribe medications allows for greater participation with this measure. As rehab codes are a trigger for start or continuation of an episode, its possible that rehabilitation may be the only current provider involvement. Not allowing rehab professionals to be attributed means that they are unable to be held accountable for outcomes and patients who otherwise qualify for inclusion will be missed if the physician is not currently engaged.

[**Q140. 3.** Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson’s and fit the measure’s intent?]

Lewy body dementia presents like Parkinson's Disease at times. It may be necessary to determine if this should be included or not based on treatment parameters.

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson’s and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

Yes. The proposed name is more clear on the various types of conditions that might qualify for inclusion.

[**Q142. 5.** Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?]

Yes

[**Q144. 7.** Should any patient cohorts be considered for exclusion from the measure? How might such patients be identified using Medicare claims data?]

It may be necessary to exclude patients with Lewy Body Dementia. If that is determined, those patients could be identified by ICD10 code on the claim.

[**Q145. 8.** Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are the other indicators of quality that are not currently captured in a MIPS quality measure?]

Falls, functional outcome measures

Comment Number 23

- **Date:** 3/7/2024
- **Submitter Name, Credentials, and Organization:** Louis Prevosti, MD, Individual
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

attribute only E&M office visits to clinicians that are trigger events

do not attribute therapeutic visits to related services (that are not the triggering MD, DO, PA, NP) to the triggering provider. Eg.: surgeon diagnoses venous ulcer and orders wound care by a separate entity/organization not under his/her control and

attribute therapeutic visits delivered by the same provider to the triggering provider. Eg.: surgeon diagnoses venous ulcer and renders procedures in his/her clinic/organization under his/her supervision

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

yes it is a good indicator

additional codes related to procedures to treat the specific ulcer. Eg.: venous ablations for venous ulcers, arterial revascularization procedures for arterial ulcer, etc

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

remove speech and language pathology services. These are not related to skin ulcers and should not be assigned to the ulcer diagnosis.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

seems good

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

patients with burns
patients with Kaposi's sarcoma
patients with skin cancer
patients with Stephen's Johnsons syndrome
patient with traumatic wounds

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

diagnostic studies to determine venous and arterial disease
appropriate management of ulcer. Eg.: venous ulcer does not need hyperbaric oxygen therapy.
appropriate treatment of underlying condition. Eg.: proper management of underlying venous disease and not just wound care for a venous ulcer

Comment Number 24

- **Date:** 3/7/2024
- **Submitter Name, Credentials, and Organization:** Michelle McEvoy, RN, United Vein & Vascular Centers
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes, very comprehensive. The combination of E&M codes and ICD- 10 DGN codes represent the patient population seen in our vascular and wound practices.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

As vascular practice, we agree clinicians listed in the Attribution Code type who are eligible to participate in MIPS and bill at least 30% of the trigger/confirming services during the episode is appropriate when attributing episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

As a vascular practice, we agree an 80% threshold should be applied when categorizing non-pressure ulcers into sub-groups including diabetic ulcers, arterial ulcers, venous ulcers and when none of the diagnosis codes reach the threshold, multi-ulcer types. In addition, the 120-day look back prior to the episode plus the day of the episode start is a good indicator of patient heterogeneity and resource use.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

The only High-Level Code Label for the treatment of venous ulcers associated with the OP service clinician category is varicose vein stripping lower limb (053). We would like to see the following procedures added to the High-Level Code Label Column on the Service Assignment: Part A and B with the service category of OP Clinician.

- 36470, 36471 – Physician-compounded foam sclerotherapy, for the treatment of incompetent extremity truncal veins and other incompetent extremity veins
- 36465, 36466 – Injection of non-compounded foam sclerosant with ultrasound
- 36475, 36476 – Endovenous Ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency
- 36478, 36479 – Endovenous Ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser
- 36482, 36483 – Endovenous Ablation Therapy of Incompetent vein, extremity, by transcatheter delivery of a chemical adhesive
- 37765, 37766, 37799- Stab phlebectomy of varicose veins
- 36473, 36474: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical

Rationale: As noted by Schul et al, “Chronic venous disorders are common, with varicose veins occurring in approximately 40% of the population. Venous leg ulcers affect 1% to 2% of the population, with the prevalence increasing ≤ 4% for those aged >65years. Both conditions are expensive and together are responsible for ≤ 2% of the annual healthcare budget expenditure of Western societies. Venous ulcers represent the most advanced form of chronic venous insufficiency (CVI). Venous ulcers that fail to respond to non-invasive interventions can be successfully treated with a minimally invasive endovenous procedures which may include ultrasound guided foam sclerotherapy, thermal ablation (endovenous laser ablation or radiofrequency ablation) and chemical adhesive ablation. The ESCHAR (Effect of Surgery and Compression on Healing and Recurrence) and EVRA (Early Venous Reflux Ablation) trials have shown that surgical correction of superficial venous reflux reduces venous ulcer recurrence, accelerates healing times (EVRA), and has been proven to be cost-effective.”

References:

Schul MW, Melin MM, Keaton TJ. Venous leg ulcers and prevalence of surgically correctable reflux disease in a national registry. J Vasc Surg Venous Lymphat Disord. 2023 May;11(3):511-516. doi: 10.1016/j.jvsv.2022.11.005. Epub 2023 Jan 19. PMID: 36681297.

Gohel MS, Heatley F, Liu X, Bradbury A, Bulbulia R, Cullum N,et al. A randomized trial of early endovenous ablation in venous ulceration. N Engl J Med 2018;378:2105-14.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

No additional measure-specific risk adjustors were identified.
No additional patient-level indicators were identified.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

No changes

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Quality ID #420: Varicose Vein Treatment with Saphenous Ablation: Outcome Survey

Quality ID #441 Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)

Quality ID #127 Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Foot wear

Comment Number 25

- **Date:** 3/11/2024
- **Submitter Name, Credentials, and Organization:** Emily Greenstein, APRN, CNP, American College of Clinical Wound Specialists
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes, intent of the measure is captured. However, there are concerns with the way the coding comes in. Type of ulcer verse ulcer location. What is the trigger code? This might be more of a subgrouping issue.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

How does this work in larger groups, multiple providers reporting under one TIN? Also what is considered “reasonable influence”? Wound care patients are seen by multiple providers, the field testing reports have shown us that there is a problem I.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Yes and no, the ulcer location needs to be considered also. For example treatment for an arterial ulcer on the arm is different than treatment of an arterial ulcer on a leg. We recommend making sure they are using 2 codes the type and the location.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Speech therapy, skilled nursing care and PT/OT not related to the wound specifically should not be included.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

How were the risk stratification numbers calculated? Nothing explains this on the reports.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Fistula, wounds related to lupus and other autoimmune diseases, calcinosis cutis, radiation dermatitis, traumatic wounds that have turned chronic such as bites, gun shots, and penetrating wounds.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

Would like to hear what other measures could be evaluated.
Some that could be considered would be Hgb A1C and smoking cessation. However, these issues might not be managed by a wound care provider so they would have no control over them.

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

More explanation of each category and how risk stratification is calculated.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

There was some concerns voiced about the accuracy of the top 3 contributing providers.

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Need more explanation

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Field testing FAQ, Measure Testing Forms

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Quick reference specifications, Measure flowcharts, Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received Acumen email notification, Attended field testing webinar

Comment Number 26

- **Date:** 3/12/2024
- **Submitter Name, Credentials, and Organization:** Caroline E Fife, MD, Individual
- **Comment Text:**

Re: Non-Pressure Ulcers Episode-Based Cost Measure Field Testing Feedback

Dear Acumen, LLC, and Members of the Non-Pressure Ulcers Episode-Based Cost Measure Clinician Expert Workgroup,

I served as a member of the Clinician Expert Workgroup, but I write this letter in the capacity of a practicing wound care practitioner. I fully support the development of a measure which would reflect the cost of the care for which I am responsible. Although I was originally board certified in Family Practice (FP), for 34 years I have practiced only wound care. Since wound care is not a recognized medical specialty, and since I often provide the plurality of care for my patients in a given calendar year, I was deeply concerned in 2016 after reading my "QRUR" report which showed that hospitalizations for heart failure among my wound care patients were being attributed to my TIN. Since nearly 40% of my patients with chronic ulcerations have heart failure as a comorbid condition, and since these patients are often hospitalized for CHF exacerbations, CMS was mistakenly attributing these costs to me and there was no mechanism by which I could correct this. My costs were dramatically higher than my peers in FP and in 2016, I achieved 3 out of 10 points for the cost measure applied to me, calculated among patients whose healthcare costs I had no part in determining. As a result, few practitioners support the development of an accurate cost measure for "wound care" services more than I.

Thus, I reviewed my Field Test report with a sinking heart. The Alliance of Wound Care Stakeholders (which I represent on the Workgroup) has provided a detailed comment letter, as has the APMA. I will not repeat that information. Instead, I will focus on the concerns raised by my Cost report, through the lens of a clinician practicing in a hospital-based outpatient department (HOPD).

How can the "National Average" Cost be different for different doctors?

Below is my [table] from another wound care practitioner. Why is the "national average" different? It must not be a "national" average, if so. Is it a national average calculated specific to a group, such as by specialty, or is it by risk group? My specialty designation is Undersea and Hyperbaric Medicine. I hope at least that I am being compared to other UHM specialists rather than to other FPs (my primary specialty). And by the way, this is not an issue that an individual doctor could know about! You'd have to see the reports for your colleagues!

Most wound care practitioners ONLY practice wound care. Wound Care is practiced by so many different specialties and it does not seem useful to subdivide it by primary specialty. What is the value of having the average cost of a non-pressure ulcer for an FP, the average cost of a non-pressure ulcer for an internist, the average cost of a non-pressure ulcer for Emergency Medicine, etc.? All of us are practicing wound care.

[Tables from confidential Field Test Reports are redacted]

Here is Table 3 from the same two doctors. The share of episodes must not be "national" here either since they are different.

[Tables from confidential Field Test Reports are redacted]

How can the "National Average" for Amputations be different for different doctors?

In Table 3, the national average of "Amputations for Circulatory System disorders" is [redacted percent] but in my colleague's report it is [redacted percent]. How is that possible?

Who are these doctors outside my TIN?

I looked at Table 4: Top Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs. This table lists 5 practitioners, and I did not recognize the names of <u>any</u> of them. I have never referred to any of these physicians nor have they ever referred a patient to me. Yet, they have contributed the most to my episode costs. How is that possible? Most of them are not even in my geographic area. I am confident that whatever costs they are associated with were never under my "reasonable control."

When I reviewed the associated Excel spreadsheet column W (NON_ATTR_NPI), of the approximately 53 physicians listed, I have had referral relationships with 9. The others I do not know. Furthermore, some of the hospitalizations for patients occurred in cities distant from my own (including more than 100 miles away) and thus could not possibly be under my control. Indeed, I do not have admitting privileges at any of the hospitals listed.

Of particular concern, [practice name redacted] is listed several times in column W as if it is a "clinician", as is [practice name redacted] which is another laboratory. Why are laboratory services listed in column W as if they are "Clinicians outside your TIN?"

There is a serious problem with attribution: Example -My most costly patient:

[Patient information redacted]

Here is what I have learned from this case:

- Costs have been attributed to me for services ordered by an NP who saw the patient after I was no longer caring for her.
- The charges provided by the NP who cared for the patient were excessive and highly questionable based on what I know about the patient but are nevertheless attributed to me.
- Calcinosis and late effects of radiation should be excluded from the cost measure.
- I need to know how "skin substitute" charges are being collected and allocated.

There is a serious problem with attribution: Example-My second most costly patient

[Patient information redacted]

Here is what I have learned from this case:

- Patients with diabetes on dialysis and who are doomed to an amputation will create cost outliers. Failing to adequately account for this situation will make physicians reluctant to provide care to these unfortunate individuals.
- Costs are being attributed to me which are outside of my control.

There is a serious problem with risk classification
Patient #2 above has the following comorbid conditions:

- Type 2 Diabetes
- Renal failure on dialysis
- Advanced peripheral arterial disease with gangrene
- primary hypertension
- iodine deficiency related thyroid disease
- heart failure
- peripheral neuropathy
- gastroesophageal reflux
- hyperlipidemia
- hypercholesterolemia
- major depression
- prostatic hypertrophy with urinary tract symptoms
- central sleep apnea
- anemia
- cerebrovascular disease
- history of falling
- aortic aneurysm
- ischemic heart disease status post coronary bypass

- right bundle branch block requiring a pacemaker
- malnutrition
- diabetic retinopathy
- obesity

His risk score is only [risk score]. How is that possible?

It appears based on column H that my average risk score is [risk score]. I am concerned that this is not reflective of the complexity of the patients we see. When I last looked at my CMS calculated HCC score, my HCC score calculated by CMS was [risk score] and based on CMS data, my wound center patients had the following disease prevalence:

[Table redacted]

The U.S. Wound Registry to which I contribute data shows that the average number of comorbid conditions among my patients is about [number of comorbidities] and they take [number of medications] medications on average. I realize that the risk score created for this cost measure is not the same as the HCC score, but do not see how the risk could be as low as it appears to be in my spreadsheet.

Here is what I am concerned about:

- There is a serious problem with the way that risk is determined, and a new method should be created (why does HCC not work)?
- I do not understand how individual patient risk will be taken into account for the cost calculations, even if I trusted that the risk was calculated fairly.

There is a serious problem with the Episode of Care calculation

I used DOB for all the patients to identify them in my EHR. I added a new Column S (patient's first visit with me) and column T (last visit with me) in order to compare them to the episode of care. I note the following problems:

- For my most expensive patient, the START date of the episode was the LAST date that I was involved in her care. Hers is not the only such example.
- Overall, I was not involved in the care of the patients for 94% of the episode you calculated
- That means the majority of the costs were determined by another practitioner and were not under my control.
- Many patients had been in my care for weeks and yet the trigger and confirmatory codes happened at the end of their care.
- The average true episode of care for my patients was only a few weeks. Clearly a one year episode of care is too long.

Additionally, two of the most expensive clinicians associated with "my" patients are podiatrists. The only way that their care could be so costly was if they are using skin substitutes for which I am being held accountable. If the patient is still in "my" episode of care, do those costs NOT accrue to them since they are the ones ordering them?

In reviewing my report, I found the Directors of two other wound centers in my list of physicians. This indicates to me that the patient visited more than one Wound Center during the episode of care. This may represent the patient getting a second opinion or "doctor shopping." If this scenario results in the patient being managed by another clinician and potentially not seeking care with me any longer, I'll still be attributed the costs even though my

relationship with the patient has ended (with or without my knowledge). Is that right? In this example, are there overlapping episodes? Will the Directors of the other wound centers open their own cost episodes? Will I still be attributed their costs if my relationship with the patient ends with/without my knowing?
Wound care practitioners are CONSULTANTS. We only control our own costs. We do not control the costs of other consultants, nor can we control the costs of patients who leave our practice and go elsewhere.

Where are the arterial ulcers?

I see many arterial/ischemic ulcers. That diagnosis is not listed in column C. How will you find them? How will you create a fair risk classification for them? On table 2, the arterial ulcer count is [number]. Is it [number] for everyone or just me? How are you finding them since they require two codes?

Many patients have multiple ulcers, but you are not classifying them that way

In looking at column C, nearly all patients with venous ulcers have multiple venous ulcers. It appears that if there are multiple ulcers of the same type, you are only able to identify them as having ONE ulcer. In your classification, “multiple” means multiple ulcer TYPES. Thus, if a patient has 10 ulcers of the same type, you do not know that and thus cannot correctly risk classify them.

I was not MIPS Eligible over this time frame but have a Field Test report

I was not MIPS eligible in the time frame of this cost measure because I was under the reporting threshold. Initially, I did not even look for a Field Test report for that reason. I was “opt in” eligible and I have submitted MIPS data by “opting in.” How did that impact the cost measure calculation? Many of my colleagues in the full-time practice of wound care do NOT have field test reports. Why would that be the case? How might it affect your evaluation of the data?

Why are podiatry costs attributed to me when I do not refer to those podiatrists?

Two of the five “top spending” practitioners are podiatrists. I would like to understand how and if their use of CTPs (over which I had no control) contributed to my Part B costs.

It seems likely that there is a problem with the DME supply category

I order surgical dressings from DME Providers on perhaps 75% of my patients, yet I have a [number] in the category of wound care products. What then is included with “Durable Medical Equipment and Supplies” for which I am at [percent]? I only practice two days a week. It seems likely that wound care products are actually included in the category of “Durable Medical Equipment and Supplies”.

There are serious attribution problems based on Table 3

Regarding the costs attributed to “Your TIN”, I assume this means the service that you have *attributed* to me regardless of whether I ordered them or whether the patient was under my care. Most of these are services that I do not order, and which are not under my control. I do not admit patients to the hospital, provide inpatient services, order speech therapy, order oxygen therapy or perform joint injections. I do not admit patients to a SNF or inpatient rehab, perform injections or infusions, or provide anesthesia services. Here is a list of the items on Table 3 that I have not ordered or performed in over 30 years:

- Physician services for hospitalization
- Ultrasound
- Oxygen
- Emergency Department services
- Skilled Nursing facility services or admissions
- Physical, Occupational, or speech and language pathology therapy
- Inpatient rehabilitation or long term care hospital services
- Anesthesia services
- Injections and infusions

Some things are not on Table 3 that should be:

There are a number of costs that SHOULD have been present in my report but are not. For example, I frequently refer patients for vascular services and imaging such as MRI and MRA. What about OUTPATIENT wound debridements of which I do many? Are these part of the category called “skin procedures” or does that refer to CTPs/skin subs? How are major vs. minor procedures defined? We need those detailed by CPT code.

Why aren’t amputations a major focus of the report?

Why not calculate amputations for DFUs since reducing amputations related to DFUs is a major focus of CMS? Most importantly, how are all those “amputations for circulatory system disorders” calculated? What about amputations for patients who do NOT have circulatory system disorders?

Where are the reports of my colleagues who practice wound care?

Many clinicians in the full-time practice of wound care were unable to find Field Test Reports on the QPP sites, particularly those in academic and large multispecialty practice settings. Why? Was it due to ACO participation? What clinicians would not have had reports even if they had many eligible patients?

The measure suggests that Acumen does not understand wound care services

Now speaking as a member of the workgroup, I am very concerned that the Acumen team does not understand the way that wound care services are provided. For example, it does not appear that you understand what a “skin substitute” is, based on the fact that the wrong codes were included in the list of “skin grafts.” We discussed this during the meeting and provided the correct codes. Can we meet again to explain what these products are and how the service is provided? Why were vascular grafts included in the list? Where are charges for the skin substitutes?

How is Site of Care accounted for in the cost model?

I do not think that the Acumen team understood the importance of the of “site of service” in the cost model. In the doctors’ office (site of service 11), the cost of the skin substitute product and the cost of hyperbaric oxygen therapy are allocated to the PHYSICIAN. However, when physicians provide wound care in the hospital-based outpatient department (HOPD – site of service 22), the cost of the product and the cost of the technical service are paid as part of the hospital fee and are not part of the physician payment. Additionally, all services provided in the doctor’s office are paid at a higher rate than in the HOPD, in recognition of the fact that the physician is responsible for all the overhead. This means that site of service will have a PROFOUND impact on apparent costs for wound care services. Most wound care practitioners who are not podiatrists are working in the HOPD. How was the cost model adjusted to account for site of service so that fair comparisons could be made?

How did you handle the huge challenges with ulcer coding?

ICD10 codes are simply not adequate for CMS to identify the wound type. DFUs and arterial ulcers cannot be identified except by using TWO codes**.** There are no “ulcer codes” that are specific to diabetic foot ulcers or arterial ulcers. There is no standard way that these problems are identified in EHRs. Most of these problems end up being coded as non-specific ulcerations. ICD10 recommends that the underlying problem (e.g. “diabetes”) is coded first. HOW DID ACUMEN HANDLE THIS? The committee tried to alert Acumen that coding guidelines would impact your ability to identify ulcers by type.

The reports are not interpretable by busy clinicians

I provide the Table below just as an overview.

[Table redacted]

I serve on the Clinician Expert Workgroup, and yet I do not understand the tables provided in my report. What does the “Mean ratio of Winsorized annualilzed observed to expected” cost mean? Seriously, I do not know what “winsorizing” means in this context. The Cochrane Collaboration provides a “plain language” summary of even highly complex evidence analyses. Why can’t CMS provide a “plain language” summary of the Field Test Reports and what they mean?

Summary of concerns

I am deeply worried about the fact that I am responsible for charges that occurred after I was no longer seeing these patients, and that the cost measure includes charges that were likely not incurred specially in the management of the wound. How can the fact that the patient is no longer under the care of the clinician be conveyed? Does the episode have to be 365 days when most wound care practitioners see patients for far less time than that? My biggest concern is that you have no method of understanding the outcome of the patient. There are risk stratified wound healing quality measures for DFUs and VLUs, but they are only available through a QCDR.

How will you use the Field Test reports to decide if a cost measure “worked?”

As a workgroup member, I am deeply concerned that not only is there a lack of understanding of the way that services are provided, but a failure to incorporate the concerns and the input of the members. It feels as though the committee was simply a perfunctory step and that some predetermined model was followed without alteration. It seems as if there is a “wizard behind the curtain” and we are not allowed to see exactly what the wizard is doing.

Thank you for the opportunity to provide feedback on the Non-Pressure Ulcers episode-based cost measure currently under development. I would welcome the opportunity to review my Field Test report with you personally, and so that we can learn from it in order to create a workable cost measure for non-pressure ulcers. The current cost measure should not be utilized. We want a cost measure that works. Can we try again?

Yours sincerely,

Caroline E. Fife, MD

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Rehab services is not a logical trigger code. You should have used the application of skin SUBSTITUTES (CTPs) and not "skin grafts." These codes were provided to the Acumen team. Starting HBOT could also have been a confirming claim.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

365 is too long of an episode. It is clear from the reports that multiple doctors are providing wound care services in the 365 day time frame. I think you will have to limit the episode to the charges actually ordered by that doctor or limit the time frame to 24 weeks.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

If it were reliably possible to identify the ulcers by a specific ICD10 code then I would say yes. However, because DFUs and arterial ulcers require TWO codes, and are often only identified by a nonspecific code depending on the EHR or the service, it is not possible to use ulcer type to evaluate resource use. It might be possible to evaluate resource use for VLUs since those have a discrete code set.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Exclude joint injections. You failed to include skin substitutes as far as I can tell. Inpatient admissions are more likely for comorbid conditions, I do not think that you were able to include only hospitalizations for wound related problems. I do not even know what "skin procedures are." I am not convinced the ED services were wound related. Wounds do not need oxygen. I do not think that PT services should be included and certainly not speech, OT or language. what about MRI and MRA and angiograms? those should be included.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

There is not enough data made available on the risk model for me to answer this question. I only know that my complex patients appear to have too low a risk score.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Exclude all autoimmune diseases (SLE, rheumatoid arthritis), calcinosis, and late effects of radiation.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

USWR22 (Nutritional Assessment and Intervention Plan in patients with Wounds and Ulcers)
USWR30 (Non-Invasive Arterial Assessment of Patients with Lower Extremity Wounds or Ulcers for Determination of Healing Potential)
USWR32 (Adequate Compression at Each Visit for Patients with Venous Leg Ulcers (VLUs) Appropriate to Arterial Supply)
USWR33 (Diabetic Foot Ulcer (DFU) Healing or Closure)
USWR34 (Venous Leg Ulcer (VLU) Healing or Closure)
USWR35 (Adequate Off-loading of Diabetic Foot Ulcers (DFUs) Performed at Each Visit, Appropriate to Location of Ulcer)
https://uswoundregistry.com/quality-measures/
There are no MIPS measures that are relevant.

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

Why are national averages different in different field test reports? How can they be "national" averages if they are not the same? What is Winzorization? DO NOT CREATE DIFFERENT METRICS BASED ON SPECIALTY. Everyone is practicing wound care.

More granular reporting on vascular interventions and studies would be useful.

We need granular reporting on what skin substitutes were used or at least the charges pertaining to skin substitutes.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

The files are important because I found out what doctors the patients were seeing THAT I DID NOT KNOW ABOUT. I DID NOT REFER TO THESE DOCTORS. The patients left my care and saw other practitioners and the costs were attributed to me. We can't "coordinate care" when patients are no longer in our care in the first place.

[**Q158. 3**. The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

The national averages are different in different reports. You did not tell me if the national distribution was by specialty (which is silly in the case of wound care); if you are going ot provide the DOB and Medicare number, you might as well provide the patient name so we can look them up more easily. The CSV is full of PHI so why stop at patient name? What is winzorization?

[**Q159. 4**. What information was the most useful for helping you to understand your cost measure performance?]

Draft measure specifications,Field testing FAQ,CSV with patient-level information

[**Q162. 5**. What other feedback do you have about the field test reports?]

See my letter

[**Q165. 6**. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure?]

Codes list

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Received Acumen email notification

Comment Number 27

- **Date:** 3/14/2024
- **Submitter Name, Credentials, and Organization:** Samantha Shugarman, American College of Radiology
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Movement Disorders

[**Q138. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

We defer to the measure development TEP.

[**Q142. 5.** Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?]

Bone scans generally do not have clinical utility for movement disorders and neurodegenerative diseases. For the imaging services defined in the current cost measure methodology and codes list, spine imaging (MR or CT) might be useful in certain cases (e.g., Spinal Muscular Atrophy and Related Syndromes and multiple sclerosis). PET and SPECT neuroimaging may also offer utility for Parkinsons' disease or Parkinsonian disorders.

Please review the see the American College of Radiology's Appropriateness Criteria for Movement Disorders and Neurodegenerative Diseases for comprehensive evidenced-based analyses and imaging recommendations. While certain imaging tests are identified as "usually not appropriate," they should not necessarily be excluded from the list of clinically related services for the measure. Some/many of these may be provided even though the appropriateness of the service may be questionable. Can Acumen analyze claims to assess the frequency of services identified as less appropriate to determine the necessity to include them in the measure's list of clinically related services?

Comment Number 28

- **Date:** 3/14/2024
- **Submitter Name, Credentials, and Organization:** Stephanie Woelfel, PT, DPT, CWS, Individual
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Non-Pressure Ulcers

[**Q147. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Yes, the appropriate patient cohort is identified by the trigger codes.

[**Q148. 2.** How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?]

I have significant concerns related to the "reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient" aspect of this measure being correctly captured. Costs related to outside hospital stays, skilled nursing facility admissions, and/or treatment of patient co-morbidities that are unrelated to the patient's wound are some examples of costs currently being attributed via this measure that should not be.

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

The above stratification system does not account for patients that have multiple wounds of the same etiology. Resource use caring for a patient with one diabetic foot ulcer would be significantly different than resources required for a patient with 4 diabetic foot ulcers -- especially if those ulcers are located bilaterally and two limbs are involved. In my hospital outpatient practice, over 75% of our patients have multiple wounds and those would not be accurately captured by the "ulcer type" categorization that currently exists.

Another variable that is not accounted for by using ulcer-type categorization alone is wound size. A patient with a 2 cm x 2 cm venous wound will require much fewer resources than a patient with a circumferential venous wound around the entire lower extremity.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

I believe that speech therapy services and joint injections should be removed from this measure. "Post-acute care" services should be operationally defined to specifically include only outpatient or home health services SPECIFICALLY related to wound care -- skilled nursing facility admissions should not be included as part of "post-acute care". Physical therapy services included should also be SPECIFIC to wound management/the wound diagnosis. As an example, a patient with a venous insufficiency wound that is receiving physical therapy solely for rehab following a shoulder surgery should not have those PT services attributed. Only the physical therapy specifically related to managing the patient's wound should be included. Non-contact, non-thermal low-frequency ultrasound and negative pressure wound therapy (standard and disposable) should be included in their appropriate categories.

[**Q151. 5.** Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?]

I feel improved granularity into the risk adjustment calculation is needed in the context of specific patient scenarios to determine whether or not the current model is accurately accounting for patient complexity in this wound population. Social determinants of health (zip code of residence, socioeconomic status, etc.) should be added to the risk profile.

[**Q152. 6.** Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.]

Additional diagnoses for exclusion:

- Necrotizing fasciitis/Fournier's gangrene
- Delayed effects of radiation therapy
- Overall category of auto-immune diseases as this would include vasculitis and scleroderma above as well as additional related diagnoses
- Active cancer treatment due to the documented healing deficits associated with many treatment medications

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

- 318 Falls – Screening for Future Fall Risk
- 126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation (only applies to a subset of non-pressure ulcers)
- 127 Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear (only applies to a subset of non-pressure ulcers)

Additional measures that would be relevant and capture a larger percentage of the overall non-pressure ulcer category would be the following measures from the US Wound Registry (recognized by CMS as a Qualified Clinical Data Registry):

- USWR-35 Offloading of diabetic foot ulcers (DFU's) at every visit
- USWR-32 Compression of venous leg ulcers (VLU's) at every visit
- USWR-30 Arterial assessment of all patients with a lower extremity wound or ulcer
- USWR-22 Nutritional screening of all patients with chronic wounds and ulcers

Of note, many if not all of these USWR measures are strongly recommended and/or required in many Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCD's) related to wound care.

[**Q156. 1.** Was it helpful to have both types of service categories in the report, or was one more informative than the other? Across these tables, which are the most useful service categories for helping you to understand your cost performance and identify potential practice changes? Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)? How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports? Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding your cost performance?]

There needs to be some type of "plain language" interpretation provided for these reports if there is any expectation that clinicians will be able to interpret them in a meaningful way.

[**Q157. 2.** The field test reports (PDF and CSV) contain information about other providers who contribute cost to your measure. How useful are the current metrics in helping review referral patterns and care coordination opportunities which could help lower costs? What other metrics would be useful to encourage care coordination?]

Many other providers contributing costs do not appear to be in any way related to the wound management of the patient. This provider attribution needs to be improved significantly to capture anything close to ACTUAL cost of care.

[**Q162. 5**. What other feedback do you have about the field test reports?]

I have had on-going difficulty accessing my facility's own field test reports and reserve additional comments until I have the ability to review that data.

[**Q167. 7**. How did you find out about field testing? - Selected Choice]

Other (specify) - Member of the Clinician Expert Workgroup

Comment Number 29

- **Date:** 2/1/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Hospice care for ALS

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

End stage of life

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

Symptoms Starting to progress more rapidly now and I am alone and homeless

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Every day simple tasks are more difficult to do

Comment Number 30

- **Date:** 2/2/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Non-Pressure Ulcers

[**Q51. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? Do you feel like your clinicians are taking your concerns seriously? Why or why not? Do you feel your family/caregivers receive appropriate and comprehensive education to aid wound care? Why or why not? Does your care team coordinate with each other about your care? How does that affect your care?]

The only medical team my family member received was in the rehab center. No specialty saw him until I insisted on a licensed physician seeing him. I had no knowledge of non-pressure ulcers while he was in rehab. Therefore, I was not in a position to request a specialty that deals with skin ulcers.

[**Q52. 2.** Medications: Do you have any concerns about adhering to your medication dosage or frequency? How do you and your care team decide which medications you should take? Which clinician(s) oversee(s) your medications? Have you experienced any side effects from your medications? If so, did any require medical care? Have you experienced any difficulty obtaining medications? If so, why?]

This did not apply to my family member as we are at a disadvantage when they are in a long-term facility.

[**Q54. 4.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

The plan change in that a nurse starting an electrical procedure on his feet, and I was not provided information as to what was happening.

[**Q55. 5.** Services: Can you speak to your experience or perspective on redundant services being provided (e.g., getting an imaging service when the patient just had one elsewhere and the facility cannot access the previous one)? Please share any information about the impact of preventive care or follow-ups after wound closure. Has it had an impact on wound recurrence? What durable medical equipment (DME) do you think was the most helpful to improve or maintain your current lifestyle? If you've experience wound care at an inpatient rehabilitation facility and at home, what was the difference in care for these settings (e.g., the resources provided)?]

All care was in the rehab facility.

[**Q56.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

A licensed skin care specialty talked with me about his non-pressure ulcers along with treatment options.

Comment Number 31

- **Date:** 2/2/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter

- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Family practice 3x/yr. Neurologist 2x/yr. PT as needed. PT Works in conjunction with Massage therapist whom I see 2x/month. PT and massage therapist exchange notes and develop plan together. MD and Neuro touch base annually regarding standing orders for labs as well as port maintenance.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Only infusible medications are available cost-wise to me as copays for self administered medications are $2-3K/month. Massage therapy...essential in managing spasticity...is an out of pocket $300/month. Neuro-psych testing was ordered 18 months ago and no one in our area will test persons over 65 without becoming part of a clinical trial in aging site which is an hour drive each way. Online testing is not available.

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

It takes a month or longer to get a PT appointment once discharged from care and Medicare requires discharge once initial goals are met. PT is sometimes essential to manage acute pain episodes related to spasticity or falls and 4-6 weeks of lost sleep and decreased QOL takes a major toll on this 70+ year old body, mind and spirit. A discharge note should contain a plan to resume service without the wait for another intake visit when a chronic condition exists that could flare at any point in time.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Massage therapy is, by far, the most helpful to keep pain and spasticity managed in conjunction with a regular program of stretching and fall prevention exercise (from PT). There are times when PT appointments can be terribly disruptive to a work schedule with 3-4 appointments each week. This would not be necessary if the PT were available when needed and not a month after the pain syndrome surfaces and really takes hold. It takes longer to address and is more resource heavy.

Comment Number 32

- **Date:** 2/2/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Originally monthly in early diagnosis of my sister MS

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Insurance

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

No

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Monthly infusion appears to be helping my sister

Comment Number 33

- **Date:** 2/2/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Neurologist, Internal Medicine, Physical Therapist
Physical Therapist, Internal Medicine, Physiatrist, Occupational Therapist, Psychologist
Somewhat
not clear

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Limited access to physical therapist. Neurologist or Primary care provider is the lead of the care team and who is taking care of the care coordination. Lack of reimbursement for complimentary interventions.

Given that it is a chronic condition, care coordination is very important. Physicians of different disciplines are siloed; a care team formation is lacking unless you are at an academic medical center.

It is the daily life activities that is most important even with certain physical and mental deficits.

Out-of-pocket expenses are high for interventions to improve the quality of life!

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

Usually, it is the neurologist who handles the medication and taking care of the side effects.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Family caregivers are an essential part but there is no support for them. The neurological problem affects the whole family and not just the patient.

Comment Number 34

- **Date:** 2/2/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson’s and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)], Non-Pressure Ulcers

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

All the listed clinicians are part of my care team except internal medicine. Depending on the acuity of the issues we're managing, I see my family doctor, PA, or NP 2-4 times a year, virtual or in person. I see my neurologist twice a year and the cardiologist when needed, not once a year. I've seen my PT 10 times in 14 years. I have a program that I manage myself and go in for a tune-up or when I've deteriorated or fallen.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

I have never been an inpatient. Knock on wood. I live in Boston, and clinicians are coming out of our ears. I develop long-term relationships with my team. When I need them, I'll text the portal and say it's urgent or not. I always get a response within a business day. If I don't, I change the clinician as I did with the urologist. Medicare doesn't cover DME very well. Usually schlock as with the walker. I'm a white man of privilege, and I buy what I need. I pay for massages, acupuncture, and chiropractic out of pocket. They are all critical to me staying out of the hospital. Some meds I need are ridiculously expensive, I'm on Medicare Advantage. They wanted a 20% co-pay for an Ocrevus infusion until I bumped up my plan for an additional $200 a mont (well worth it) and they wanted a $200 a month co-pay for another med, until I was turned on to Mark Cuban's pharmacy where get it for $20 a month out-of-pocket.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

It's hard to pinpoint what helps more than others. It's a package. I do know that massage, acupuncture, chiropractic and PT are all key to functioning, but I need to do the work. I am a networker. I support others and they support me. My whole team supports me.

Comment Number 35

- **Date:** 2/3/2024
- **Submitter Name, Credentials, and Organization:** Diane, Individual
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Non-Pressure Ulcers

[**Q51. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? Do you feel like your clinicians are taking your concerns seriously? Why or why not? Do you feel your family/caregivers receive appropriate and comprehensive education to aid wound care? Why or why not? Does your care team coordinate with each other about your care? How does that affect your care?]

Family Practice. Yes they took it seriously. Yes, I received appropriate wound care. Yes, they coordinate treatment.

[**Q52. 2.** Medications: Do you have any concerns about adhering to your medication dosage or frequency? How do you and your care team decide which medications you should take? Which clinician(s) oversee(s) your medications? Have you experienced any side effects from your medications? If so, did any require medical care? Have you experienced any difficulty obtaining medications? If so, why?]

PCP oversees meds. No problems with this issue.

[**Q53. 3.** Additional Costs: Please share any information about out-of-pocket costs you accrue and its impact on your ability to access care. Do you have any concerns regarding the frequency of home dressing care provided by any caregivers? If so, what are they?]

No additional costs. No concerns

[**Q54. 4.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

No complications

[**Q55. 5.** Services: Can you speak to your experience or perspective on redundant services being provided (e.g., getting an imaging service when the patient just had one elsewhere and the facility cannot access the previous one)? Please share any information about the impact of preventive care or follow-ups after wound closure. Has it had an impact on wound recurrence? What durable medical equipment (DME) do you think was the most helpful to improve or maintain your current lifestyle? If you've experience wound care at an inpatient rehabilitation facility and at home, what was the difference in care for these settings (e.g., the resources provided)?]

No concerns. did receive wound care in both a rehab facility and home health care. Both were excellent.

[**Q56. 6.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

wound care and pain management
I did not experience any problems with my care.

Comment Number 36

- **Date:** 2/4/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

All of the above I see them as needed at least once per year. Family practice, Physical Therapy, Cardiology more frequently.
Physical therapy, internal medicine and cardiology will be most important. They all coordinate through shared medical records.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Treatment for mobility, pain nd renal funcion. Major problems with cost of complementary care not covered by medicare or my supplemental insurance. Medicl pharma limited by pharmcy managers moving meds to higher price categories.

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

None and no to the rest.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Physical therapy is most effective. Internal medicine least because of difficulty in diagnosing and treating dibetes and neurolgy because there is no local ms spcialist avilb;e.

Comment Number 37

- **Date:** 2/7/2024
- **Submitter Name, Credentials, and Organization:** Barbara Burdett, Individual
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson’s and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

I worked as a SSW along with a RN to assess the needs of patients with movement disorders. We set up home and community based services as a team funded with Medicaid and state funding. An annual assessment was conducted to evaluate increased needs. The client visited their medical as needed.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Many questions with little space. Our program was through [Program name redacted]. We focused on long term care at home with community based services. The program was designed to provide care at home instead of institutional care, costing the government far less. L

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

If acute circumstances occurred, the patient was referred to medical care for evaluation and at times hospitalization or long term care.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Home and community based services are far superior to institutional care if the Individual can remain safely at home.

Comment Number 38

- **Date:** 2/7/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Non-Pressure Ulcers

[**Q51. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? Do you feel like your clinicians are taking your concerns seriously? Why or why not? Do you feel your family/caregivers receive appropriate and comprehensive education to aid wound care? Why or why not? Does your care team coordinate with each other about your care? How does that affect your care?]

As I have family with recent leg amputation from ulcers on the foot and bottom leg area, I know depression do not show itself. Energy-related motivation is hulted full blown. Being able to do certain activities that a person does not do as much, instead that is replaced with isolation meaning less community engagement simple as a walk or movement that could have prevented the small sore that turned into ulcers and only going to the ER when in pain. No, I don't think when the doctors are telling us it will get worse and the symptoms are not good meaning the self care not only care givers also the nothing is wrong/everything is fine feelings coming from the patient.

[**Q52. 2.** Medications: Do you have any concerns about adhering to your medication dosage or frequency? How do you and your care team decide which medications you should take? Which clinician(s) oversee(s) your medications? Have you experienced any side effects from your medications? If so, did any require medical care? Have you experienced any difficulty obtaining medications? If so, why?]

Being well aware of what the medication is doing and for remembering the sensitivity of feeling and emotions if the feelings and emotions played the biggest role and were ignored then that role is still present.

[**Q53. 3.** Additional Costs: Please share any information about out-of-pocket costs you accrue and its impact on your ability to access care. Do you have any concerns regarding the frequency of home dressing care provided by any caregivers? If so, what are they?]

Cost of artificial limbs are a far reach and help is needed for low income to no income patients. Rent alone leaves little money for food and much less for energy-related things energy like utilities and energy like discouragement.

[**Q54. 4.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

Covid in an assisted living environment. How?

[**Q55. 5.** Services: Can you speak to your experience or perspective on redundant services being provided (e.g., getting an imaging service when the patient just had one elsewhere and the facility cannot access the previous one)? Please share any information about the impact of preventive care or follow-ups after wound closure. Has it had an impact on wound recurrence? What durable medical equipment (DME) do you think was the most helpful to improve or maintain your current lifestyle? If you’ve experience wound care at an inpatient rehabilitation facility and at home, what was the difference in care for these settings (e.g., the resources provided)?]

At home it is less controlled meaning that my family would be less inclined to being forth coming when it falls back on comfortness and less uncomfortable way of self care and being cared for. In other words a professional nurse we would expect to be checking looking snooping closely and taking appropriate nurse care rather than a family friend making sure he is comfortable and just ok. Ensure good care is questionable.

[**Q56.** 6. Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Someone assisting with low self esteem. Clean and not in pain. It is harder to access things like a soda pop. That is an example of how the change is happening. And now with the amputation it is set in as a new reality.

Comment Number 39

- **Date:** 2/14/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

My primary care, neurologist, physical therapist, psychiatrist and pain management doctors all given me help with my breathing, shoulder and neck pain, muscle spasms and dizziness. They try to give the best quality of care by being in the loop with one another and changing my medication to help with nerve pain and management.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

I don't really understand how my pain is being treated and I tried a few things like getting a hospital bed. Listening to my body when it hurts and knowing how to respond when I can't take anymore pain. The doctors have been really helpful in listening to me concerning my pain. I wanted to know about alternatives for my pain such as chiropractic therapy and acupuncture therapy but my insurance cover for certain parts of my body.

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

After neck surgery in 2022, I have been experiencing meralgia paresthetica in my right thigh all way up to my hip and it is so painful. Now I have to get injections for the pain and that isn't working properly. Now I have a new pain in my thigh and now I have to have shoulder injections because there's no tear in my shoulder so they can't operate.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

I have a wonderful doctor and a wonderful staff but my primary doctor says maybe I won't be healed from the pain because all measures have been almost depleted. And that scares me

Comment Number 40

- **Date:** 2/15/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)], Non-Pressure Ulcers

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Proper diet and stretching routine, not more than 7 hrs of sleep, and walking.No my team tends to get scattered Yes they are bilingual.

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

It's hard to find good Dr on medical but it's gotten better

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Chiropractor and massage and it affects me with age, if Dr considered looking at reports instead of gossip.

Comment Number 41

- **Date:** 2/18/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson’s and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Last year I was with a medical insurance [name redacted] that did not appear to have a care team and did not have a Parkinson's Disease program. Originally was sent by my family doctor to a PA for a frozen shoulder. After receiving a cortisone shot and still having stiffness and discomfort the PA transferred me to a Physical Therapist (PT). I saw the PA twice in 2022. I saw the PT every 2-3 weeks from Oct. 2021 to July 2023 I had PT approx. 21 times until I asked PT to inform my family doctor of the tremors. I saw a neurologist three times :March-Oct. 2023 Had to explain why I needed to see a movement disorder specialist as suggested by all Parkinson's Disease specialist. Was able to see movement disorder doctor. I would have appreciated exercise class, diet consultation. I never received a request from family doctor to see him and neurologist's nurse called me and asked if I didn't believe the neurologist diagnosis of PT. She didn't understand why I requested a movement specialist.
In January I changed to a different insurance plan [name redacted] and have already seen a movement specialist, primary physician. I have appts. with movement specialist, primary, and endocrinologist.
My primary has already prescribed PT for balance which is my primary concern and continued exercise classes fitting my need would be useful. I am hoping there is coordination between doctors with my new insurance.
I believe the new insurance plan has non-English resources. I was happy this insurance provided me with several up-to-date pamphlets.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Previous insurance did not explain any services for PT support. As a member of patient advisor council for first insurance I was aware of post and long term care support.
I have found information for accessing all medical care as I am new with this insurance. I did receive a directory of departments' telephone numbers and locations that I can call with questions.
I don't have DME but will need to know where and who can order if necessary.
On occasion I have needed chiropractic care that I believe is necessary to help patient to get to a point where they can address the medical problems.
Outcomes that help patient to be as independent as possible.
Out-of-pocket costs for physical therapy are a problem for PD (to help with balance) and exercise classes are necessary for balance. A nutrition class is important as well. Staying healthy requires exercising, eating healthy, occupational & physical therapy and support groups with emphasis to Parkinson Disease. I am spending $$200-$250 each month just for exercise and would probably cost another $100-$150 for PT. Since Medicare patients income is limited; there might be a decision on which program to use.
No I haven't experienced difficulty obtaining medications. Several individuals in support group have not been able to purchase new medication because of cost. In support groups we inform each other of prices, best pharmacy to visit, and even how friends have obtained medicines from Canada. It's difficult hearing a when a member says they are running out of funds, must sell their home and hope the money will last.

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

From listening to those at support group, often times the patient does not hear well and may miss instructions or assistance with a problem. PD slows your abilities and memory; instructions and explanations should be in writing and placed in folder for easy access. During support group, elderly members who have hearing loss and sight problems feel they are brushed off by staff. We don't want to admit we didn't hear or understand. Having the information on paper and having staff go thru it a second time is important. Typically takes three times to remember information.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Physical therapy is helping with balance and my fear of falling.
PD organizations typically have support groups offered on various days. Would be helpful if staff reminded patients of these groups.

Comment Number 42

- **Date:** 2/20/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Physical Therapy

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Hospice provided the services we needed

Comment Number 43

- **Date:** 2/22/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Family Practice (once every 6 mo), Neurologist (once every 3 mo), physical therapist (once every week). In the future, I think physical therapist & neurologist will be most helpful. I relay information among the three; it is helpful.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable

Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

No problem with getting non-procedural care, but complementary interventions are hard -- except for physical therapy. None of the expense of a Naturopathic Doctor or supplements (both very helpful) is covered, and it's expensive. My gym class, designated for people with Parkinson's, is not covered, and it's $148/mo.

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Most effective: exercise classes and groups.

Comment Number 44

- **Date:** 2/23/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson’s and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

Family Practice, Neurologist
I am 77 years old and am in need of bathroom, kitchen and entrance upgrades now.
No
I do speak English.

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Little understanding of post-acute or long-term services.

Non-procedural care is ALMOST IMPOSSIBLE to obtain.

Yes, it is hard for me to go to their offices.

Yes, they are TOO EXPENSIVE.

TOO EXPENSIVE.

PHYSICAL THERAPY. I CANNOT AFFORD PT.

$25.00 FOR EVERY SESSION OF PT ADDS UP FAST.

YES, THEY ARE TOO EXPENSIVE.

NO.

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

DOUBLE PNEUMONIA WITH HOSPITALIZATION.
Physical Therapy would have helped, IF I COULD HAVE AFFORDED IT.
NO.PHYSICAL THERAPY, MASSA

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

PHYSICAL THERAPY AND MASSAGE THERAPY.
MASSAGE THERAPY.
I HAD NO FOLLOW UP CARE IN MY HOME AFTER RELEASE FROM HOSPITAL.
I CANNOT GO MANY PLACES AS I DO NOT KNOW HOW FAR I WILL HAVE TO WALK; SO I HAVE TO TAKE MY SCOOTER, WHICHN IS HARD FOR MY HUSBAND TO GET IN AND OUT OF THE CAR, AS HE IS 83 YEARS.
NO.

Comment Number 45

- **Date:** 3/7/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Non-Pressure Ulcers

[**Q51. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? Do you feel like your clinicians are taking your concerns seriously? Why or why not? Do you feel your family/caregivers receive appropriate and comprehensive education to aid wound care? Why or why not? Does your care team coordinate with each other about your care? How does that affect your care?]

Yes one of my family members primary care physician was but not initially. I feel like we as patient and family caregivers had to speak up and out about the detailed services we needed. Then the doctor was accommodating and understood we were knowledgeable about our needs. We should have been believed and partnered with from the beginning,I feel. Definitely the education and wound care instructions shared with all family members, personal care attendants and home health nursing staff made a positive difference in care! Because communication and education was optimal my loved one ‘s wounds healed. Sharing information and having training materials like handouts and brochures helped with at home care. Plus having wound care specialists, occupational therapist and PT’s train daily staff and caregivers helped significantly. Coordination and communication was the keys that impacted positively my Loved Ones care the most.

[**Q52. 2.** Medications: Do you have any concerns about adhering to your medication dosage or frequency? How do you and your care team decide which medications you should take? Which clinician(s) oversee(s) your medications? Have you experienced any side effects from your medications? If so, did any require medical care? Have you experienced any difficulty obtaining medications? If so, why?]

My mother and oldest sibling’s care regarding their medication regimen required good communication between the doctor, nurses and home care aide which required medication logs in a notebook visible and accessible by all staff mainly home health RN and LPNs. Great tool because medication instructions and last time given is recorded and initialed by giving individual. Both Mom and [name redacted] had and has labeled medication carriers that stay in a specific location for safe but easy access. No both have been blessed not to have side effects from medication related to non pressure wound care.

Yes I have learned some medications was not ever offered to my mother and sibling that might have been helpful and I do not know why. Maybe the doctor was not knowledgeable about the medicine or thought we would not be able to afford it or it could be the doctor knew it would be contraindicated because of another complex health diagnosis they had. My mother passed away before I could ask the question and my oldest sister wounds healed.

Pain management and the need for pain relief has always been a challenge but we navigate this barrier as black women by knowing about our diagnoses, keeping pain logs to justify need for treatment and advocating and addressing the need for why the pain medication is essential. Though often it the elephant in the room for Black and Brown people more often than not especially if you live with a Chronic Condition.

[**Q53. 3.** Additional Costs: Please share any information about out-of-pocket costs you accrue and its impact on your ability to access care. Do you have any concerns regarding the frequency of home dressing care provided by any caregivers? If so, what are they?]

Because my mother had substantial assets in her last years of life, it was a struggle every month to face out of pocket costs for medication and services we knew she needed. She was penalized for working hard and acquiring property and a lovely home in her old age. Medicare covered but so much and she did not qualify for Medicaid. We were always dealing with that barrier to care.

We had a good home care team for mom in her final months of life. Therefore wound care and dressing changes worked. Their constant education of all of us family and staff made the difference.

[**Q54. 4.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

Communication and education eliminated complications for our family. We are grateful.

We could have all did better with prepping mother when there was going to be a change in her personal care attendant for whatever reason…sick child or person unable to come to work due to car problems.

Yes we tried to give her names 2 of who would be caring for her and on what date and time, just in case someone had to fill in for someone else.

[**Q55. 5.** Services: Can you speak to your experience or perspective on redundant services being provided (e.g., getting an imaging service when the patient just had one elsewhere and the facility cannot access the previous one)? Please share any information about the impact of preventive care or follow-ups after wound closure. Has it had an impact on wound recurrence? What durable medical equipment (DME) do you think was the most helpful to improve or maintain your current lifestyle? If you've experience wound care at an inpatient rehabilitation facility and at home, what was the difference in care for these settings (e.g., the resources provided)?]

We did not experience redundancy.

Preventative wound care measures were in place therefore we did experience recurrent wounds.

Medical equipment was hospital bed in home, sliding board for transfers, gait belt for walking and circulation splints when wounds healed being placed on and off in a timely manner. When mobility became limited bed positioning, range of motion exercises and healthy nutritional foods. Last few months of life my mother required a hoyer lift. So things got very expensive but needed for her to maintain life and an oxygen was used.

My mother died at home in hospice and we had good care and I am grateful. The care at home was better than the care she received in the rehabilitation center and nursing home long term care facility.

[**Q56.** 6. Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

I am grateful for the home health care and hospice. I really wish the rehabilitation and long term facility care was better. I wish the staff was more knowledgeable and kind not to mention attentive. My mother was ready to leave that place not long after she got there due to these factors at both places. We her children honored her wishes to leave.

Comment Number 46

- **Date:** 3/11/2024
- **Submitter Name, Credentials, and Organization:** Dominique Bolds, Individual
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson's and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)], Non-Pressure Ulcers

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

None

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Yes

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

No

[**Q49. 4.** Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Sometimes

[**Q51. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them?

Do you feel like your clinicians are taking your concerns seriously? Why or why not? Do you feel your family/caregivers receive appropriate and comprehensive education to aid wound care? Why or why not? Does your care team coordinate with each other about your care? How does that affect your care?]

No really

[**Q52. 2.** Medications: Do you have any concerns about adhering to your medication dosage or frequency? How do you and your care team decide which medications you should take? Which clinician(s) oversee(s) your medications? Have you experienced any side effects from your medications? If so, did any require medical care? Have you experienced any difficulty obtaining medications? If so, why?]

Yes

[**Q53. 3.** Additional Costs: Please share any information about out-of-pocket costs you accrue and its impact on your ability to access care. Do you have any concerns regarding the frequency of home dressing care provided by any caregivers? If so, what are they?]

No

[**Q54. 4.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

No

[**Q55. 5.** Services: Can you speak to your experience or perspective on redundant services being provided (e.g., getting an imaging service when the patient just had one elsewhere and the facility cannot access the previous one)? Please share any information about the impact of preventive care or follow-ups after wound closure. Has it had an impact on wound recurrence? What durable medical equipment (DME) do you think was the most helpful to improve or maintain your current lifestyle? If you've experience wound care at an inpatient rehabilitation facility and at home, what was the difference in care for these settings (e.g., the resources provided)?]

Never been treated but have been seen and evaluated

[**Q56.** 6. Value of Care: What treatment or services are the most effective in helping you feel better? Which of these were least effective? What aspects of your care experience could have been improved? How is your current treatment affecting your current lifestyle? Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

No

Comment Number 47

- **Date:** 3/13/2024
- **Submitter Name, Credentials, and Organization:** Individual Commenter
- **Comment Text:**

[**Q44. 2.** Which measure(s) will you be providing feedback for?]

Movement Disorders [i.e., Parkinson’s and Related Disorders, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)]

[**Q46. 1.** Care Team: What types of clinicians and non-clinicians are part of your care team? If the following types of clinicians were part of your care team, when and how often would you see them? If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle? Does your care team coordinate with each other about your care? How does that affect your care? Does your care team have resources for non-English speakers?]

PCP
Nurse Practitioner
Neurologist
Physical Therapist
Physician Assistant
Cardiologist

Care coordination was mostly done by family. The PA was the one who primarily was in charge of the Parkinson's treatment after the first neurologist retired. the second neurologist became ill and the clinic never really found us another one. Physical therapy would have been more beneficial in the beginning of the diagnosis or an exercise physiologist because we could have learned beneficial exercise earlier. Speech therapy and occupational therapy could have been started earlier so we could have learned adaptive techniques and types of clothing. Home health care services would have been most helpful to learn what type of home reduces fall risks and modifcations in the bathroom. All of this stuff was left up to family to figure out

[**Q47. 2**. Access to Care and Treatment: What is your current understanding on post-acute care services and long-term services and support? What is your experience in accessing non-procedural medical care? Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)? Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare? What were the barriers, if any, to complimentary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complimentary interventions are services that are usually not a part of standard care and may not be covered by Medicare. What treatment outcomes matter most to you and your caregivers? Please share any information about out-of-pocket costs you accrue (e.g., complimentary interventions) and their impact on your access to quality care. Have you experienced any difficulty obtaining medications? If so, why? Have you experienced any difficulty being referred to additional clinicians? If so, why?]

Trying to obtain Parkinson's medication in hospitals and skilled nursing facilities was a nightmare. We had to supply meds until they could get them from a pharmacy. One hospital never got it on the formulary so we had to do it. The DME should be covered by Medicare as needed, not every 5 years. These items get worn out and break after repetitive use. Home health care services were terrible because lack of part-time employees and lack of training with parkinson's and fall risk patients.

[**Q48. 3.** Complications: What complications or side effects have you experienced? Which one(s) required medical care? What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications? Did your care plan change after you experienced these complications?]

the Deep brain stimulator could have been replaced earlier before infection set in and before my mom got to old to get a new one. Her life probably could have been extended.

Comment Number 48

- **Date:** 2/26/2024
- **Submitter Name, Credentials, and Organization:** Brian G. Loder, Individual
- **Comment Text:**

Thank you for providing my performance report on Non-Pressure Ulcer measure field testing. After reviewing the data, I believe my data is skewed based on the complexity of wounds I see in the place of service Hospital Outpatient (2). The cases tha t are seen there aremore complexand have already failed care by other physicians in my comparisongroup. I believein order to properly perform a fieldreview on non-pressureulcers for our TIN, comparatives would need to be made to other providers billing services in a Hospital Outpatient Wound Care Center.

Sincerely,
Brian G. Loder DPM

Comment Number 49

- **Date:** 2/28/2024
- **Submitter Name, Credentials, and Organization:** Rachel Groman, MPH, American Association of Neurological Surgeons and the Congress of Neurological Surgeons
- **Comment Text:**

To whom it may concern:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we appreciate the opportunity to provide feedback on the episode-based cost measure currently being field tested titled, “Movement Disorders: Parkinson’s and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS).”

The AANS and the CNS appreciate the iterative and collaborative process that Acumen and the Centers for Medicare & Medicaid Services (CMS) have undertaken to develop these measures. One of our members, Jason Schwalb, MD, a stereotactic and functional neurosurgeon specializing in surgery for neurological disorders that impact movement, serves on the measure development workgroup and actively participates in the workgroup discussions. After consulting with Dr. Schwalb, other neurosurgeons who treat these same disorders, and a member who has served on earlier Acumen cost measure development workgroups, we assembled the feedback below in response to Acumen’s survey questions. Above all, the Movement Disorders cost measure should accurately reflect the role and value of neurosurgeons. It should not create real, or even perceived, disincentivizes that discourage neurologists and other clinicians from referring patients with disabling conditions for effective neurosurgical procedures that are evidence-based and considered standard of care.

These procedures can dramatically improve quality of life over non-surgical management. In many cases they are actually more cost-effective over the long term, especially when accounting for improvements in patient independence.

General Comments/Concerns

- An ongoing concern since the initiation of this project is the failure of these measures to evaluate cost in the context of quality. If quality considerations are not directly factored into measurements of cost, then cost measures could have the unintended consequence of disincentivizing appropriate care that is evidence-based and accounts for patient preferences. The AANS and the CNS continue to strongly urge Acumen and CMS to work with clinical experts to build algorithms and/or incorporate clinical data sources, such as registry data, so that performance measures simultaneously evaluate both cost and quality and assess how variations in cost impact the quality and appropriateness of care.

- While the AANS and the CNS appreciate CMS and Acumen's efforts to improve cost performance feedback reports over the years, they are still extremely confusing — even to clinicians who serve on the measure development workgroup. If a clinical expert who spent countless hours on webinars discussing the intent, methodology and specifications of this measure is overwhelmed by and cannot make sense of the information presented, then there is little chance that other recipients will know what to do with the data in these reports. The feedback reports could benefit from more detailed explanations and additional pop-up boxes describing what each table and data point is trying to convey, why a clinician should care about this information, and what the clinician can do with this information to improve patient care. We also strongly recommend that Acumen add dummy data to the mock reports and accompanying spreadsheets. Without dummy data, these documents are of little value. We suggest that Acumen pick a representative real-life clinician's report — perhaps one with near-median performance — and present those data in an anonymized way.

Specific Comments/Concerns

1) Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).

   The triggers identify any patient seen as an outpatient, including via telemedicine. However, the fact that only eight neurosurgeons met the criteria for being considered during the pilot analysis throws the process into question. We estimate that only about 100-150 neurosurgeons perform more than 20 surgeries for the Parkinson's Disease patient cohort. At least two of these neurosurgeons, who perform more than 50 surgeries a year, did not meet the case minimum of attributed patients to qualify for a field test report, which seems to align with the intent of the measure as specified by the workgroup. This makes us wonder about the characteristics of the 5% or so of neurosurgeons that were, in fact, captured by this measure. We would appreciate it if Acumen could provide us with more detailed information about the characteristics of this small cohort of neurosurgeons, including an explanation of what makes these particular subspecialists methodologically unique compared to their peers. The fact that this measure currently captures only a fraction of the neurosurgeons performing surgeries on these patients raises the question of whether it is even appropriate to include neurosurgeons as a potentially attributable specialty.

The AANS and the CNS request that Acumen remove surgical attribution entirely from the measure to improve the results' accuracy. If the numbers are already so small, then including surgeons as an attributable clinician type will not reflect anything of value. At the very least, Acumen must refine the subgrouping and risk adjustment approach, as described below, to minimize any negative incentives for surgical referrals.

2) Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.

Episodes should not be attributed to non-prescribing clinicians. If the goal of MIPS is to control costs and ensure quality, it does not make sense to attribute episodes to a group with no control over either. At the same time, PT/OT and speech therapy services should be accounted for in the analysis of costs and quality to determine if they are of added value in appropriate subpopulations attributed to managing clinicians.

3) Are there any conditions that should or should not be considered for inclusion in the group of those in the Movement Disorders measure? For example, are there additional degenerative diseases that could activate similar services to Parkinson’s and fit the measure’s intent?

G23 includes Pantothenate Kinase-Associated Neurodegeneration (PKAN), Progressive Supranuclear Palsy (PSP), Multiple System Atrophy (MSA), Fahr’s Syndrome, Shy-Drager Disease, and other basal ganglia abnormalities should not be included in this measure. These are heterogeneous and tend to have quite poor prognoses, leading to high costs. If Acumen excludes Huntington’s Disease due to a small sample size and heterogeneity, it should exclude these far rarer conditions.

4) Clinician Expert Workgroup members provided feedback that the current measure name, “Movement Disorders,” isn’t reflective of the conditions currently included (Parkinson’s and Related Disorders, MS, and ALS) in the measure. The Clinician Expert Workgroup recommended changing the name to “Progressive Neurological Disorders Affecting Movement” to better encompass the conditions included in the measure. Does the new proposed name appropriately account for Parkinson’s and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?

The AANS and the CNS believe that the proposed name is an improvement over “Movement Disorders” since no neurologist or neurosurgeon would consider ALS or MS a movement disorder (nor does ICD-10). However, the problem with “Progressive Neurologic Disorders Affecting Movement” is that it is too broad and all-encompassing and suggests that the measure captures conditions like spinal muscular atrophy, hereditary ataxias and dystonia, among others. Instead, we recommend titling the measure “Parkinson's Disease, Multiple Sclerosis and Amyotrophic Lateral Sclerosis.”

5) Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?

- Decompression of peripheral nerve is not relevant to these conditions.
- “Other or therapeutic nervous system procedure” is so vague as to be meaningless.
- The inclusion of DRG 23 and 25 is problematic since this could be used for implantation of a deep brain stimulator, which should be encouraged in appropriate patients, or a craniotomy

for a subdural hematoma from a fall, which is bad and could be the result of poor outpatient management (assuming the patient is compliant with recommendations). There does not seem to be a way to account for this.

- Including deep brain stimulation (DBS) as a cost in a shared payment model will disincentivize utilization of the standard of care for many patients. We recommend the exclusion of neurosurgical care in this population.

6) Are there any changes that should be made to the current risk adjustors, such as to add or remove variables? Are there measure-specific variables that should have their specifications updated?

As noted earlier, more accurate subgrouping and risk adjustments would help to address our concerns about this measure creating disincentives for surgical referrals. Most importantly, we believe that it is critical that episodes captured by this measure are further stratified by surgical and non-surgical care. Sub-grouping in this manner will result in more accurate and meaningful clinical comparisons by ensuring that the measure fairly compares clinicians with a similar case mix. We also recommend that CMS include a short description at the top of the score reports clarifying that this is a cost measure examining the performance of surgical and non-surgical management independently so that anyone reviewing the report knows that this large cost driver has been considered. Other comments related to subgrouping and risk adjustment are listed below:

- We are concerned about Acumen’s standard use of Hierarchical Condition Category (HCC) codes as risk adjusters without carefully considering the clinical circumstances. HCC was developed for the Medicare Advantage program. It is not a robust model for that purpose, let alone this exercise. We would argue that some items listed as risk adjusters would be more appropriately accounted for using subgroups, regardless of the underlying diagnosis. For example, quadriplegia and paraplegia (HCC 70 and 71) should be subgroups instead of risk adjustors. Quadriplegia and paraplegia are common concerns for ALS patients, but not Parkinson's Disease patients. A Parkinson's Disease patient with quadriplegia has something else more pressing going on and would not be clinically relevant to the rest of the patient population.

  Another example is Spinal Cord Disorders/Injuries (HCC72), which is included as a risk adjuster despite ALS being a type of spinal cord disorder. At the same time, spinal cord injury patients should be excluded from this measure. Similarly, HCC73 is itself ALS, so this measure is risk adjusting for one of the conditions it is measuring.

  Listed below are the HCCs that we have concerns within the context of a measure that attempts to evaluate numerous different neurological disorders simultaneously:
  - HCC70: Quadriplegia
  - HCC71: Paraplegia
  - HCC72: Spinal Cord Disorders/Injuries
  - HCC73: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
  - HCC74: Cerebral Palsy
  - HCC75: Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
  - HCC76: Muscular Dystrophy
  - HCC77: Multiple Sclerosis
  - HCC78: Parkinson's and Huntington's Diseases
  - HCC79: Seizure Disorders and Convulsions
  - HCC80: Coma, Brain Compression/Anoxic Damage
  - HCC99: Intracranial Hemorrhage

  - HCC100: Ischemic or Unspecified Stroke
  - HCC103: Hemiplegia/Hemiparesis
  - HCC166: Severe Head Injury
  - HCC173: Traumatic Amputations and Complications
  - HCC189: Amputation Status, Lower Limb/Amputation Complications
  - HCC77: Multiple Sclerosis

- Patients undergoing DBS or pump placement in the episode should be sub-grouped, or at a minimum, the occurrence of each should be a risk adjuster. Their short-term costs are inherently higher. Again, this measure should not disincentivize surgical treatments that are the standard of care for appropriate patients.

- For patients with ALS or MS, there should be risk adjustment for the pre-existing presence of an implanted intrathecal pump and recent complications related to the pump.

- Past DBS: The lookback window for this is only four months, which means a patient could have had a long-standing DBS implant that is doing fine and does not meet criteria for this risk adjuster. The ICD-10 codes that Acumen is looking for to make this determination are:

  - T85110: Breakdown (mechanical) of implanted electronic neurostimulator of brain electrode (lead)
  - T85120: Displacement of implanted electronic neurostimulator of brain electrode (lead)
  - T85190: Other mechanical complication of implanted electronic neurostimulator of brain electrode (lead)
  - T85731: Infection and inflammatory reaction due to implanted electronic neurostimulator of brain, electrode (lead)
  - Z4542: Encounter for adjustment and management of neurostimulator
  - Z9682: Presence of neurostimulator

- This risk adjuster would be better titled "history of DBS with recent complication" since one of these codes would have to be listed no earlier than four months before the episode starts. We recommend that Acumen use two separate adjusters: 1) history of DBS without recent complication and 2) history of DBS with complication.

- There is no accounting for patients with long-standing implants who are doing well. Many patients may have programming every 6 to 12 months and not be captured in the four-month lookback window but then be captured during the year of the measure. There are also maintenance costs for patients with DBS who are doing well that need to be accounted for in this model.

- Z45.42 and Z96.82 are not specific for DBS and include spinal cord and peripheral nerve stimulators. There needs to be specificity to ensure that spinal cord stimulator (SCS) and peripheral nerve stimulator (PNS) implants are not part of the risk adjustment.

- 4% of patients with MS have facial pain, which may be treated with stereotactic radiosurgery and rhizotomy and, in rare cases, with craniotomy and microvascular decompression. These codes should also be included in risk adjustment. Neurologists in participating TINs should not be discouraged from referring patients with pain to appropriate care to reduce suffering.

7) Should any patient cohorts be considered for exclusion from the measure? How might such patients be identified using Medicare claims data?

The AANS and the CNS believe that neurosurgical treatments should be excluded if patients undergoing surgical treatment for these conditions cannot be adequately represented, if quality related to these procedures cannot be adequately measured, and if clinicians will be economically disincentivized from referring patients for appropriate procedures that could improve quality of life and long-term costs that are accrued over greater than a one-year episode.

8) Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are there other indicators of quality that are not currently captured in a MIPS quality measure?

The most relevant measures of the value of care for these conditions are:
- Maintaining independence;
- Reducing falls;
- Aspiration pneumonia, pressure ulcers, and subsequent complications (sepsis, intubation, etc.);
- Reducing non-elective hospital admissions; and
- Prolonging life with a good quality of life.

Other than the two existing MIPS measures evaluating falls, no MIPS quality measures currently assess these factors within this patient population.

Conclusion

The AANS and the CNS thank Acumen and CMS for the opportunity to participate in this process and for considering its ongoing feedback. We look forward to continuing to work with the Agency as it continues to refine this measure and the feedback reports associated with it. We would be happy to schedule a meeting with you to discuss these concerns and more appropriate ways to approach cost measurement in the future. Please do not hesitate to contact us if you have any questions or need additional information.

Sincerely,

Anthony L. Asher, MD, President	Alexander A. Khalessi, MD, President
American Association of Neurological Surgeons	Congress of Neurological Surgeons

cc: Michelle Schreiber, MD, Director, Quality Measurement and Value-based Incentives Group, CMS

Staff Contact:
Rachel Groman, MPH
[Contact information redacted]

Comment Number 50

- **Date:** 3/14/2024
- **Submitter Name, Credentials, and Organization:** Dyane Tower, DPM, MPH, MS, CAE, American Podiatric Medical Association
- **Comment Text:**

Dear Acumen, LLC, and Members of the Non-Pressure Ulcers Episode-Based Cost Measure Clinician Expert Workgroup:

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 input on the draft specifications for the Non-Pressure Ulcers episode-based cost measure currently under development. APMA is also a clinical association member of the Alliance of Wound Care Stakeholders. Given our clinical focus, we hope our feedback will inform refinements to the measure before it is considered for potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS).

While APMA strongly supports the development of an episode-based cost measure for non-pressure ulcers, we cannot support the measure in its current form. Despite having representation on the workgroup that developed this measure, we still have many questions and concerns about its construct and the manner in which feedback is presented, which are outlined below. As such, we request a meeting with Acumen staff and CMS representatives to walk us through these questions and to share specific examples of member feedback reports that include confusing information.

APMA provides the following feedback for consideration:

<u>Feedback based on Questions for Field Testing Measure Specifications:</u>

1. *Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).*

From the information provided, APMA believes the trigger codes, at this stage, appear to appropriately identify a patient cohort that reflects the measure's intent.

2. *How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?*

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 those between different specialties.

In an Episode-Level CSV File, one of the attributed patients (episodes) listed does not list an attributed clinician (under the "attr_clin" tab). To confirm, does this mean that although the TIN billed the trigger event (trigger and confirming claims), no single clinician in the TIN billed at least 30% of the trigger or confirming codes on Part B Physician/Supplier claim lines during the episode and as such, there is no individual-level accountability?

For this same episode, which was an Arterial Type Ulcer, the CSV File lists three (3) clinicians within the TIN providing services (i.e., "num_w_rend") and one (1) clinician from outside the TIN that rendered care during the episode (i.e., "num_o_rend). As far as we can tell, this file does not identify the three (3) clinicians in the TIN rendering services or to what extent they contributed to the total costs of the episode (vs. non-attributed clinicians). It would be helpful if Acumen could include that information in these files.

Further, in the column listing non-attributed clinicians who contributed the most to the episode ("non_attr_npi"), two (2) non-surgeon clinicians who are members of the attributed TIN are listed as the top two (2) non-attributed contributors to the cost of the episode. One (1) clinician, who is not part of the TIN and who is a vascular surgeon (as attained through the TIN's administrator), is listed as the third top contributor. The breakdown of costs related to this episode also shows the following:

- Part B costs contributed 4% to the total observed cost of the episode
- Inpatient Surgical costs contributed 96% to the total cost of the episode

Based on the limited information presented, it seems like the vascular surgeon, who is not even part of the attributed TIN, is contributing a significant portion of the episode's total costs (96%), while the clinicians in the TIN are presumably contributing a very small fraction of the total costs (4%). However, the vascular surgeon is listed third on the list of non-attributed contributors. If this is accurate, it does not seem appropriate to assign this TIN with responsibility over the costs of this episode. We would appreciate if Acumen could clarify whether the measure is working as intended based on the above example.

APMA would be happy to share additional examples from actual Field Testing Reports related to 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 where 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.

APMA would also like to share that based on actual Field Testing Reports, members of the TIN being attributed the cost measure have not met or worked specifically with providers listed in their report or Excel files. Clinicians are being attributed costs that they have limited to no influence over. 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.

Like other chronic care episode-based cost measures, APMA requests consideration be given to an additional check during the attribution process and that this check be applied to the TIN level as well as the TIN-NPI level to ensure the clinicians with reasonable influence are being identified for attribution. Additional discussion would need to take place to determine what an appropriate check would be. In review of Field Testing Reports, it has become clear that something is not right with the measure as currently specified. It is unclear if it is something in the trigger/confirming codes, service assignment, attribution, or the lack of an additional check to make sure the clinician being attributed the cost measure is someone able to reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient.

3. *Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?*

On the surface, it seems as though 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. However, while ulcer type seems reasonable on the surface, we are not convinced that it is the right or only indicator of heterogeneity.

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 non-pressure ulcer that triggered attribution, but for the costs associated with any/all of the non-pressure ulcers presenting during the episode window. And, potentially for other pressure ulcers since the debridement codes are used for certain square centimeters of debridement and not number of ulcers being debrided. In the previous example, if the second ulcer to appear is diagnosed as an arterial or venous ulcer, does the episode switch to a “multiple ulcer type” episode mid-episode? Or, would a new episode for the same patient need to be triggered according to the measure specifications as an arterial or venous ulcer separate of the already triggered diabetic ulcer type episode window? APMA requests that significant consideration be given to these real- world scenarios as discussions related to measure development and refinement continue.

If ulcer type is decided to be the approach to manage heterogeneity, APMA requests that the example scenario below be considered in the approach to sub-grouping:

- A clinician uses L97422: Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed and accompanies that ulcer code with an ICD-10 code for diabetes, e.g. E11.621.
    - In review of actual Field Test Reports, we believe ulcers are being mis-sub grouped based on the scenario above with L97 codes leading to subgrouping into “non- specific ulcer type.”
    - In looking back at specific patients within reports, we found that many of the episodes labeled “non-specific ulcer type” were in fact, diabetic or arterial in nature. Patients had diabetes or arterial disease as a diagnosis, but not the first diagnosis. APMA requests that coding of non-pressure ulcers be part of a future meeting so this topic can be explored. It is imperative that non-pressure ulcers be grouped like- with-like to make reasonable comparisons.

4. *Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.*

APMA needs additional clarification to answer this question. In the Service_Assignment_AB tab of the measure specifications, we’ll use Initial Sort Order #2521 to illustrate the question. For this service, Varicose Vein Stripping, Lower Limb, the service assignment decision is “Sometimes assign, depending on diagnosis.” The row then goes on to make mention of I70; Atherosclerosis; “Assign depending on 5-digit diagnosis;” I70631; Atherosclerosis Of Nonbiological Bypass Graft(S) Of The Right Leg With Ulceration Of Thigh; and, “Yes, assign for all services with diagnosis. When this row says “…depending on diagnosis” in column H, the service assignment decision, is that diagnosis the non-pressure ulcer diagnosis or the diagnosis listed in column Q? Can you explain whether columns

H and P are referring to the same “diagnosis?” In general, APMA requests that more guidance and clarity be provided on how to read and interpret the measure specifications and reports.

APMA requests consideration be given to the removal of “joint injections” and “speech and language pathology therapy.” These services would not be clinically related to a non-pressure ulcer.

APMA notes that post-acute care services are listed in the service categories. On the Service_Assignment_AB tab of the measure specification file, are there any skilled nursing facility, inpatient rehab, or long-term care hospital details? It appears many of the other service categories, such as ED, HH, IP Medical, IP Surgical, etc. are listed in column B. Are/will details be available for the other service categories?

APMA also asks how we are to interpret the Service_Assignment_D details when the High Level Code Description reads “No NDC description available.”

5. *Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?*

Yes. APMA appreciates that testing and risk-adjustment aims to navigate the tension between ensuring fairness for clinicians treating higher caseloads of vulnerable patients and the possibility of masking poor performance and perpetuating disparity if clinicians are held to different standards. APMA would like to see more analysis related to social risk factors.

APMA also asks that Acumen share information on how/why certain variables are selected for “Interaction” and how those should be interpreted.

APMA would like to hear Acumen’s feedback regarding the effectiveness of risk adjustment for certain populations. For example, how do you know risk adjustment for a certain population is sufficient (i.e., patients on dialysis, patients with peripheral artery disease)?

Additionally, as we note below in the section regarding feedback based on the reports, we ask that detailed information be provided related to the risk scores and risk brackets. APMA requests that information on how the patient risk scores are calculated be shared and that the average and range of patient risk scores be provided to the Clinician Expert Workgroup as well as to TINs and TIN-NPIs in their reports.

6. *Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.*

Yes. APMA believes that consideration for exclusion should be given to the following additional conditions:

a. Sjögren’s syndrome is a chronic autoimmune disease that is commonly manifested by immune attack on the exocrine glands with resultant dry eyes and dry mouth. Sjögren’s syndrome patients also have disease in other organs. One of the most common extraglandular manifestations is vasculitis. Skin vasculitis, with palpable purpura clinically and leukocytoclastic vasculitis on pathological examination, is common.1 We believe patients with Sjögren’s syndrome should be excluded, for the same clinical reasons as patients with vasculitis are excluded.
b. Calcinosis cutis is a condition in which calcium salts are deposited in the skin and subcutaneous tissue. It is classified into five main types: dystrophic, metastatic, idiopathic,

iatrogenic, and calciphylaxis. Dystrophic calcification is the most common cause of calcinosis cutis and is associated with normal laboratory values of calcium and phosphorus. There is an underlying disease, systemic sclerosis, dermatomyositis, mixed connective tissue disease, or lupus, that induces tissue damage and creates a nidus for calcification.2 Although a distinct clinical syndrome, it shares many characteristics with calciphylaxis, which is already excluded.

c. Radiation therapy can result in compromised wound healing through the complex interaction of cytokines and growth factors. Disruption of wound healing phases through radiation can lead to skin atrophy, soft tissue fibrosis, desquamation, and epithelial ulceration.3 The alteration of the wound healing process in irradiated skin should be considered for exclusion from this cost measure.

d. Systemic Lupus Erythematosus (SLE) is an autoimmune disease. Autoimmune diseases, such as SLE deteriorate the physiologic wound healing process.4 The inflammatory status in the setting of autoimmune diseases may affect angiogenesis and new tissue formation, resulting in prolonged healing and failure of skin grafts.5

e. Animal bites, human bites, puncture wounds, burns, and gunshot wounds should be considered for exclusion due to the unique nature of the mechanism of action of the injury.

7. *Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?*

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. APMA, as expressed to CMS previously and through other avenues, remains concerned regarding the lack of meaningful measures for podiatrists, including a lack of meaningful quality measures to link with the proposed non-pressure ulcer episode-based cost measure. APMA would like to hear what quality measures Acumen/CMS considered with the non-pressure ulcers episode-based cost measure.

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)

The above MIPS CQMs are not directly related to non-pressure ulcers but could be considered relevant to the cost measure in a preventive care sense; however, these measures may not be available in the near future of MIPS Performance Years as a result of their topped-out status. APMA seeks clarity on if/how such preventive-focused measures may/may not align with the cost measure, especially since not all patients eligible for an episode have diabetes. Thus, the above MIPS CQMs will not provide a true assessment of the value of care provided to all patients with non-pressure ulcers.

It is likely that meaningful measures to evaluate the quality of non-pressure ulcer care have not yet been developed. APMA strongly encourages CMS to work with stakeholders to develop meaningful measures in alignment with the cost measure.

We have identified qualified clinical data registry (QCDR) measures that could be evaluated for alignment. Namely the following QCDR measures from the US Wound Registry:

- USWR 35: Off-loading of DFUs at every visit
- USWR 32: Compression of VLUs at every visit
- USWR 30: Arterial assessment of all patients with a lower extremity wound or ulcer

- USWR 22: Nutritional screening of all patients with chronic wounds and ulcers
- 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)

APMA would like to highlight the current barriers related to quality measure uptake by electronic health records (EHR). The above QCDR measures, while potentially in alignment with the non-pressure ulcers episode-based cost measure, are not currently available widely due to lack of EHR interest in adding these measures to their platforms. There will need to be discussion related to the availability/accessibility of any quality measure that is associated with such an episode- based cost measure.

APMA representatives serving on the Clinician Expert Workgroup appreciate and look forward to an opportunity to review feedback on the quality measures through a lens of quality alignment and suggest relevant refinements to the non-pressure ulcers episode-based cost measure specifications. As this work proceeds, it is critical to ensure that any quality measure tied to this cost measure is evaluating the same patient population and same set of clinical circumstances to arrive at the most accurate assessment of overall value.

Feedback Related to the Presentation of the Field Test Report Materials

APMA reviewed the Field Test Reports, especially through the lens of whether the information presented would help clinicians identify actionable improvements to patient care and cost efficiency and whether the field testing materials present the information in a way that explains the measure.

1. In general, while field testing aims to ensure that clinicians will understand the episode-based cost measure and what actions they could take to improve their performance on the measures, we do not believe this information is digestible for our practicing clinician members**.** Despite APMA's effort to educate its members about this feedback opportunity, very few, if any, were able to devote the time to this exercise. The amount of documentation explaining the measure methodology and specifications is voluminous and not easily interpretable. The feedback reports themselves are still very confusing, leaving readers wondering what exactly each table and data point are trying to communicate and what a clinician should do with this information to improve care (more specific examples are provided below). Even the instructions associated with accessing the feedback reports are cumbersome, which frankly scares clinicians away from engaging in this process. Our members, many of whom are in small, independent practices, are already facing significant burdens associated with MIPS compliance, so any initiative to collect public feedback on measures under development should be as user-friendly and intuitive as possible. APMA is concerned that busy practicing clinicians do not have the time or cost measure-specific knowledge to review their reports in a meaningful way. Our clinician-members are already overly burdened administratively, including with their participation in the MIPS program. Additionally, holding the field testing process during an already challenging window of time (February 2024) made engagement with our members regarding this process extremely challenging. During this time, clinicians are already tasked with submitting MIPS performance data for the 2023 PY and likely still preparing for their 2024 MIPS PY participation because CMS releases MIPS resources extremely late in the year. Even with our own efforts at APMA to educate/inform our members of the field testing process, many were/are overly burdened and disenfranchised by the MIPS program and did not participate because they were already overwhelmed with activities related to MIPS compliance.
2. Page 2 of the PDF report indicates that the measure assesses "…specialty-adjusted cost." Can you explain how the measure is specialty-adjusted? It also indicates that "…the measure adjusts for cost variation across specialties and across TINs with varying specialty compositions." Can you

explain how this adjustment works and how we are to interpret the results of this adjustment? The Draft Cost Measure Methodology PDF was not explicit.

3. Page 2 of the PDF report also indicates that “This chronic condition measure includes the costs of services that are *clinically related to the* *attributed clinician’s role* *in managing care* during a Non-Pressure Ulcers episode.” In review of the current reports, it seems as though the measure includes the costs that are *clinically related to the condition being treated, namely non-pressure ulcers* as opposed to “…the *attributed clinician’s role* in managing care during a Non-Pressure Ulcers episode.” Examples throughout this letter demonstrate that costs are being attributed to the clinician simply because they are clinically related to the condition being treated. An assumption is being made that by billing the trigger and confirming code, that the attributed clinician is managing all the care associated with the non-pressure ulcer and that they have reasonable influence over the frequency, intensity, or occurrence of the clinically related services provided to a non- pressure ulcer patient. Those assumptions are not always true. How can those instances be accounted for?

4. Page 2 of the PDF report says that the score is “…adjusted for your group’s specialty composition.” Can you explain what that means/what impact it has on the score? What impact does the specialty composition have on the risk bracket?

5. Page 3 of the PDF report includes a detailed description for Figure 1 that is currently in the yellow notes box when you hover over the image. We recommend that text be included in the full text of the PDF.

6. Page 5 of the PDF report discusses the risk bracket. Is the risk score for each episode the same as the risk score in column H of the Excel file? We believe there is utility in sharing the TIN or TIN-NPI’s average patient risk score and the overall range of patient risk scores and a figure/histogram so a TIN or TIN-NPI can fully appreciate where they are in relation to other clinicians. We request that the report present additional risk score information, including the average risk score for the TIN or TIN-NPI and the range of patient risk scores for all clinicians attributed the cost measure.

7. Page 5 of the PDF report discusses the BETOS Classification System for grouping Part B service codes into clinically meaningful categories. In going to the website provided in the footnote, information on how these codes are categorized was not readily apparent. Is there additional information on how these service codes are categorized? We believe this may answer some of the questions below, such as what is a “skin procedure,” but request confirmation and clarification from Acumen.

8. Table 3 of the PDF report:
    a. Why is the hospital inpatient service related to amputations specific to “Amputations for Circulatory System Disorders.” Are other reasons for amputations not considered?
    b. What is considered a Major Procedure?
    c. What is an Ambulatory/Minor Procedure?
    d. What is the definition of Skin Procedures?
    e. We recommend removal of Joint Injections.
    f. We recommend removal of Speech and Language Pathology Therapy.
    g. Is MRI being included in the measure?
    h. Which category includes skin substitutes/cellular-based tissue products?
    i. Why do the national averages in the table differ between reports? In seeing several actual reports, the national averages are reported as different numbers.

9. Page 8 of the PDF report shows the top clinicians within the TIN and outside the TIN contributing to the Part B costs. We see in a Field Test Report that there are individuals listed in both columns of the table when several of these individuals only provide care under the one TIN. They should not be listed as an NPI outside the TIN. Can you explain how/why this may be happening?

10. Page 9 of the PDF report shares the risk-adjusted costs. How should a clinician be interpreting their cost measure scores and Figure 1 histogram and their risk-adjusted costs and Figure 2 histogram? What is the actionable difference between a provider-level score and an episode-level cost?

11. Page 9 of the PDF report includes a detailed description for Figure 2 that is currently in the yellow notes box when you hover over the image. We recommend that text be included in the full text of the PDF.
12. In the Excel file, Column W, Non-Attributed NPI, is defined as "The names of the top 3 non-attributed clinicians that contributed the most to the cost for this episode. The names are listed in order from the clinician who contributed the most to least cost among the top 3." Based on an actual report that we reviewed, APMA has concerns about the information in this column. There are instances where the same name, thus NPI, is listed multiple times in the same cell, instances of entities/LLCs with NPIs (not clinicians/individuals) being listed, and instances when NPIs were listed in an order that does not appear to be from "most to least cost." We ask that the details of the data populating this column be evaluated further for accuracy.
13. In the Excel file, Column W, Non-Attributed NPI, there appear to be LLC and other business entities listed. We request confirmation/clarification regarding these entities and them being listed as top cost non-attributed NPIs.

Additional Feedback

Reasonable Influence

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 the measure while only 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.

In the Field Test Reports, there were also instances in Table 4 where the same providers are listed on both sides of the table, those being "NPIs Within Your TIN" and "NPIs Outside Your TIN" when the NPIs within the TIN only provide services under that one TIN. APMA requests that additional validation of these data points be explored. APMA would be happy to provide Acumen with an example of this inaccuracy.

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. For example, 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" and would appreciate a direct response from Acumen explaining the rationale for these decisions or actions that Acumen plans to take mitigate these concerns.

Specialty Groups List

APMA requests additional information regarding the list of specialty groups listed on page 18 of the Draft Cost Measure Methodology PDF, footnote 28. What is the purpose of this list of specialty groups and why were these specific specialty groups included and others not?

Sub-grouping

APMA is concerned that coding may not properly identify an ulcer for sub-grouping. As shared above, APMA has concerns that with the example using an L97 code and a secondary code indicating the patient has diabetes, e.g. E11.621 is not capturing the appropriate sub-group. This ulcer should be sub-grouped with other “diabetic ulcer type” ulcers. Most diabetic foot ulcers, arterial ulcers, and venous leg ulcers require multiple ICD-10 codes to appropriately represent the ulcer, using one code to represent the underlying cause and then another additional code to identify severity/depth of the ulcer.

An additional example: A clinician uses L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed, and also uses a second code for diabetes, e.g. E11.621. Will this ulcer remain in the non-specific ulcer subgroup, or will it become a diabetic ulcer? How will such differences in coding be accounted for? We believe this ulcer should be sub-grouped with other “diabetic ulcer type” ulcers.

Score

APMA members are concerned with understanding how to achieve a favorable cost score. Even after thoroughly and diligently reviewing the Field Test Reports and having representation on the Clinician Expert Workgroup, we do not feel as though we can answer that question. As evidenced in this letter, we have many questions and concerns that we hope will be answered before the Non-Pressure Ulcers episode-based cost measure moves forward in the measure development process:

- How would a provider get a good cost score?

- What if the standard of care is expensive? Will the provider be punished with a bad cost score?
- How does a provider know what the right amount of cost for an episode is?
- What are concrete steps that podiatrists can take during the performance year to ensure they score well on this measure?
- How can a provider perform better on cost?
- How can a provider be sure that their score does not include costs associated with decisions being made by clinicians outside their TIN/community/state/reasonable influence?

Cost

APMA requests additional information related to how the appropriate amount of cost for an episode is determined. An example related to non-pressure ulcer would be, are the clinicians with high costs doing too much or are the clinicians with low costs doing too little? How does one determine where the standard of care/guidelines amount of care is on the continuum of the cost of an episode? APMA recognizes Acumen/CMS relies upon extremely large datasets to come up with the initial estimates of the expected costs. However, if the clinicians in the dataset are doing more or less of any assigned service (such as debridement or imaging studies), how can there be certainty that the costs being used within the episode are the “right” costs? For example, two clinicians may each have episodes of $5,000 but one’s costs are all debridement costs and the other had debridement, imaging, and revascularization costs. They both have the same cost for the episode, but which one had appropriate costs? Another example would be that there may be a situation where the standard of care calls for a service that incurs higher costs than options that are considered below standard of care. In a situation like this, we are concerned that our members may be negatively impacted by employing standard of care, ultimately appearing as higher cost. APMA acknowledges that details related to this exist within the methodology documents; however, we request that a version be provided that has less technical and more accessible/understandable language for the clinician community.

Setting of Care

APMA wants to highlight the potential difference in costs related to the setting of care/site/place of service. Podiatrists may not have direct influence over the setting of care for services being attributed to them. An example is multilayer compression for the treatment of venous leg ulcers. In many situations, patients with venous leg ulcers require multilayer compression to address the underlying venous stasis disease and may be seen at either a hospital outpatient department wound healing center or in a podiatrist's private office. The care provided at both settings is likely to be identical. In this scenario, the podiatrist likely plays no role in whether they see the patient at the hospital outpatient department wound healing center or in their private office. This is pertinent to this discussion of cost because the costs attributed to the provider that are associated with caring for this condition can vary significantly based on the site of service. When performing this service, there is significant cost associated with the multiple layers of compression applied. In the hospital outpatient department wound healing center, the costs of acquiring these products are borne by the hospital outpatient department. In the private office setting, these costs are borne by the provider. We do not see how the current model accounts for the costs associated with a service that can vary wildly based on where the service is performed, even when the same service is being provided by the same practitioner. This is especially problematic when considering that the practitioner may not reasonably influence where a patient receives such services.

Standard of Care

APMA would like to understand whether there is anything in the episode-based cost measure specification to indicate when someone may not be receiving standard of care. Is there an opportunity to use the data to be able to determine if there is a treatment missing from an episode, especially one considered to be standard of care? An example would be related to compression therapy for a venous ulcer. Compression is widely considered to be the standard of care for this condition – is there a mechanism to look at the data points to capture this treatment? If not, why not? Additionally, and similarly, is there a way to identify instances of vascular studies/revascularization for an arterial ulcer? If not, why not?

Ulcers With a Goal Outcome that is Not "To Heal"

APMA appreciates that there are scenarios where the treatment goal is not ulcer healing per se, but rather keeping the ulcer from getting worse (i.e., larger, infected), especially in complex cases where the general health of the patient is poor and other medical issues are being prioritized. In cases where the goal is to keep the ulcer from worsening and certain products or services should not be used, is there a way to identify use of such products to deem their use inappropriate?

Skin substitutes/cellular tissue products (CTPs)

APMA requests that there be additional discussion related to skin substitutes/CTPs. There are different costs associated with skin substitutes/CTPs based on product type and place/site of service. APMA also seeks clarity on where skin substitutes/CTPs are categorized within the measure specifications. Finally, APMA requests clarity on how use of skin substitutes/CTPs correspond with patient outcomes. In some cases, use of these products may be more costly, but it may also contribute to significantly improved patient outcomes. Without a consideration of quality in addition to cost, we are concerned that the cost measures may paint an incomplete picture of the care that is provided to patients with non-pressure ulcers.

Distribution of Services

APMA requests that data be shared related to the distribution of services included in the measure. Debridement codes, skin substitutes/CTPs, and data specifically highlighting what the major contributors to the cost of non-pressure ulcers would be most meaningful to APMA.

Inpatient/SNF/IRF/LTCH Charges

APMA seeks clarification on the mechanism for identifying the reason/diagnosis for inpatient stays, both medical and surgical, skilled nursing, inpatient rehab, and long-term care hospital. How are these stays identified as being clinically related to the non-pressure ulcer? Does the/a non-pressure ulcer or other appropriate (i.e., cellulitis, osteomyelitis) code need to be listed as the <u>principal</u> diagnosis?

An example is a patient who is admitted to the hospital for an inpatient stay with a principal diagnosis of a Chronic Obstructive Pulmonary Disease (COPD) exacerbation. If a non-pressure ulcer is listed as a condition within that inpatient stay, what, if any, of the charges from the inpatient stay would be part of the costs attributed back to a clinician who is within an open attribution window?

If the same non-pressure ulcer patient above, with a hospital inpatient stay and a principal diagnosis of COPD exacerbation, is then transferred to a skilled nursing facility (SNF) for continued treatment/management of their COPD, but receiving wound care for the non-pressure ulcer, how are the costs associated with the SNF stay attributed? Are all costs associated with the SNF stay attributed? Are only costs associated with the treatment/management of the non- pressure ulcer attributed? APMA seeks clarity on how/when services during otherwise unrelated inpatient/SNF/IRF/LTCH stays are attributed to an episode.

Additionally, in an actual Field Test Report, we saw a patient with a non-pressure ulcer who, unbeknownst to the clinician being attributed the episode, had a stroke during the episode window. There were home health costs associated with this episode of care. Home health services were not reasonably influenced by the attributed clinician, and it is unknown as to what those services were and whether they were even related to the non-pressure ulcer. If an attributed patient had a stroke and subsequent home health services were ordered because of the stroke, those costs should not be included in the episode. Additionally, if those home health services were ordered to care for the non-pressure ulcer leading to the episode, they were not under the direct influence of the attributed clinician.

Multiple Windows for Multiple Clinicians

APMA seeks to understand whether it is possible that multiple clinicians who are part of the care team, but in different TINs, are opening their own attribution windows during the same time. For example, a podiatrist codes a trigger and confirming code and thus begins an attribution window. A few weeks later, a nurse practitioner (NP) in a different TIN is also caring for the same patient's non-pressure ulcer and submits codes that would be considered a trigger and confirming code pair. Does the NP in a different TIN open their own attribution window within the episode already started by the wound care clinician?

APMA understands that with other chronic condition cost measures there is attribution methodology indicating that the same patient can be attributed to multiple clinicians and clinician groups. APMA asks for confirmation that multiple clinicians can have episode windows for the same patient at the same time.

Service Category

APMA requests clarity around what services are included in the Service Categories, namely in Table 3 of the PDF report and what codes/services are included in each of the service category listings. For example, what codes/services are considered “Skin grafts and Wound Debridement” or what are “Major Procedures” compared to “Ambulatory/Minor Procedures?”

We also ask that the Clinician Expert Workgroup reconsider the inclusion of “Joint Injections” and “Speech and Language Pathology Therapy” as they are irrelevant to wound care.

Service Attribution

APMA requests evaluation of the Service_Assignment_AB tab in the measure specifications file. As an example, APMA is requesting clarity around designation of “Skin Graft” High Level Code Label for line 4933: Atherosclerosis Of Unspecified Type Of Bypass Graft(S) Of The Right Leg With Ulceration Of Thigh. We would like to understand how/why certain ICD-10 codes are categorized to certain High Level Code Labels.

Part-time work

APMA requests feedback as to whether part-time employment status has an impact on a clinician’s episode-based cost measure scoring. Are part-time clinicians eligible for attribution and if so, does the measure adjust for employment status? If part-time employment status is a factor, what is the definition of “part-time?”

Patient Relationship Codes

APMA looks forward to hearing additional information regarding how patient relationship codes (PRCs) may be helpful for attribution methodology. APMA understands there was a recent webinar related to 2024 Physician Cost Measures and Patient Relationship Codes (PCMP) Technical Expert Panel (TEP) and we look forward to the discussion related to PRCs 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.

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 appreciate if Acumen could respond directly to our questions in writing. As noted earlier, we also would greatly appreciate a meeting with Acumen staff and CMS representatives to walk through our questions so that we can better understand the measure construct and areas still in need of refinement.

Thank you for the opportunity to provide feedback on the Non-Pressure Ulcers episode-based cost measure currently under development. If you require additional information, please contact Dyane Tower, DPM, MPH, MS, CAE, Senior Medical Director, and Director of Clinical Affairs at [contact information redacted]. Thank you for your time and consideration.

Sincerely,
Sylvia Virbulis, DPM

President

Comment Number 51

- **Date:** 3/14/2024
- **Submitter Name, Credentials, and Organization:** Marcia Nusgart, R.Ph, Alliance of Wound Care Stakeholders
- **Comment Text:**

Dear Acumen, LLC, and Members of the Non-Pressure Ulcers Episode-Based Cost Measure Clinician Expert Workgroup:

On behalf of the Alliance of Wound Care Stakeholders, Chair Dr. Matthew G. Garoufalis, Vice Chair Kara Couch and I are providing input on the draft specifications for Acumen, LLC's Non-Pressure Ulcers Episode- Based Cost Measure which is currently under development. The Alliance is a nonprofit multidisciplinary trade association of physician specialty societies, clinical and patient associations, wound care provider groups, wound care clinics and business entities operating in the wound care area. Our mission is to promote quality care and access to products and services for people with wounds through effective advocacy and educational outreach in the regulatory, legislative, and public arenas. These comments were written with the advice of our members who not only possess expert knowledge in complex chronic wounds but also those who are part of the workgroup and those who participated in the field testing.

The Alliance cannot support the Non-Pressure Ulcers Episode-Based Cost Measure as it is currently written. While the Alliance understands the importance of developing a cost measure relevant to chronic ulcers, the measure needs to be created in such a way to ensure its success. Our own analysis of the complete Medicare dataset has demonstrated that chronic ulcers affect 16% of Medicare beneficiaries,[1] an increase of 3% since 2014,[2] and the most conservative estimate of their annual cost is $25 billion but the real cost is likely more than 3 times that number. We offer these comments so that they can be used to further improve the cost performance category of the Merit-based Incentive Payment System (MIPS) and accurately reflect the wound care clinicians' work. We are extremely concerned with the following issues (although our concerns are not limited to these issues):

- Costs are being attributed to clinicians inappropriately as clinicians are being held accountable for the work of other clinicians.
- Tests are being performed outside of a clinician TIN which they have no control over, yet are being attributed to them.
- Codes that should have been added were not included in the measure and codes that should not have been included are included in the measure.
- Costs are being attributed to the clinician simply because they are clinically related to the condition being treated as opposed to "…the attributed clinician's role in managing care during a Non-Pressure Ulcers episode."
- Costs are being attributed to a clinician for care provided in hospitals or facilities not associated with the clinician's TIN.

The Alliance is also extremely concerned that members who participated in the measure development workgroup have expressed frustration with the measure as it is currently written. It appears Acumen did not listen to the input from the experts participating in the workgroup. As such, we hope our feedback along with that of other stakeholders and the workgroup members will inform Acumen to make refinements to the measure before it is considered for potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS). However, at this time, we reiterate that the Alliance does not support the measure as written as there are errors in the attribution calculations and the codes listed that must be addressed before moving forward.

Specific Feedback on Questions Posed

In response to the specific questions posed, the feedback that the Alliance has received from our members is provided below.

1. *Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).*

   The Alliance agrees that the trigger codes appropriately identify the patient cohort.

2. *How can the Non-Pressure Ulcers measure best attribute episodes to clinicians or group practices who reasonably influence the frequency, intensity, or occurrence of the clinically related services provided to a non-pressure ulcer patient?*

   The Alliance is extremely concerned about the issue of correct attribution to the TIN. Based on our review of actual Field Test reports, it is clear that the current measure does not fairly capture the frequency, intensity, or occurrence of clinically related services *that are under the reasonable influence of the attributed clinician.* The following are examples based on review of actual reports where none of these costs are under the reasonable control of the TIN yet these costs are being attributed to it:

   - costs at hospitals in cities distant from the TIN are attributed to the TIN;
   - costs occurring after the physician is no longer involved in the case are attributed to the TIN;
   - costs of other providers not associated with the TIN are being attributed to the TIN;
   - costs for skilled nursing facility hospitalizations (rarely required specifically due to a chronic non- pressure ulcer); and
   - costs for treatment of comorbid diseases unrelated to the wound are also being attributed to the TIN. None of these costs are under the reasonable control of the TIN and yet these costs are in fact being attributed to the TIN in all the field tests that we have reviewed.

   Chronic non-healing ulcers are a symptom of underlying disease(s), not a disease of their own. Research consistently demonstrates that the average patient with a chronic ulcer has at least 8 comorbid conditions and that the severity of their comorbid diseases is greater than the ulcer.[3] Conditions such as congestive heart failure, diabetes (in patients with all ulcer types), atrial fibrillation, COPD, depression, ischemic heart disease and renal disease all have a high prevalence. These conditions are managed by numerous specialists following the patient simultaneously. The physician caring for the wound has no influence over the care required for these other medical conditions, and yet the current cost measure attributes many such costs to the wound care practitioner. Physicians who have reviewed their field tests and looked back at specific patients have seen SNF hospitalizations for stroke attributed to their TIN, physical therapy for stroke and falls attributed to the TIN, emergency department visits for heart failure attributed to the TIN, and many hospitalizations for underlying disease attributed to the TIN. It is clear that with patients as complex as those with chronic ulcerations, the broad range of services included in a 365-day episode are NOT all related to the ulceration.

Furthermore, non-pressure ulcers often require a multi-disciplinary approach, as evidenced by the number of NPIs rendering care. Therefore, 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.

There are too many issues with the attribution of costs within this field test. They need to be corrected in order for this measure to be meaningful and successful. Until then, this measure is not accurate and will cause problems with its implementation if it moves forward without substantive revisions.

3. *Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non- pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?*

The Alliance is concerned that ulcer type may not be a good indicator of patient heterogeneity and resource use for the following reasons:

- Wound number

A decade of data from the largest wound care QCDR (the US Wound Registry) have shown that the vast majority of patients have more than two ulcers. [4] We are concerned that if the ulcers are of the same type, they are conflated into one code and thus CMS is unable to know when multiple ulcers exist of the same type. A risk stratification was developed to predict the likelihood of healing in order to report healing rates to CMS under MIPS. Also, research on the Wound Healing Index demonstrated that the statistical likelihood of healing one wound is inversely proportional to the total number of wounds present, so accurate risk stratification requires insight into the total number of wounds/ulcers present. [5] We would like to know whether Acumen was able to evaluate this from the data.

- Wound type(s)
  - When these ulcers are of different types, we are not sure that a category of “multiple ulcers” sufficiently captures the resource use. For example, a patient with both a diabetic foot ulcer and a venous ulcer would need both off-loading and compression, but a patient with a different combination of ulcers would need a different set of services. Thus, even the category of “multiple ulcers” would need to be subdivided according to the types and the number of ulcers.
  - There are no ICD-10 codes for a “diabetic foot ulcer.” An ICD-10 code exists for “diabetes with an ulceration” but this is a code for diabetes. Thus, capturing a diabetic foot ulcer requires two codes to be used, one for a chronic ulcer on the foot and the other for diabetes. We do not understand how this was handled in the cost measure.
  - Similarly, there is no ICD-10 code to capture an arterial ulceration and we are not clear how the necessary combined codes were handled.
  - We certainly agree that resource use must be evaluated for each ulcer type

separately but are not sure how this can be done in the absence of needed ICD-10 codes or with multiple different types.
    - With the exception of venous ulcers, non-pressure ulcers are always coded with 2 codes - the anatomic location of the wound as well as the wound type. However, depending on the payer, some clinicians code the underlying condition first (as it should be done) while others code with the ulcer first as required by the payer in their jurisdiction. However, unless both codes are accepted together there will be inaccurate subgroupings – as seen in the field testing - which will continue if not addressed. We are not sure how this can be managed given the lack of needed codes, but it clearly impacts the ability to crate reliable risk categories. This needs to be addressed.
    - Variations in the use of dual code sets mean that the apparent "type" of an ulceration may change from one provider to another even though the patient is being seen for the same problem.
- Site of service impact

This issue was apparently raised in the committee meetings, but no plan was put forward to account for this issue. There are dramatic differences in cost for identical services provided at different sites of service (e.g., office-based care vs. care in the hospital-based outpatient department vs hospital inpatient). We hope you will provide us with a clearer understanding of how this will be handled in the cost calculations for a given provider as we are not able to discern this information from the current measure or from the field testing that was conducted.

For example, many if not most, wound care practitioners work in the hospital-based outpatient department (HOPD), but the hospital facility charges associated with all of their services are not part of the measure. These facility fees cover the cost of many products such as cellular and/or tissue-based products (CTPs), often incorrectly referred to as "skin substitutes." The physician payment for many services (e.g., debridement) are reduced in the HOPD since those practitioners are not responsible for practice overhead. This makes those physicians appear to have significantly lower costs than colleagues in an office setting. Practitioners in private practice are responsible for the often very high cost of CTPs, which are covered by the hospital in the HOPD. These differences are not caused by differences in resource use, but the allocation of costs. No method has been suggested to account for this, nor is the site of care included in any report.

4. *Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale*

The Alliance does not believe that speech therapy services, joint injections or skilled nursing facility hospitalizations should be included in the non-pressure ulcer cost measure. We also do not think that infusion services provided by other practitioners should be attributed to the TIN since that clinician has no control over infusions provided by another physician. We agree that PT could and should be included in the measure but only if it is possible to determine that the services provided are related to the treatment of the patient's wounds. It would not be appropriate to attribute the treatment of a patient who had a fall or was being treated to rehabilitate their shoulder within a cost measure for wound care.

Furthermore, the Alliance is deeply concerned about the reporting of costs CTPs, often inaccurately referred to as "skin substitutes". The codes representing "skin graft" in the measure currently contain many inappropriate codes and needs to be corrected. Correct codes have already been provided to Acumen but were not used.

5. *Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment?*

The Alliance would appreciate having a clear understanding of how the risk calculations were arrived at and whether the data suggest they accurately depict patient complexity. For example, in reviewing actual Field Test reports with two practitioners, it was not clear that the complexity associated with the highest spend patients was reflected in their risk score. Without greater insight into how risk adjustments were done, we are unable to recommend changes.

The Alliance is concerned about the risk adjustment for patients on dialysis and believe food insecurity and other social determinants should be reflected in the risk classification – which they are not currently.

6. *Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please specify.*

Based on feedback from our members the Alliance recommends additional conditions be added to the list of excluded episodes. These would include the following:

a. Ulcers associated with fistulae.
b. Late effects of radiation therapy.
c. Systemic Lupus Erythematosus.
d. All autoimmune and inflammatory diseases due to their association with vasculitis – which is already excluded. These diseases include but are not limited to: psoriatic arthritis, rheumatoid arthritis, Chron's disease and ulcerative colitis, systemic lupus erythematosus, and Sjögren's syndrome, just to name a few.
e. Calcinosis cutis (a condition in which calcium salts are deposited in the skin and subcutaneous tissue). Although a distinct clinical syndrome, it shares many characteristics with calciphylaxis, which is already excluded.
f. Late effects of radiation.
g. Active cancer treatment (due to the common use of anti-neovascular agents which serve to prevent healing by blocking the granulation tissue response).
h. Certain traumatic wounds that become chronic (i.e., animal bites, human bites, gunshot wounds, puncture wounds, burns and any other similarly identified wounds by the workgroup experts).

7. *Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?*

No organization has worked harder for the development of national MIPS measures that are relevant to chronic ulcer patients than the Alliance. We first began working with the relevant organizations (e.g., National Quality Forum) in 2009 but found no support for such measures, despite the fact that 16% of Medicare beneficiaries have a chronic wound or ulcer. Due to the unwillingness of national quality organizations to support the development of wound/ulcer relevant measures in MIPS, the Alliance partnered with the US Wound Registry, a CMS recognized Qualified Clinical Data Registry (QCDR) to develop a suite of relevant QCDR measures.[6] Since wound care is not a specialty, CMS agreed (after much advocacy and education on the part of the Alliance) to allow the Alliance of Wound Care Stakeholders to act as a de-facto specialty society. These measures were first approved by CMS in 2015. The 2024 CMS approved measures can be found here: https://uswoundregistry.com/quality-measures/

The most relevant QCDR measures are:

- USWR-35: Off-loading of DFUs at every visit
- USWR 32: Compression of VLUs at every visit
- USWR30: Arterial assessment of all patients with a lower extremity wound or ulcer
- USWR 22: Nutritional screening of all patients with chronic wounds and ulcers
- 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)

The MIPS program is woefully lacking in relevant quality measures. Some measures are tangentially relevant such as Measure #001: A1C control in diabetic patients with ulcers, but since this measure is limited to diabetics, the measure is not relevant to at least half the patients with non-pressure ulcers.

One of the Alliance members, the American Podiatric Medical Association (APMA) has two measures specific to diabetics WITHOUT active ulcers, specifically:

- #126: Diabetic Foot and Ankle Care, Peripheral Neuropathy — Neurological Evaluation
- #127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

Diagnosed neuropathy is an exclusion for measure # 126, and since all patients with an active DFU have neuropathy, that measure is not relevant to diabetic patients with active DFUs. Additionally, the purpose of measure #126 is to identify diabetics “at risk” for a DFU so that interventions can be implemented in hopes of preventing DFUs. This is a laudable goal for patients before an ulcer develops but is a moot point among diabetic patients who already have an active ulcer.

Measure # 127 can be performed in diabetics with an active ulcer, but the measure is aimed at preventing a DFU by ensuring that patients have appropriate protective footwear, a moot point when an ulcer has already occurred and when other forms of off-loading must then be implemented. Both of the APMA measures are gradually being “topped out” by CMS due to the high-performance rate of reporting clinicians. Thus, in addition to questions about the relevance of these measures in patients with active DFUs, their future availability within MIPS is in question.

At this time, the QCDR measures developed jointly by the Alliance and the USWR remain the most relevant measures with which to understand the quality aspect of care among patients with non-pressure ulcers.

Feedback Related to the Presentation of the Report Materials

The Alliance is fortunate to have members who are experts in the area of billing and coding. However, we do not think it is possible for the typical practicing physician to make use of their Field Test report. Recognizing that even scholarly organizations like the Cochrane Collaboration provide “plain language” summaries of their findings, we strongly urge Acumen and CMS to create a plan language explanation of the report. The Alliance would be happy to collaborate with you on such an initiative.

Additional Feedback/Questions

The Alliance has other serious concerns and questions which we believe are important to raise because answering them will improve the success of any cost measure including but not limited to the following:

TIN and Attribution

1. How can Acumen ensure that the services being provided are being attributed correctly to the right TIN?
2. Why are wound care practitioners being compared to doctors in the same specialty? Since wound care is not a specialty, how is the measure specialty-adjusted? For a clinician who has a specialty of Family Medicine or Internal Medicine, but practices primarily wound care, how would that clinician be adjusted based on specialty when there isn't a wound care specialty? Comparing by specialty is not fair to those in the wound care space as their costs will be widely different than others in the same specialty and will be unfairly held accountable. We emphasize that the family practitioners, internists, emergency medicine practitioners and preventive medicine practitioners are not simply providing wound care services occasionally within their primary specialty but are actually practicing "wound care" full time. Unfortunately, there is no taxonomy which allows you to identify them as a group. Subdividing the costs by a specialty is not useful and prevents a fair assessment of wound care service cost. The single exception to the above rule may be podiatry in which wound care services may sometimes be provided within the specialty.
3. The measure states that it adjusts for cost variation across specialties and across TINs with varying specialty compositions. How does this adjustment work and how are those who conducted the field test supposed to interpret the results of this adjustment?
4. Why is the TIN being attributed inpatient admissions for a patient's comorbid conditions or complications when they are being admitted to the hospital if the admission has nothing to do with the patients' ulcer/wound care.? Why is the TIN being held accountable/responsible for this admission cost?
5. Why is the TIN responsible for care given in another state, inpatient admissions in hospitals where they do not have privileges, or for lab tests ordered (and in some cases not by them or anyone in their care team)?
6. Why is the TIN responsible for charges that occur after they are no longer seeing the patient? How can the fact that the patient is no longer under the care of the clinician be conveyed? Does the episode have to be 365 days when most wound care practitioners see patients for far less time than that?
7. Table 4 identifies the "NPIs Within Your TIN" and the "NPIs Outside your TIN". How is this information being used? One group practice found NPIs inside their TIN listed as both inside and outside their TIN. Another practitioner found her NPI listed in "Column W" as a non-attributed NPI. We are concerned that these errors represent problems in the attribution methodology.
8. Based on the actual reports we have seen, the column labeled "Your TIN" includes services that the practitioners would never order or perform. Thus, we assume that this column is more accurately labeled "Activities *attributed* to your TIN". Please confirm if this assumption is correct.
9. How are Nurse Practitioners (NP) initial evaluations attributed and how is the subsequent care attributed when the subsequent care is being provided by someone other than the NP who conducted the initial evaluation? For example, a patient is seen by the NP and an initial evaluation is conducted. It appears that when subsequent care is performed (and

determined by the DPMs and MDs employed by the practice group), it is being attributed to the NPs. These clinical decisions are clearly outside the control of the NP. As such, the attribution of costs to NPs is a significant problem.

10. It is possible that multiple clinicians who are part of the care team are opening their own attribution windows during the same period of time for a patient. For example, a wound care clinician codes a trigger and confirming code and begins an attribution window. A few weeks later, another practitioner who is caring for the same patient's non-pressure ulcer also codes - what would be considered a trigger and confirming code pair. Does the second practitioner open their own attribution window within the episode already started by the wound care clinician? This is not clear in the field testing or in any of the discussions held during the work group.

Field Test participants

11. What clinicians are being chosen to participate in the field study – only MIPS eligible? Non-MIPS eligible? We are aware of many MIPS-eligible clinicians who would undoubtedly have had more than 20 relevant episodes, but who found no Field Test Report on the QPP website. Can you help us understand why some wound care clinicians would NOT have found a field test report despite having relevant episodes? We are concerned because these practitioners are in academic settings (e.g., medical school faculty) and believe that those scenarios should be included. We would like to understand why some large practices might not have been included in testing.

DFU Coding

12. Diabetic foot ulcer coding: What will happen when a clinician uses L97422: Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed and follows that ulcer code with an ICD-10 code for diabetes, e.g. E11.621.?
    a. Will the ulcer in the scenario above be sub-grouped as "non-specific ulcer type" or "diabetic ulcer type?"
    b. How many ICD-10 codes are used to place a non-pressure ulcer into one of the distinct sub- groups?
13. How are "amputations for circulatory system disorders" calculated? What about amputations for patients who do NOT have circulatory system disorders? Why not calculate amputations for DFUs since reducing amputations related to DFUs is a major focus of CMS?

Cellular and/Tissue Based Products for Skin Wounds (CTPs) or Skin Substitutes and Skin Related Questions

14. The Alliance is deeply concerned about the accounting of data pertaining to Cellular and/or tissue-based products (CTPs), often inaccurately referred to as "skin substitutes." The charges vary dramatically based on the site of service in which they are applied. We need additional information to understand where the product costs are captured since these are separate from the application costs. How is Acumen addressing the different sites of service? Why are the costs of CTP products not represented as a line item?
15. Furthermore, why did Acumen not include the correct HCPCS codes for CTPs when the work group provided them? Correct coding information was provided to Acumen in the early stages of the development of this measure, yet the measure still does not contain the correct codes.
16. What is the definition of skin procedures?

17. The Alliance requests that Acumen explain why Atherosclerosis Of Unspecified Type Of Bypass Graft(S) Of The Right Leg With Ulceration Of Thigh is designated a “skin graft” in line 4933 on the Service Assignment AB tab of the measure specifications file.

Risk Scoring

18. How are patients with multiple ulcers of the same type identified? It appears that if there are multiple ulcers of the same type, one is only able to identify them as having one ulcer – which skews the data and thus the cost attributed to the clinician. It appears that in your classification, “multiple” means multiple ulcer types as opposed to the number of ulcers. Many wound care patients have multiple ulcers of the same type. Thus, if a patient has 10 ulcers of the same type, how will this be acknowledged or reported? If this information cannot be identified, there is no way to correctly risk classify them. How will Acumen address this issue?
19. In reviewing the risk score and the brackets without knowing the range of risk scores and the brackets providers are being put in, it is not clear what an individual provider score means. More transparency on averages, what the score and the risk bracket means is necessary.
20. We find the information regarding risk scoring unhelpful. How is it calculated? How does it related to HCC, a concept which many physicians do understand? Do physicians have an average of patient risk scores like they have with an HCC score?

More Information or Clarification Needed

21. The Alliance needs additional clarity on the Service Categories (see Table 3). We wish to understand what codes and services are included in each category listed? We want to understand what are considered “major procedures” vs. “ambulatory/minor procedures?”
22. What is the mechanism for identifying the reason/diagnosis for inpatient stays, both medical and surgical: skilled nursing, inpatient rehab, and long-term care hospital stays? How are these stays identified as being clinically related to the non-pressure ulcer? Does a non-pressure ulcer or other appropriate (i.e., cellulitis, osteomyelitis) code need to be listed as the principal diagnosis?
23. Does part-time status have an impact on a clinician’s episode-based cost measure scoring?
24. How is the “national average” calculated? Is it a national average calculated specific to a specialty or is it by risk group? We have noted in reports that the national average is not the same in every report. How is that possible?
25. We are concerned that correctly implementing the standard of care can actually increase total cost over the one-year time horizon, such as referring a patient for revascularization. Long term, these interventions likely decrease the risk of amputation. However, given the slow progression of vascular disease, early diagnosis may appear to increase costs rather than decrease them.
26. Conversely, we wonder if there is a way to determine when appropriate care has *not* been provided. For example, all patients with VLUs should have charges for compression bandaging. Is this something that can be addressed?
27. The Alliance believes that some data analytics are of tremendous value to the field of wound care and urge that data relating to the distribution of debridement charges, the use of hyperbaric oxygen therapy, the use of CTPs and the major contributors to cost be shared publicly.
28. How can a physician use the report to inform specific actions in order to improve their performance in the cost measure? The report does not provide any “actionable” information. Additionally, we are deeply concerned that physicians will decide not to care for

patients with the most severe wounds because they will worry about having outlier costs.

29. We would like to understand what costs are “normal” for ulcers of various types? Is there a “target” for ulcers of various categories?
30. Why are laboratories like Quest Diagnostic services listed in column W of the Excel spreadsheets as if they represented practitioners?
31. What is included in the DME category? It appears that it is not accurate based on field testing results.
32. Why are “Amputations for Circulatory Disorders” included in Table 3, but not amputations for other problems that might not be related to circulatory disorders? And where did the national average of 25% come from in Table 3?

The Alliance would appreciate having a dialogue to discuss these questions/issues as well as a written response from Acumen.

Conclusion

Thank you for the opportunity to provide feedback on the Non-Pressure Ulcers episode-based cost measure currently under development. While we appreciate the hard work that went into the crafting of a cost measure for non-pressure ulcers, the Alliance is extremely concerned with the measure as crafted. We believe that there is a lack of transparency which needs to be addressed. It is also evident that Acumen did not utilize the expertise of the workgroup members – which is disheartening. Based on our workgroup member feedback as well as those conducting field testing, it is apparent that Acumen does not fully understand or comprehend the wound care space and it may be necessary to provide some educational sessions in order for this measure to succeed. The Alliance is happy to conduct a session in order to provide the wound care education needed to better inform the creation of a meaningful and accurate measure – which we are in favor of. However, as stated previously, the measure in its current form does not accurately capture the data necessary for a fair, reliable, accurate measure and therefore the Alliance does not and cannot support the non-pressure ulcer cost measure at this time**.**

In addition, the APMA, an Alliance member has also submitted its own comments. The Alliance supports and agrees with the issues they raised in their comment letter as well. We urge Acumen to carefully review the comments being provided to them along with the significant and substantive issues of concern. The Alliance is hopeful that the information/feedback provided will help Acumen create an accurate cost measure. We request a meeting with you to facilitate that goal.

Should you have any questions or need any additional information please do not hesitate to contact Marcia Nusgart [email redacted].

Sincerely,

Matthew G. Garoufalis, DPM, FASPS, FACFAOM, CWS
FAAWC Alliance of Wound Care Stakeholders Chair
Stakeholders Vice Chair
Marcia Nusgart, R.Ph. Chief Executive Officer

Kara Couch, MS, CRNP, CWCN-AP,
Alliance of Wound Care

Comment Number 52

- **Date:** 3/14/2024
- **Submitter Name, Credentials, and Organization:** Kara S. Couch, MS, CRNP, CWCN-AP, FAAWC Individual

- **Comment Text:**

Dear Acumen, LLC, and Members of the Non-Pressure Ulcers Episode-Based Cost Measure Clinician Expert Workgroup,

I served as a member of the Clinician Expert Workgroup, but I write this letter in the capacity of a practicing wound care practitioner. I whole-heartedly support the development of a measure which would reflect the cost of the care for which I am responsible but in reviewing the rest of my field test report (although admittedly, I only have a rudimentary understanding of the results), this measure is not working.

Please allow me to give background information on my clinical practice setting. Wound care is a melting pot of subspecialties and disciplines as there is not a designated wound care specialty (i.e. Woundologist). As such, it is extremely common to have multiple providers staffing an outpatient wound care practice and that these providers are from different specialties and even different practice group settings. There are at least 700 Hospital-based Outpatient Provider Departments (HOPD) in the United States and typically there are several practitioners at each location.
In my practice, we are staffed by Nurse Practitioners who are employed by the hospital and podiatrists who are employed by the Faculty Practice Group. This means we are NOT in the same TIN. This creates challenges with billing and insurances when both the Nurse Practitioner and the Podiatrist are involved in the care of the same patient but on different anatomical locations. This conundrum was evident in the results of my field test.

How can I be a non-attributing NPI to my own report?

In column W, note that I am a “non attributing NPI” in my own report. How is that possible?
Also, why is [organization redacted] even in this list?
[table redacted]

The method of Attribution may be a problem for NPs

With regards to the most expensive [patient number redacted], the entire episode is attributed to the hospital employed NP who performed her initial consultation for hyperbaric oxygen therapy for a diabetic foot ulcer. In our practice, Hyperbaric Oxygen Therapy Services are performed by the Nurse Practitioners. Although the patient’s initial visit was for her HBO consult, she did NOT start her treatment that day. She began a few days after the initial visit. She has since been cared for exclusively by podiatry. She continues to see them weekly and has not seen the NP in follow up for her wound. The podiatrist did her wound care updates to maintain her ability to do HBO and the NP was the supervising provider for the HBO. The patient underwent years of care in our center (she is still an active patient today), had months of intravenous antibiotics, surgical intervention, amputation and other chronic ulcer care. As detailed above, the podiatrists at our institution work for the physician practice group. When NPs employed by our institution perform “initial evaluations” it appears that the subsequent care which is determined by the DPMs and MDs employed by the practice group are attributed to the NPs. These clinical decisions are clearly outside the control of the NP. I would think this will be a serious problem for the attribution of costs to NPs.

In my practice group (i.e. my direct clinical partners who are employed by the same entity as I am and who treat each other’s patients during vacations and absences), all 3 of us [names redacted] are all listed as non-attributing NPI. How can this be? In addition, I do not have any knowledge of who [names redacted] are. I have been in this practice setting for 10 years and have close contact with the primary care providers and specialist providers for my patients. I know who is actively involved in the care of my patients.

[Table redacted]

Table 3 does not make sense based on our practice pattern. Our TIN had [percent redacted] of inpatient costs attributed to us but we rarely perform any inpatient care. We also rarely see patients int the emergency department, so I am flummoxed how [percent redacted] of that care is attributed to us. It is also not possible that [percent redacted] of our costs could be due to “skin procedures” (unless those include 97597 services).

[Table redacted]

We do not order antibiotics. We do not order home health services. In fact, we have not been able to get skilled home health services since COVID. We do not admit to inpatient rehabilitation or long term care facilities. We do not order DME to account for [percent redacted] of the episode. These numbers cannot be correct; and this confirms that there are serious problems with attribution.

Ulcer type might not be properly captured

[Screenshot redacted]
One of the patients with an arterial ulcer was listed under multiple ulcer types (the last line). She had ICD10 codes of I73.9, I89.0, L97.219 (she had a mid-calf wound and an above knee amputation).

One of the non-specific ulcer types was coded L97.919, R60, I50.31 and E11.40. I find this surprising because the patient had a diabetic foot ulcer that eventually became a left below knee amputation. We had treated him for many months but had not seen him in clinic for 4 months before this trigger episode (he was followed by podiatry), and he came in with bullae.

Thank you for allowing me to comment on the Non-Pressure Ulcer Episode-Based Cost Measure Field Test. After reviewing the field-testing report, I firmly believe that this measure should not be used in its current form because there are serious problems with the episode, the attribution and the diagnosis coding of ulcers. This will result in serious unintended negative consequences that are not the goal of this entire process.

Yours sincerely,
Kara Couch, MS, CRNP, CWCN-AP, FAAWC
Director, Wound Care Services
George Washington University Hospital

Comment Number 53

- **Date:** 2/29/2024
- **Submitter Name, Credentials, and Organization:** Sarah Warren, American Speech-Language-Hearing Association (ASHA)
- **Comment Text:**

[**Q136. 3**. Please choose which cost measure you would like to submit feedback for:]

Movement Disorders

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

Although it is likely that only a small proportion of patients with movement disorders will encounter a speech-language pathologist as their first clinical encounter, including them in the attribution model is important to ensure the measure is capturing all appropriate patients and that Medicare has accurate data around resource use and cost.

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson's and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

ASHA remains concerned that the title of the measure might create confusion for patients and clinicians. We would recommend changing it to "Progressive neurological disorders of movement."

[**Q143. 6.** Are there any changes that should be made to the current risk adjustors, such as to add or remove variables? Are there measure-specific variables that should have their specifications updated?]

ASHA remains committed to ensuring that social determinants of health are reflected in all quality measures across payers. The survey does not appear to capture SDOH and ASHA hopes Acumen will capture this information in the final measure.

Comment Number 54

- **Date:** 3/14/2024
- **Submitter Name, Credentials, and Organization:** Alice Bell, American Physical Therapy Association
- **Comment Text:**

[**Q136. 3.** Please choose which cost measure you would like to submit feedback for:]

Movement Disorders and Non-Pressure Ulcers

[**Q138. 1.** Do the trigger codes appropriately identify a patient cohort that reflects the measure intent? If not, what changes should be made to ensure that the measure has strong potential to impact spending for a comparable patient cohort? Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., exclusions, risk adjustment).]

Since the episodes are only being attributed to prescribing clinicians the trigger codes are appropriate. Should that be changed and attribution assigned to non-prescribing clincians, APTA would recommend removing the rehabilitative service codes from the trigger codes. Also, only the occupational and physical therapy evaluation codes 97161, 97162, 97163, 97165, 97166, 97167 should be included to start the episode. All PM&R codes should be included as confirming codes.

[**Q139. 2**. Should episodes be attributed to non-prescribing clinicians such as PTs/OTs/SLPs and clinicians/groups that do not prescribe medications for movement disorders? Please describe why or why not.]

Episodes should not be attributed to non-prescribing clinicians as it is the prescribing clinician who is generally managing this patient population and non-prescribing clinicians have limited influence over the patient’s medical and pharmacologic management.

[**Q141. 4.** Does the new proposed name appropriately account for Parkinson’s and Related Disorders, MS, and ALS? Do you have other suggestions for the measure name?]

Yes, no other suggestions.

[**Q142. 5.** Do the current service assignment rules appropriately capture clinically-related services that can reasonably be influenced by attributed clinicians and groups? Are there other services that should be added to help distinguish variation in cost performance?]

No additions

[**Q145. 8.** Which quality measures are the most relevant to the Movement Disorders measure to assess the value of care? Are the other indicators of quality that are not currently captured in a MIPS quality measure?]

- 130 Documentation of current medications
- 134 Screening for Depression
- 155 Falls Plan of Care
- 182 Functional Outcome Assessment
- 290 Mood Disorders and Psychosis for Patients with Parkinson’s Disease
- 291 Cognitive Impairment or Dysfunction for Patients with Parkinson’s Disease
- 293 Rehabilitative Therapy Referral for patients with Parkinson’s Disease
- 318 Falls – Screening for Future Fall Risk
- 374 Receipt of Specialist Report
- 386 ALS Patient Care Preferences
- 487 Screening for Social Drivers of Health
- 498 Connection to Community Service Provider
- 503 Gains in Patient Activation Measure

[**Q149. 3.** Is ulcer type a good indicator of patient heterogeneity and resource use in caring for patients with non-pressure ulcers? Are there any additional claims-based indicators of resource use we should consider when sub-grouping for the Non-Pressure Ulcers measure?]

Yes, I don’t believe this would be claims based but an additional consideration would be the number and total surface area of wounds.

[**Q150. 4.** Should any of the service categories (listed above) be refined (e.g., are there specific services that should be added to or removed from the measure)? Please explain your rationale. Are there any additional service categories we should consider for service assignment for the Non-Pressure Ulcers measure? Please explain your rationale.]

Debridement as an out-patient service. Also make sure there is inclusion of non-thermal ultrasound.

[**Q153. 7.** Which quality measures are the most relevant to the Non-Pressure Ulcers measure to assess the value of care?]

- 130 Documentation of current medications

- 134 Screening for Depression
- 155 Falls Plan of Care
- 182 Functional Outcome Assessment
- 318 Falls – Screening for Future Fall Risk
- 374 Receipt of Specialist Report
- 487 Screening for Social Drivers of Health
- 498 Connection to Community Service Provider
- 503 Gains in Patient Activation Measure
- 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- 441 Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
- 126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation
- 127 Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear
- 358 Patient-Centered Surgical Risk Assessment and Communication