ACUMEN

2024 Public Comment Summary Report for the Comprehensive Reevaluation of the Total Per Capita Cost (TPCC) Measure

May 2024

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1 OVERVIEW

1.1 Project Title

MACRA Cost Measures: Call for Public Comment for Total Per Capita Cost (TPCC) Measure Reevaluation

1.2 Dates

The Call for Public Comment ran from April 25, 2024 to May 17, 2024.

1.3 Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, to develop and maintain cost measures for 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. This work is under the contract “Physician Cost Measures and Patient Relationship Codes (PCMP)” (contract number 75FCMC18D0015, Task Order 75FCMC19F0004).

The measure maintenance process gives CMS and measure developers the opportunity to ensure measures continue to function as intended. On an annual basis, the measure developer reviews MIPS cost measures and recommends to CMS whether minor, non-substantive refinements may be needed to keep measures up-to-date with changing codes and clinical standards. Every three years, CMS and measure developers consider measures for comprehensive reevaluation. During comprehensive reevaluation, measure developers can more holistically review the measure, seek public comment, and consider, with CMS, many aspects of measure specifications, in addition to the updates completed through annual maintenance. In some instances, a measure might only need minor or no changes to specifications, while other measures may undergo more substantive changes to improve the measure’s importance, scientific acceptability, or usability. Depending on the extent of the refinements, measures may require rulemaking to adopt substantive changes prior to use in MIPS.

The current TPCC measure was added to the MIPS cost performance category beginning with the CY 2020 performance period/2022 MIPS payment year. After three years in MIPS, CMS and Acumen began a comprehensive reevaluation process with an initial public comment period in July 2023 to determine whether potential refinements should be made to the TPCC measure. Interested parties largely requested CMS revisit the TPCC measure’s attribution methodology to better capture clinicians responsible for primary care-type services and prevent attributing the measure to highly specialized group practices under their taxpayer identification

numbers (TINs) due to the billing patterns of advanced care practitioners (ACPs) (i.e., nurse practitioners [NP], physician assistants [PA], and certified nurse specialists [CNS]). Acumen held a technical expert panel (TEP) on March 13, 2024, where TEP members discussed refinements to the measure's attribution rules to better identify ACPs in specialized group practice TINs and simplify candidate event logic. A summary of this discussion is available in the TEP summary report.[1]

As a continuation of this comprehensive reevaluation process, Acumen requested additional public comment in April to May, 2024 on the following potential refinements: a) exclude ACPs in TINs composed of only ACPs and excluded specialties, b) remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification, and c) add an included specialty check on the confirming claim of the candidate event. These refinements are further described in the TEP summary report.

The Call for Public Comment included a set of questions focused on the measure's attribution methodology, but interested parties were also encouraged to provide any additional feedback about other measure specifications.[2] This document summarizes feedback from interested parties gathered throughout this public comment period, which will inform the refinements Acumen recommends to CMS for adoption into the measure's specifications. CMS will review any recommended changes to the TPCC measure and determine whether to propose any changes to the TPCC measure in future rulemaking.

1.4 Information about the Comments Received

Acumen solicited public comments and conducted education and outreach using the following methods:

- Posted a Call for Public Comment on the CMS Measures Management System (MMS) Current Public Comment Opportunities webpage
- Sent multiple email notifications to Acumen contacts, including targeted outreach to previous participants in measure development and contacts from relevant specialty societies
- Sent multiple email notifications to the MMS listservs

We received 15 letters and 14 completed surveys from 23 organizations and 3 individuals. Two organizations submitted both a completed survey response and a letter. Representatives from one organization submitted two completed surveys. Additionally, two organizations

[1] Physician Cost Measures and Patient Relationship Codes (PCMP) Technical Expert Panel Summary Report (2024), https://mmshub.cms.gov/sites/default/files/2024-pcmp-tep-summary.pdf
[2] MACRA Cost Measures: Call for Public Comment for Total Per Capita Cost (TPCC) Comprehensive Reevaluation (2024), https://mmshub.cms.gov/sites/default/files/2024-04-19-tpcc-public-comment-posting.pdf

submitted a joint response via separate letters. The verbatim text of each submitted comment is presented in Appendix A: Public Comment Verbatim Report.

2 INTERESTED PARTY COMMENTS: FEEDBACK SUMMARY

This section summarizes feedback received throughout the public comment period, as well as additional clarifications about the measure specifications. The following subsections describe feedback on the types of care relationships the Total Per Capita Cost (TPCC) measure should capture (Section 2.1), proposed refinements to the TPCC measure's attribution methodology (Section 2.2), and additional feedback on other TPCC measure specifications (Section 2.3).

2.1 Intent and Scope of the TPCC Measure

This section summarizes feedback we received relating to the intent of the TPCC measure to capture the cost of primary care and other forms of ongoing care management. Commenters shared input on the types of care relationships they believe the measure should capture (Section 2.1.1) and the measure's exclusion criteria (Section 2.1.2).

2.1.1 Types of Care and Care Relationships Captured

Commenters commonly described primary care relationships as the type of care relationship that most aligns with the intent of the TPCC measure. Many commenters discussed the importance of capturing preventative care and chronic disease management as elements of primary care delivery. In addition to these types of care, commenters listed care coordination, care management, and patient education as important care types to be included within the scope of the TPCC measure. Commenters also highlighted the role of specialists in the delivery of primary care to complex patients whose severity of illness may require long-term management.

2.1.2 Exclusion of Specialty Providers

Commenters expressed concern that the TPCC measure's exclusion criteria, as currently specified, does not adequately exclude specialties not responsible for ongoing care management. Several commenters noted that candidate events are attributed to TINs that would otherwise be removed from the measure due to the inclusion of ACPs. These commenters also noted that ACPs in specialties such as radiology, anesthesiology, and cardiology are attributed the TPCC measure despite providing specialized care. TPCC measure specifications currently classify radiology, anesthesiology, and interventional cardiology CMS (previously Health Care Financing Administration [HCFA]) specialty designations as excluded specialties. Clinicians with CMS specialty designations classified as included specialties under the current TPCC measure specifications, which include ACPs, can be attributed candidate events at the clinician level. Some commenters expressed support for the inclusion of ACPs responsible for primary care in all practice types. Commenters recognized the challenge of identifying ACPs providing specialized care given that there is no specialty designation for ACPs who may take on a diverse

role in the delivery of both primary and specialty care. Other commenters maintain that ACPs responsible for providing specialized care should be removed from attribution.

2.2 TPCC Measure Attribution Refinements

This section summarizes feedback we received on proposed refinements to the TPCC measure's attribution methodology, as described in the TEP summary report.[3] The following subsections describe feedback received on specialty exclusions for ACPs (Section 2.2.1), simplifying candidate event logic (Section 2.2.2), and other additional feedback on the measure's attribution methodology (Section 2.2.3).

2.2.1 Adjusting Specialty Exclusions for ACPs

The majority of commenters supported the proposed attribution refinement to exclude ACPs in TINs composed of only ACPs and excluded specialties. Several commenters noted that specialized TINs were often attributed to the measure due to the presence of only a few ACPs. Commenters recommended this refinement be implemented as soon as possible and applied retroactively to scoring for the 2023 performance period to limit downward payment adjustments that may result from the current attribution methodology in the 2025 payment year.

Some commenters noted that the proposed attribution refinement is not sufficiently restrictive as it does not capture ACPs providing specialty care in large multi-specialty TINs. One commenter asserted that the proposed attribution refinement will not work for hospital medicine groups, which often have both included and excluded specialty clinicians. This commenter requested the removal of hospital medicine groups from the measure. These commenters recommended CMS collaborate with health care and specialty organizations to explore alternative methods to accurately attribute ACPs.

Two commenters opposed the proposed attribution refinement. One of the commenters stated that clinicians will still be unable to directly claim responsibility for delivering primary care. The other commenter expressed concern that practices composed of solely ACPs may be negatively affected by the proposed attribution refinement.

2.2.2 Adjusting Candidate Event Logic

Commenters that responded to the survey questions on refining TPCC candidate event logic were supportive of the proposed refinements to a) remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification and b) add an included specialty check on the confirming claim of the candidate event. Commenters stated that these refinements will improve the ability of providers to identify their attributable patients within the scope and intent of the measure.

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[3] Physician Cost Measures and Patient Relationship Codes (PCMP) Technical Expert Panel Summary Report (2024), https://mmshub.cms.gov/sites/default/files/2024-pcmp-tep-summary.pdf

Some commenters described scenarios that may result from the current "+/- 3 days, Any TIN" rule. These commenters explained that a TIN providing primary care may not be attributed the TPCC measure because a patient received a primary care service, such as a laboratory test, from a separate TIN more than 3 days after the initial trigger event. One commenter noted that under the current logic, some TINs, especially non-excluded specialty practices, may be attributed the measure despite only treating an acute concern.

2.2.3 Additional Feedback on the TPCC Attribution Methodology

In addition to responding to questions about proposed attribution refinements to the TPCC measure's specialty exclusion criteria and candidate event logic, commenters also provided general feedback on the TPCC attribution methodology. This feedback includes suggestions on how to identify ACPs in specialized TINs, revise candidate event logic, and define primary care relationships.

Commenters provided alternative approaches to refine the TPCC attribution methodology to address the attribution of specialized TINs. Several commenters suggested the TPCC attribution methodology adopt other coding mechanisms to identify specialty clinicians. One commenter requested that billing entity taxonomy replace CMS specialty designations. Note, CMS uses CMS specialty designations from Medicare claims for the purposes of determining QPP eligibility; the use of CMS specialty designations in cost measures aligns with this. Some commenters suggested excluding providers based on the majority specialty count within a TIN. For example, one commenter recommended excluding ACPs from TINs composed of 75% or more excluded specialties. Commenters also recommended creating categories based on patient conditions (e.g., cardiovascular conditions, cancer, and trauma) to identify types of specialists and adding place of service codes to identify and exclude ACPs providing specialty care.

Several commenters suggested additional ways to simplify candidate event logic. Commenters expressed support for providing clinicians with a method of identifying their relationship with patients at the time of service. They argue that this approach would improve the accuracy of attribution, allow clinicians to identify changes in their relationship with a patient, and provide physicians with greater certainty regarding which patients will be attributed to them. One commenter recommended CMS revisit candidate event logic entirely due to concerns that the "+90 days, Same TIN" rule would raise similar issues as the "+/-3 days, Any TIN" rule.

Commenters requested CMS more closely define primary care relationships in the TPCC attribution methodology. These commenters expressed concern that Evaluation and Management (E/M) codes, which are used to represent the beginning of a primary care relationship, also capture one-time interactions to treat an acute concern or specific condition. One commenter added that it may be unfair to attribute certain costs to emergency physicians who serve as the first point of contact for many patients in the health care system and often order follow-up care

from clinicians, specialists, and other providers. Another commenter noted that the measure could penalize providers who are subject to the Emergency Medical Treatment and Labor Act (EMTALA), which requires the provision of emergency medical care regardless of a patient's insurance status or ability to pay. To note, emergency medicine is an excluded specialty under the current TPCC measure specifications. Emergency physicians are removed from TPCC measure attribution at the clinician level. Additionally, only Medicare services are included in the calculation of the TPCC measure.

To better define primary care relationships, many commenters suggested modifying the TPCC attribution methodology to incorporate the use of patient relationship codes (PRCs) or other similar codes. PRCs are Healthcare Common Procedure Coding System (HCPCS) Level II modifier codes that clinicians report on claims to identify the type of relationship they have with a patient. Commenters explained that PRCs improve attribution by allowing clinicians to explicitly describe their relationship with patients. Moreover, commenters suggested clinicians may be more likely to report patient relationship codes if they expect these codes will accurately reflect patient relationships, thereby improving their measure score. One clinician encouraged CMS to use PRCs to determine whether a care visit should trigger attribution. Note, the measure developer has considered the use of Patient Relationship Categories and codes, but these codes are not currently used frequently enough to be included in attribution. One commenter also urged CMS to revise the TPCC attribution methodology to resemble attribution methodologies of the Medicare Shared Savings Program (MSSP) and CMMI Making Care Primary (MCP) model. In addition to using PRCs, one commenter recommended CMS use HCPCS add-on code G2211 to better identify the delivery of primary care.[4] We note that this newly added code describes visit complexity inherent to outpatient E/M visits associated with medical care services that serve as the continuing focal point for all needed health care services and/or medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

2.3 Additional Feedback on Other TPCC Specifications and Use

The remaining feedback is summarized below and broadly covers other TPCC measure specifications. The following sections discuss accounting for patient heterogeneity (Section 2.3.1), assessing costs of care (Section 2.3.2), measure score calculation (Section 2.3.3), use in MIPS (Section 2.3.4), and feedback reporting (Section 2.3.5).

2.3.1 Accounting for Patient Heterogeneity

Commenters from oncology societies suggested excluding patients on chemotherapy from the TPCC measure's patient cohort. One commenter introduced the idea of a beneficiary-level

[4] AMA CPT Code Description Licensing. Codes and descriptions included are from the Current Procedural Terminology (CPT®) Copyright 2020 American Medical Association. All rights reserved.

exclusion as one way to remove all patients on active chemotherapy. Other commenters recommended adding Medicare Part D prescription drug services to the TPCC measure's chemotherapy service category exclusion criteria to remove clinicians responsible for chemotherapy and to reflect an increase in use of Part D chemotherapy drugs. While surgical and radiation oncology are already classified as excluded specialties, commenters also requested CMS consider adding medical oncology to the list of excluded HCFA specialties. These commenters explained that many of the primary care services included in the measure's trigger methodology may also be necessary for cancer care. For example, x-rays, procedures, and laboratory tests indicative of primary care are often part of routine cancer care management.

Some commenters noted that the TPCC risk adjustment methodology only considers chronic conditions in the year prior and does not account for current acute conditions or newly diagnosed chronic conditions treated for the first time during the current year. One commenter shared that clinicians with a higher-than-average amount of patients that develop new chronic conditions during the year may be penalized by the measure. Another commenter questioned whether the measure's risk adjustment model accurately predicts costs for diagnosis codes, such as for spine-related conditions, that may not indicate severity of disease or predict the likelihood of requiring certain services like spine surgery.

2.3.2 Assessing Costs of Care

Several commenters stated that the TPCC measure attempts to hold clinicians accountable for costs associated with care for which they are not responsible (i.e., medical decisions made by another provider, outlier spending, conditions the clinician did not treat). One commenter noted that the measure does not identify the types of services and costs that are reasonably affected by primary care. Several commenters mentioned that clinicians are unable to determine whether they are making referrals to providers who order unnecessary test or procedures. Commenters recommended CMS focus on aspects of cost that clinicians can reasonably control to avoid incentives to undertreat patients. One commenter expressed concerns about the potential for double counting costs in the TPCC measure. Note, the TPCC measure does not double count costs, as explained in more detail in the Shared Data Across Cost Measurements factsheet.[5]

Additionally, commenters expressed concern that MIPS does not appropriately credit clinicians for future cost savings. Commenters recommended the exclusion of preventative services from cost measures as these services prevent health issues from arising and avoid high costs associated with treating advanced illnesses. One commenter noted that TPCC penalizes clinicians by only capturing short-term investments in primary care. Commenters also noted that

[5] Centers for Medicare & Medicaid Services: https://www.cms.gov/files/document/shared-data-across-cost-measurements-3-13-20.pdf

MIPS does not provide clinicians with the support and flexibility needed to invest in improving care over time.

2.3.3 Measure Score Calculation

Several commenters expressed support for a return to an annual evaluation of costs in the TPCC attribution methodology. We note that the TPCC measure currently calculates an annual score based on risk-adjusted monthly costs. Risk-adjusted monthly costs were implemented as an intermediary step in 2020 for calculating the overall performance period (i.e., annual) score. Commenters stated that monthly benchmarking fails to consider variability in patient complexity (e.g., seasonality of patients due to spikes of the flu during the winter or heat strokes during the summer). One commenter expressed concern that clinicians who treat chronic conditions and those that treat acute conditions may not be attributed fairly since spending for certain conditions may be distributed over several months. Note, each clinician, and group, is assessed on costs of care for attributed beneficiaries from the time of the initial candidate event service through the end of the performance period.

Several commenters questioned the reliability and validity of the TPCC measure. Some commenters expressed concern that the measure's risk adjustment methodology and variations in cost were not adequately tested, especially relating to monthly benchmarking. Additionally, one commenter stated that the use of outdated CPT coding specifications may result in inaccurate results and unintended consequences. However, all MIPS cost measures undergo annual maintenance to ensure new codes are reflected in specifications.

2.3.4 Use in MIPS

A few commenters recommend removing TPCC from MIPS entirely and at minimum, removing it from MIPS Value Pathways (MVPs) due to concerns that the measure holds clinicians accountable for costs outside of their reasonable control and may negatively impact patients. One commenter mentioned that the measure compares ACPs to other ACPs, rather than related specialty practices, which could compound cost differentials in the measure and lead to unfair scoring. Other commenters noted that groups, including oncologists and dermatologists, may perform poorly on the measure, resulting in a decline of quality and cost-effective care. They explain that concerns about downward payment adjustments can lead to longer patient wait times, delayed diagnoses, and higher care costs, which threatens patient outcomes.

2.3.5 Feedback Reporting

Several commenters stated that the lack of timely, useful information on TPCC measure performance is a large gap in the MIPS cost performance category. They explained that clinicians struggle to monitor their performance and identify opportunities for improving care delivery throughout the year. One commenter mentioned that the lack of timely feedback

especially affects small, independent practices that may not have the same level of data interoperability compared to larger practices. Other commenters noted that using retrospective claims data limits CMS's ability to provide timely feedback to interested parties. Commenters urged CMS to prioritize making more timely performance information available to providers. One commenter urged CMS to develop more resources for providers new to MIPS and providers looking to understand how to make routine improvements.

Commenters recommended several changes to how CMS shares TPCC performance feedback. One commenter requested CMS provide clinicians with quarterly feedback reports during the performance period, similar to the field testing reports released during the measure development process. Commenters also supported including cost categories in provider data, details on cost measure overlap, comparative performance data in performance feedback, and a way to verify final MIPS scores. One commenter requested that feedback reports include the following:

- A clearly defined set of data elements that will be reported back to any eligible clinician that triggers the measure and a data element "table" in the appendix of measure specifications
- A clearly defined timeline for when data will be provided
- Request for public comment or additional feedback on measure specifications

Other commenters recommended CMS provide the public with comprehensive analytics regarding the real-world application of the measure, including specialties attributed, the average and range of performance scores, and the number of attributed episodes.

3 OVERALL ANALYSIS AND RECOMMENDATIONS

We appreciate and have carefully considered the responses collected from the public comment period for the reevaluation of the Total Per Capita Cost (TPCC) measure. CMS will consider all the feedback received during the public comment period, feedback from the PCMP Technical Expert Panel, and empirical analyses to evaluate potential refinements to the measure's attribution methodology.

CMS will consider the following potential attribution refinements for future implementation: a) exclude advanced care practitioners (ACPs) in TINs composed of only ACPs and excluded specialties, b) remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification, and c) add an included specialty check on the confirming claim of the candidate event. If CMS determines substantive changes should be made to the TPCC measure, CMS will propose such changes through notice-and-comment rulemaking prior to use in MIPS.

Unless and until CMS proposes and finalizes any changes to the TPCC measure through notice-and-comment rulemaking, the TPCC measure will also continue to be maintained as usual through the annual maintenance process. The annual maintenance process typically involves coding updates to reflect any new or different codes that are released during the year.

We also encourage interested parties to reach out to the QPP Service Center (QPP@cms.hhs.gov) or email macra-cost-measures-info@acumenllc.com with additional feedback on the TPCC measure or MIPS generally so that we can consider this in any future maintenance or reevaluation activities in the MIPS cost performance category.

APPENDIX A: PUBLIC COMMENT VERBATIM REPORT

This appendix contains the verbatim texts of the comments received. The information is provided in a list format. The list presents the name, affiliated organization, and date of submission (date of receipt of the comment via email or survey submission). The submitter name for each comment is the name of the person who submitted the letter or filled out the survey. For some comment submissions, the person who signed the comment letter is not the same as the person who submitted the comment nor the same as the contact person provided in the comment.

Please note that the verbatim text has been edited to improve the readability of this report. We omitted letter template details (e.g., company logo), email signatures, and sensitive personally identifiable information (e.g., phone numbers and email addresses). Also, respondents' complete survey responses were concatenated together.

3.1.1 Comment Number 1

- **Date:** 4/26/2024
- **Submitter Name, Credentials, and Organization:** Pam Shelbourn, RN, MSN, CPHQ,
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

accountability for primary care attribution

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

No. Hospital-based physicians are excluded from this measure, but APRNs and PAs working in hospitalist group are not

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

primary care practitioners should not be excluded

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

TINs with multiple groups may not have a representation of their primary care attribution

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

Physicians are assigned a specialty code for exclusion. Why can't this be assigned for all billing providers? Or-attestation that all billing providers under the TIN represent an excluded specialty.

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

yes

[Topic #2 Adjust Candidate Event Logic Q3. Please provide any additional comments about simplifying candidate event logic below. For example, would these approaches lead to certain types of care being left out of the measure despite being within the measure's intent?]

Data does not indicate a large % impacted if implemented.

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

Some patients use a specialist as their primary care provider, which is outside of control by PCP and specialist. Billing codes for outpatient vs inpatient in the hospital setting don't account for separation of primary care services

3.1.2 Comment Number 2

- **Date:** 5/1/2024
- **Submitter Name, Credentials, and Organization:** Christal Mandella, BSN, RN, LifeBridge Health
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

Alot of our organizations have specialists that have a primary taxonomy as internal medicine. Is it possible to exclude these somehow if they do not provide primary care services?

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

See previous answer.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

I do not. In Maryland, NPs and PAs are treated nearly the same as MDs & DOs. I know a lot of practices that are comprised solely of APPs in Primary Care, so excluding them could skew the TPCC measure. Anyone who bills for primary care services should be included.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

I think it is worth examining further. I don't think it should be defined solely by provider type, but those that trigger primary care billing should be included int he measure

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

See above. Any clinician that triggers a primary care code should be included regardless of primary taxonomy.

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

Yes

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

Yes

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

A simple way to understand, other than the lengthy measure specs, would be helpful to those new to MIPS. Also, if ways to improve performance on this measure could be published, it could help many practices understand how to more accurately bill and more routinely make improvements to their practices and care being given to patients.

3.1.3 Comment Number 3

- **Date:** 5/15/2024

- **Submitter Name, Credentials, and Organization:** Meghan Eigenbrod, MPH, American Academy of Neurology
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

The AAN agrees that it appropriately measures primary care, however, the TPCC should measure preventive care (including prevention of a disease); and Chronic disease management (prevention of complications of an existing disease and prevention of recurrences/severity of existing disease complications); and Care coordination (facilitating the patient's passage through the healthcare system for needed care); and Care management (crafting a comprehensive plan of care meeting all the patient's clinical needs).

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

A. When the TPCC measure is assigned to a specialist when they are not acting as a primary care physician (a false positive assignment) and B. When it does not accurately identify the occasions when a specialist assume the responsibility for providing primary as well as specialty care (a false negative). An example of A is that 17% of neurologists are assigned responsibility for the TPCC. An audit of these cases should examine if other primary care and services were delivered to those patients by the neurologist. Effective Identification and quantification of primary care services might be accomplished in a more accurate way by modifying a phased, condition-specific method for billing for specialty care presented to PTAC by the AAN previously.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

Yes

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

No

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

Given the small number of practitioners and patients impacted by these circumstances, the suggested approach is probably sufficient, An alternative would be to consider use of a specific

code set used by the clinician to identify and claim responsibility for delivering primary care if something like the attached payment alternative model was put in place.

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

Yes

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

Yes

[Topic #2 Adjust Candidate Event Logic Q3. Please provide any additional comments about simplifying candidate event logic below. For example, would these approaches lead to certain types of care being left out of the measure despite being within the measure's intent?]

Use of primary care specific codes in conjunction with the phased, episodic payment model attached would also solve for attribution issues.

3.1.4 Comment Number 4

- **Date:** 5/13/2024
- **Submitter Name, Credentials, and Organization:** Paul Hartlaub, MD, MSPH
- **Comment Text:**

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

Yes

3.1.5 Comment Number 5

- **Date:** 5/15/2024
- **Submitter Name, Credentials, and Organization:** Danielle Siedlecki, RD, CDN, National Spine & Pain Centers
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

primary care

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

It is supposed to

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

Yes. Please ensure this crosses over for Individual Reporting as well.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

No concerns.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

Unknown

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

Yes

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

Yes, specialists are still not primary care.

[Topic #2 Adjust Candidate Event Logic Q3. Please provide any additional comments about simplifying candidate event logic below. For example, would these approaches lead to certain types of care being left out of the measure despite being within the measure's intent?]

I do not believe so.

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

I agree with excluding PA and NP practitioners that practice within a specialist group, confirmed by the majority of physician specialists within the TIN. Please ensure this crosses over to Individual reporting as well. Perhaps there could be a specialty status that is applied.

3.1.6 Comment Number 6

- **Date:** 5/14/2024
- **Submitter Name, Credentials, and Organization:** Matthew Popovich, PhD, American Society of Anesthesiologists
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

NA

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

The general exclusion criteria for anesthesiologists and other qualified anesthesia professionals (certified registered nurse anesthetists and certified anesthesiologist assistants) are appropriate for this measure. However, the manner in which the measure is calculated, including how non-anesthesia professionals who may bill under an anesthesia group's TIN are attributed to the measure must be addressed. In 2023, we learned that several anesthesia groups received cost performance category scores on the TPCC measure. CMS assigned several anesthesia groups a cost score based on a minority of their physician and nursing staff billing. In one case, a large group billed over 500,000 cases during the year and a cost score was assigned to the group based on fewer than 500 cases (representing less than 0.1% of their total cases). We support changes to the TPCC measure that will prevent this scenario from happening in the future.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

Yes. We agree that Acumen should update the attribution methodology to exclude NP/PA/CNS if the rest of the TIN is composed of only HCFA excluded specialties (e.g. anesthesiology).

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

ASA has no concerns regarding the changes being too restrictive. This refinement would ensure a more precise and focused application of the measure.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

NA

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

NA

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

Yes, Acumen should check whether an excluded specialty has submitted the claim. The candidate event logic should not impact or be used to assign or erroneously attribute the measure to those specialties (and their TINs) excluded from the measure.

[Topic #2 Adjust Candidate Event Logic Q3. Please provide any additional comments about simplifying candidate event logic below. For example, would these approaches lead to certain types of care being left out of the measure despite being within the measure's intent?]

NA

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

On behalf of our more than 57,000 members, ASA appreciates the opportunity to provide feedback to The Centers for Medicare & Medicaid Services (CMS) and Acumen, LLC on the Total Per Capita Cost (TPCC) measure. Thank you for your consideration of our comments. We welcome the opportunity to speak with you further about our feedback in the future. Please contact Matthew Popovich, Chief Quality Officer [*redacted*], or Matthew Goldan, ASA Regulatory Affairs Operations Associate [*redacted*], for questions or further information.

3.1.7 Comment Number 7

- **Date:** 5/15/2024
- **Submitter Name, Credentials, and Organization:** Rachael Grastorf, InContext Consulting, LLC
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

Outside of the actual execution of the measure, the intent is to promote relationships with primary care providers, and specialists that are managing chronic conditions. (example: Primary Care, Endocrinology, Oncology, Cardiology, etc)

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

NO it does not. The current attribution methodology includes Physician Extenders (PAs and NPs), even when they are fully dedicated to a specialty practice, and provide no ongoing primary care services. For example, Radiology groups with NP's and PA's who conduct post-surgical follow-up visits are being attributed patients for this measure. Clinically, they have no ongoing relationship or influence over this patient's Primary Care, nor are they managing the patient's Chronic Conditions. The services they are providing don't align with the intent of the TPCC measure.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

a. We agree that the measure should be refined to exclude advanced care practitioners as described above. There are instances where this may be too restrictive, but as a general rule, the proposed refinement would eliminate attribution for advanced care providers who don't provide ongoing care to their patients.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

a. There are certain circumstances where the refinement would be too restrictive. For example, consider a TIN that's comprised of an overwhelming majority of Diagnostic Radiologists, has a few Nurse Practitioners, but also includes one Cardiologist. The NPs from that TIN would receive attribution for patients because the TIN would not be solely composed of excluded providers due to the presence of the 1 Cardiologist.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

a. CMS should consider excluding advanced care practitioners from TINS that meet a 75% threshold of excluded providers in the TIN (rather than 100% in the proposed refinement). In the example above, if TIN had a composition of 75 radiologists, NP's and 1 cardiologist, they would exceed the 75% threshold, and the NPs would not receive attribution for the primary care procedures that fell under the cardiologist's care.

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

a. Yes! It will increase visibility for providers who are attributed patients on where their patients are coming from. When the patients are attributed from another TIN, it's nearly impossible to

track where the patients came for their initial care. This adjustment would limit the patients to only those who are within the purview of the attributed provider.

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

a. Yes! Confirming claims billed under specialties that are excluded from this measure should NOT count toward attribution. A specialty check on the confirming claim would limit the attributed patients to those who are within the primary care/coordinated scope and intent of the measure. The current attribution includes patients who are seen by a specialist, but should not be included in the final attribution.

[Topic #2 Adjust Candidate Event Logic Q3. Please provide any additional comments about simplifying candidate event logic below. For example, would these approaches lead to certain types of care being left out of the measure despite being within the measure's intent?]

No additional comments at this time.

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

a. CMS should consider excluding the cost of procedures, medications, etc. that are incurred by patients from Oncology and Chemotherapy. For example, consider a patient that is attributed to a primary care provider who has an encounter with their oncologist during the year. The costs incurred during the 13-beneficiary month period that are attributed to the primary care provider will disproportionately increase due to the services & medication prescribed by the oncologist.

3.1.8 Comment Number 8

- **Date:** 5/15/2024
- **Submitter Name, Credentials, and Organization:** Rachael Grastorf, InContext Consulting, LLC
- **Comment Text:**

On behalf of InContext, LLC and the clients we represent, we appreciate the opportunity to offer our comments on the Total Per Capita Cost (TPCC) Measure as it applies to the MIPS program in the 2024 Reporting Year. We appreciate the Agency's commitment to advancing value-based care and meaningful quality measurement through the QPP. However, we firmly believe that CMS continues to tragically ignore major industry concerns related to the Cost Category in the MIPS program.

Outlined in the proceeding pages are our comments on the TPCC measure. We want to emphatically believe that with the input and changes suggested, CMS could make this measure, and its future iterations, more useful for both providers and patients.

Again, we thank you for extending this opportunity to provide comment on the TPCC Measure. As always, we look forward to working with CMS in its efforts to improve value-based care in Medicare.

Sincerely,

InContext, LLC
P.O. Box 921
New Market, MD 21774

1. **Attribution to Physician Extenders**
    a. **COMMENT:** Physician Extenders (NP's/PA's) should be excluded or included based on a majority count of the included or excluded provider-types in the group/TIN (see code listing table accompanying the measure). In the case of a specialty practice, such as radiology, this would mean excluding the NP's/PA's.

    b. **EXAMPLE:** If this recommendation was applied to a Radiology Practice with 90 Diagnostic and/or Interventional Radiologists and 10 NP's billing under the TIN, the 10 NP's would be excluded from the TPCC measure as 100% of the non-Physician Extender Providers are excluded from the measure due to their specialty.

    c. **RATIONALE:**
        - **Section 2.2 of the measure states:** "After service category exclusions are applied, clinicians who would not reasonably be responsible for providing primary care are excluded from attribution of the TPCC measure."
        - **Current State:** NP's and PA's that are part of Groups/TIN's that are surgical, or diagnostic in nature are attributed patients under this measure, thus triggering the measure for the group. Yet these TIN' and providers, other than billing E&M codes are **NOT** rendering primary care services. An Orthopaedic group for example that contains NP's and PA's should not be asked to set up Primary Care Centric Care coordination, managing chronic conditions such as: Kidney disease, Diabetes, COPD, CAD, etc. Not only does attribution take place in these surgical or diagnostic groups, but when the measure is scored, they typically perform poorly as they are being held accountable for services and outcomes that are outside of their scope of Practice.
        - **Example:** Interventional Radiology (IR) practice is attributed patients for

TPCC when they use their PA/NP to see patients in a pre- or post-operative outpatient clinic visit involving an IR procedure. This practice is being held to the overall health of this patient for a 12-month period, even though they are not this patient's primary care provider, and are unlikely to see them once the IR procedure episode of care is complete. When specialty practices such as these trigger this measure, they are unfairly compared to primary care practices.

2. **<u>Patient-level Feedback Reports:</u>**

a. **COMMENT:** For the TPCC measure (and all other existing and future MIPS cost measures), the measure steward (in this case CMS) should be **<u>required</u>** to:

- Clearly define a set of data elements (Data Model) that will be reported back to any Eligible Clinician that triggers the measure. The data element "table" should be required as an appendix to the Cost measure specification, much like the "Code list" tables accompany the measures today,
- Clearly define when (specific months during the performance year) data will be provided, including the Dates of Service that will be provided to the industry with each reporting set. This too should be a required part of the Cost measure specification,
- Then, when it's time to review a Cost measure and seek public comments, in addition to asking for public comments on Measure Specifications, the scope of the periodic review should also request comments on the items referenced above: The data elements that will be provided back to the industry along with commitments for timeliness of reporting.

b. **RATIONALE:** We believe the largest "gap" in the Cost category of MIPS is not the construction of new measures or the revision of existing measures, but instead the lack of timely, useful information provided to the industry on the cost measure results. Without this, the industry is unable to direct efforts to improve performance. This is a tremendous gap that needs to be filled, given the goal of CMS to drive providers to improve under the quality program.

c. **REQUESTED ACTION: CMS must provide more timely and actionable cost data if they truly want to hold health care providers accountable for cost and prepare providers for APM's. This is true for both the Traditional MIPS and MVP reporting options. In addition, providers should be provided with adequate cost data to validate that their Performance Year scoring is correct.**

- **CURRENT STATE:** For many, Providers cost is now worth 30% of their MIPS score and underlying payment adjustment. Unfortunately, across the industry what we see/hear is, "I have no information to make constructive change in cost …. I can't even tie the csv/excel tables to how my score was

constructed. How do I even know it's correct? We get much better information from our Commercial and Medicare Advantage VBP programs. What am I supposed to do?"

- **REQUESTED ACTION:** In our historically submitted comments, we have strongly suggested that CMS provide monthly data at the same level provided years ago under the Value Modifier program. For instance, include benchmarking information related to the different cost categories in the beneficiary file, include the NPI and the CPT paid that drove attribution, include the facility where the episode was provided (for MSPB), etc. We believe it's contrary to the overall program rules, and unfair and illogical to hold Providers accountable for understanding and optimizing cost with scant information provided eight months after the close of the performance period. There seems to be no recognition that this is a material gap in the Program overall, and as a result, it is never discussed or committed to in rule making. We believe this should be prioritized ahead of MVPs and creating additional Cost measures, where no useful information is available to support the measures and drive change.
- **EXAMPLE:** Our point here is very simple, what good is a well-constructed MIPS Cost Measure if there is no useful, timely information provided to the industry? Perhaps an appropriate analogy is: Students are participating in a well-designed class that counts for 30% of their degree. Eight months after the close of the Term, they receive a grade for this class. No information is provided throughout the term that gives them the opportunity to see how they are doing, adjust course, etc. In this example we're guessing the Professor would be fired. Our observation is that instead of driving change through: thoughtful, timely, actionable, useful information on Cost measure results, the current Cost category of the program is rapidly driving increasing levels of frustration.

3.1.9 Comment Number 9

- **Date:** 5/16/2024
- **Submitter Name, Credentials, and Organization:** Amanda Holt, American Academy of Family Physicians
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

Primary care as defined by the American Academy of Family Physicians: "...the provision of integrated, accessible health care services by physicians and their health care teams who are

accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs. Primary care physicians specifically are trained for and skilled in comprehensive, first contact, and continuing care for persons with any undiagnosed sign, symptom, or health concern (the undifferentiated patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis. Additionally, primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, schools, telehealth, etc.). Care relationship should be the patient's usual source of care.

- Transitions of care (care after hospital discharge)
- Preventive services though these should be excluded from the cost calculations.
- E/M services
- Chronic disease management

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

No, thus the reason the TEP is now recommending further refinements to the attribution methodology.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

Yes, we agree. The AAFP is pleased that CMS and its contractor, Acumen, LLC, are working to further refine the flawed attribution for the TPCC. The proposed refinement addresses the current problem of attribution to a group practice that exclusively provides specialty care based on billing by nurse practitioners, physician assistants, and clinical nurse specialists within the group practice. The AAFP is supportive of the proposed refinement, which would exclude qualified health professionals (QHPs) in group practices composed of only QHPs and excluded specialists.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

No, we do not think it is too restrictive.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

We support the AMA’s recent feedback... Refinements to the attribution process related to QHPs are important and desirable, but they do not address the other serious problems with TPCC attribution. Physicians would still have no way to indicate that they are the primary source of care for patients who are healthy and who may not need to be seen for another billable service within the next three months; these patients would not be attributed to the physician under the current methodology. Conversely, there is no way to indicate that the relationship between a patient and physician has ended, and that is also important to address since costs beyond that endpoint would no longer be within the control of the physician. Because all attribution remains retrospective, no physicians would have any certainty as to whether they would or would not be attributed patients until after the performance period ends.

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

The AAFP has repeatedly raised concerns about the use of TPCC as an independent measure of primary care success. We acknowledge that CMS is required by statute to measure cost performance in QPP and that Congress stipulated that CMS work toward capturing 50 percent of Parts A and B spending across measures. TPCC is described to be a measure of high-quality, successful primary care delivery, but the AAFP firmly believes that MIPS does not provide primary care physicians with the support and flexibility they need to invest in continuous improvement and care delivery transformation. Our concerns related to TPCC are based on its incongruence with these foundational principles that should guide any attempt to hold primary care accountable for the total cost of care: As CMS notes, primary care is recognized for its ability to improve outcomes and reduce overall spending. These are long-term outcomes that are achieved with an appropriate level of investment in primary care services. TPCC is not designed to capture the long-term cost savings that primary care is known to achieve. Rather, it's likely that TPCC penalizes primary care clinicians by capturing only the near-term investment in primary care services that improve access to comprehensive care (and therefore utilization) for underserved populations, increase utilization of recommended preventive services, and comprehensively addressing patients: medical, behavioral, and social needs. Successful continuous improvement efforts are facilitated by actionable information provided as a feedback loop in a timely fashion to those charged with driving change. The cost performance category is unique in that all the data is calculated retrospectively by CMS using claims; nothing is reported by eligible clinicians. This means that physicians are reliant on CMS to share timely, actionable information about their performance. Under the TPCC, physicians are held accountable for costs that are incurred well beyond the scope of their direct care without an actionable data feedback loop that allows them to intervene on a timely basis. There are numerous variables that can affect cost, many of which primary care physicians cannot control even when providing the best possible care. While CMS is using a TPCC methodology that takes many factors into consideration, including patient risk, clinician specialty, and outlier spending, there are many factors, particularly related to utilization driven by patient choice and other clinicians, which

drive TPCC performance that the primary care physician cannot influence when it happens in isolation. Without better information on the drivers of TPCC performance, primary care physicians are left in the dark and cannot be held accountable for spending that they do not direct. This is especially problematic for small, independent practices, especially solo practices, which continue to struggle with achieving the same level of data interoperability achieved by larger institutions. It is important to recognize that cost is just one aspect of health care that is important to evaluate. Cost measures should be logically related to and balanced with quality measures, as well as measures of diagnostic excellence and patient experience. We call on CMS to ensure that efforts to control costs do not negatively impact quality of care, accurate and timely diagnosis, and patient experience.

3.1.10 Comment Number 10

- **Date:** 5/16/2024
- **Submitter Name, Credentials, and Organization:** David Schultz, MD, FAAFP, American Academy of Family Physicians
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

Basically, it helps identify complex care primary care provides for its patients adn the scost of delivery as well as savings affordedd

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

i think there should be a distinction between ob/gym and family physicans/IM physicians as they really do not provide true internal medicine

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

yes

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

should be only those who provide primary care. also independent mid non physician practice providers are not nearly as efficient as physicians

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

yes

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

yes

3.1.11 Comment Number 11

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Jennifer Hananoki, JD, American Medical Association
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

The current version of TPCC is fundamentally flawed because it attempts to hold physicians accountable for costs associated with medical conditions that the physician did not treat, medical decisions made by another provider, or care that the physician was not involved in. It also includes aspects and types of costs they cannot influence, such as changes in the prices of drugs, or coverage decisions for high priced drugs (e.g., GLP-1s). Furthermore, because the TPCC measure includes all Medicare Part A and B spending, not just the portions of spending that physicians can control, the TPCC measure provides physicians little or no actionable information about how to lower their spending, and it gives patients no useful information about how to lower their out-of-pocket costs or how to select physicians. TPCC does not enable physicians to determine whether they are making referrals to other physicians who order unnecessary tests or procedures or whose treatments result in avoidable complications and adverse events. Nor does the TPCC help a patient determine whether a particular physician will treat that patient's specific health problems more cost-effectively than another physician would. Because of these fundamental flaws, the AMA strongly urges CMS to remove TPCC from MIPS or, at a minimum, remove it from any MIPS Value Pathway (MVP) in which there is an episode-based cost measure. If the TPCC continues to be used, it must be revised so that it is either limited to or focused on the aspects of cost that physicians can reasonably control and so that it avoids creating any incentive for physicians to undertreat patients. We recommend two changes in the TPCC:

1. Excluding all preventive services from the cost calculations, to avoid penalizing primary care physicians for the costs of these services, and

2. Grouping the services and costs in the measure into patient condition categories (e.g., separately calculating the costs of services for cardiovascular conditions, services related to cancer, musculoskeletal care services, trauma care services, etc.), so that it is clear which aspects of costs are more likely to be controlled or influenced by primary care services or by specific types of specialists.

The rationale for the first change is that TPCC currently penalizes physicians for delivering services designed to prevent health problems or treat them at early stages, because it counts the costs of those services but does not account for the savings that will accrue in the future by preventing health problems from occurring or avoiding the higher costs associated with treating more advanced illnesses. For example, patients who enroll in a diabetes prevention program will have higher costs in the performance period but will have lower costs in future periods if they avoid or delay the onset of Type 2 diabetes. Thus, TPCC penalizes physicians for taking actions today that will reduce future spending in the Medicare program. By contrast, in the Maryland Total Cost of Care Model, the Center for Medicare & Medicaid Innovation provides credit in its total cost of care calculations for the estimated future savings from reducing diabetes incidence. It would serve CMS well if its measure development contractor, Acumen, LLC, would develop a method for crediting future cost savings in TPCC. In the short term, the most feasible remedy would be to simply remove preventive services from TPCC.

The rationale for the second change is that the specialty adjustment in TPCC assumes that differences in total cost are based on differences in the specialty of the physician who is providing primary care services rather than differences in the types of treatments the patient needed during the year for their specific health problems. Moreover, the risk adjustment methodology is based only on chronic conditions in a prior year and does not consider current acute conditions or newly diagnosed chronic conditions that are treated for the first time during the current year. For example, a primary care physician who has a higher-than-average number of patients diagnosed with cancer during the year, particularly expensive-to-treat cancers, will be penalized by the TPCC because neither the risk adjustment methodology nor the specialty adjustment addresses this. However, by calculating costs related to cancer as a separate subcategory within TPCC, it would be clear whether the primary care physician's total cost per patient was higher due to those costs, or because that physician provides more services or more expensive services for the health conditions they manage directly. Similar changes are needed for specialty practices providing "primary care" services; for example, when an oncology practice is attributed a patient under TPCC, it could also be penalized under the current methodology, as research has shown.

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

No. The AMA is pleased that CMS and its contractor, Acumen, LLC, are taking steps to address the current problem of attribution to a group practice that exclusively provides specialty care

based on billing by nurse practitioners, physician assistants, and clinical nurse specialists within the group practice. We have previously written to CMS expressing our concerns that TPCC was inappropriately attributed to radiologists and hospitalists due to this problem. The AMA is supportive of the proposed refinement discussed by the Physician Cost Measures and Patient Relationship Codes TEP at the meeting on March 13, 2024, which would exclude qualified health professionals (QHPs) in group practices composed of only QHPs and excluded specialists. CMS should implement this change as soon as feasible and apply the change retroactively to limit any unfair Medicare penalties that result from the current flawed attribution methodology. It is essential that CMS apply this refinement to the 2023 MIPS performance period to mitigate unwarranted penalties to non-primary care specialists beginning in 2025. However, CMS must do more to correct the problem of inaccurate attribution due to billing by QHPs, and it must also address other serious attribution problems that were not discussed at the March 2024 TEP meeting. Because the proposed refinement would only prevent inappropriate attribution to QHPs who are part of group practices that consist solely of excluded specialties, it would do nothing to prevent inappropriate attribution to groups that have both included and excluded specialties. This is an even larger group than the group that CMS would exclude under this refinement. Specifically, there are 6,559 groups (as identified by their tax identification number [TIN]) comprised of QHPs and excluded specialties, which accounts for about ten percent of TINs. However, there are 9,032 groups comprised of QHPs in groups with included and excluded specialties, and this accounts for about 14 percent of TINs. In multi-specialty groups that include both primary care physicians and non-primary care specialists, some or all of the QHPs could be supporting the work of the excluded specialists, yet patients could be attributed to the group solely because of the non-primary care services provided by the QHPs. This would also be inappropriate, and CMS should identify the types and mixes of services that individual QHPs provide to develop additional ways to eliminate as many inappropriate attributions as possible. Refinements to the attribution process related to QHPs are important and desirable, but they do not address the other serious problems with TPCC attribution. Physicians would still have no way to indicate that they are the primary source of care for patients who are healthy and who may not need to be seen for another billable service within the next three months; these patients would not be attributed to the physician under the current methodology. Conversely, there is no way to indicate that the relationship between a patient and physician has ended, and that is also important to address since costs beyond that endpoint would no longer be within the control of the physician. Because all attribution remains retrospective, no physicians would have any certainty as to whether they would or would not be attributed patients until after the performance period ends.

For these reasons, it is essential to modify the attribution rules to include a mechanism for using patient relationship codes and to seek input from physician specialty societies about how to make this new attribution method work effectively. Primary care physicians and specialists, as well as QHPs, should be able to inform accurate attribution of patients and cost measures by including the applicable patient relationship code on their claims. The Medicare Access and CHIP

Reauthorization Act provides that [i]n order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate (i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners (42 U.S.C. 1395-4(r)(5)(A)(i)). The statute clearly envisioned that the patient relationship codes would be used for patient attribution of cost measures, and this is particularly important for a cost measure as broad as the TPCC. The current attribution rules merely make guesses, and often inaccurate guesses, about whether a patient's care is being managed by a particular physician. A far more accurate method would be to allow physicians to explicitly describe the nature of their relationship with a patient.

CMS and its contractor, Acumen, LLC, have stated that the reason for not using the patient relationship codes in the cost measure attribution methodology is that very few physicians and other eligible clinicians report these codes. But this is circular logic. The lack of reporting is due at least in part to the fact that the codes are not currently used in cost measure attribution and do not result in any additional payment or other resources. It is not surprising that busy physicians do not take the extra time to record a code when they know it will have no impact on anything. If physicians knew that their MIPS cost measure attribution would be more accurate and better reflect their clinical practice if they reported the patient relationship codes, the AMA believes many more physicians would report the codes, particularly as the cost measures account for 30 percent of MIPS final scores and MIPS penalties can be as large as -9 percent.

While we recommend that CMS examine approaches to promote and incentivize the use of the patient relationship codes, it is neither necessary nor desirable to mandate the use of patient relationship codes on all claims in order to utilize them to improve attribution. Using the patient relationship codes will require additional time by physicians and changes in their billing systems, and that may not be feasible today for many physicians, particularly those in small and under-resourced practices. If a physician does not report a patient relationship code for a particular patient, the current attribution rules can continue to be used to determine what portion of costs associated with that patient's overall care, if any, should be attributed to that physician.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

Yes. CMS should implement this change as soon as feasible and apply the change retroactively to limit any unfair Medicare penalties that result from the current flawed attribution methodology. It is essential that CMS apply this refinement to the 2023 MIPS performance period to mitigate unwarranted penalties to non-primary care specialists beginning in 2025.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

CMS must do more to correct the problem of inaccurate attribution due to billing by QHPs, and it must also address other serious attribution problems that were not discussed at the March 2024 TEP meeting. Because the proposed refinement would only prevent inappropriate attribution to QHPs who are part of group practices that consist solely of excluded specialties, it would do nothing to prevent inappropriate attribution to groups that have both included and excluded specialties. This is an even larger group than the group that CMS would exclude under this refinement. Specifically, there are 6,559 groups (as identified by their tax identification number [TIN]) comprised of QHPs and excluded specialties, which accounts for about ten percent of TINs. However, there are 9,032 groups comprised of QHPs in groups with included and excluded specialties, and this accounts for about 14 percent of TINs. In multi-specialty groups that include both primary care physicians and non-primary care specialists, some or all of the QHPs could be supporting the work of the excluded specialists, yet patients could be attributed to the group solely because of the non-primary care services provided by the QHPs. This would also be inappropriate, and CMS should identify the types and mixes of services that individual QHPs provide to develop additional ways to eliminate as many inappropriate attributions as possible.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

Refinements to the attribution process related to QHPs are important and desirable, but they do not address the other serious problems with TPCC attribution. Physicians would still have no way to indicate that they are the primary source of care for patients who are healthy and who may not need to be seen for another billable service within the next three months; these patients would not be attributed to the physician under the current methodology. Conversely, there is no way to indicate that the relationship between a patient and physician has ended, and that is also important to address since costs beyond that endpoint would no longer be within the control of the physician. Because all attribution remains retrospective, no physicians would have any certainty as to whether they would or would not be attributed patients until after the performance period ends. For these reasons, it is essential to modify the attribution rules to include a mechanism for using patient relationship codes and to seek input from physician specialty societies about how to make this new attribution method work effectively. Primary care physicians and specialists, as well as QHPs, should be able to inform accurate attribution of patients and cost measures by including the applicable patient relationship code on their claims. The Medicare Access and CHIP Reauthorization Act provides that [i]n order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate (i) use the patient relationship codes

reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners (42 U.S.C. 1395-4(r)(5)(A)(i)). The statute clearly envisioned that the patient relationship codes would be used for patient attribution of cost measures, and this is particularly important for a cost measure as broad as the TPCC. The current attribution rules merely make guesses, and often inaccurate guesses, about whether a patient's care is being managed by a particular physician. A far more accurate method would be to allow physicians to explicitly describe the nature of their relationship with a patient.

CMS and its contractor, Acumen, LLC, have stated that the reason for not using the patient relationship codes in the cost measure attribution methodology is that very few physicians and other eligible clinicians report these codes. But this is circular logic. The lack of reporting is due at least in part to the fact that the codes are not currently used in cost measure attribution and do not result in any additional payment or other resources. It is not surprising that busy physicians do not take the extra time to record a code when they know it will have no impact on anything. If physicians knew that their MIPS cost measure attribution would be more accurate and better reflect their clinical practice if they reported the patient relationship codes, the AMA believes many more physicians would report the codes, particularly as the cost measures account for 30 percent of MIPS final scores and MIPS penalties can be as large as -9 percent.

While we recommend that CMS examine approaches to promote and incentivize the use of the patient relationship codes, it is neither necessary nor desirable to mandate the use of patient relationship codes on all claims in order to utilize them to improve attribution. Using the patient relationship codes will require additional time by physicians and changes in their billing systems, and that may not be feasible today for many physicians, particularly those in small and under-resourced practices. If a physician does not report a patient relationship code for a particular patient, the current attribution rules can continue to be used to determine what portion of costs associated with that patient's overall care, if any, should be attributed to that physician.

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

Yes. The AMA appreciates that CMS and Acumen are considering ways to simplify the TPCC methodology, which is so complex and opaque that very few physicians could anticipate whether they would be attributed a patient at the time of the patient's visit.

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

Yes.

[Topic #2 Adjust Candidate Event Logic Q3. Please provide any additional comments about simplifying candidate event logic below. For example, would these approaches lead to certain types of care being left out of the measure despite being within the measure's intent?]

As discussed previously, we believe including the patient relationship codes in the TPCC attribution methodology could do more to simplify and significantly improve the accuracy of attribution and candidate event logic of TPCC, as long as the enhanced methodology is developed in collaboration with the physician specialty societies. Allowing physicians and other eligible clinicians to prospectively identify their relationship with a patient would provide several benefits, including: (1) improving accuracy of attribution by better distinguishing the relationship between the patient and the physician at the time of the service, (2) remedying flaws in the TPCC attribution methodology by allowing physicians to indicate when their relationship with a patient has changed, and (3) providing physicians greater certainty about which patients will be attributed to them for the MIPS cost measures. Notably, incorporating patient relationship codes into attribution would help resolve CMS's concerns that simplifying the candidate event logic could exclude healthy patients, because primary care physicians and other specialists managing well-controlled chronic conditions could report that they are the primary source of care for those patients. For example, a physician could be actively managing the care of a patient through patient portal message exchanges and prescription refills that are not captured in claims data, so the only way to know about the actual relationship between the physician and patient would be through the use of patient relationship codes.

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

In addition, the AMA continues to be extremely concerned with the shift to monthly benchmarking to evaluate a physician's performance on TPCC. We are particularly concerned that this change compromises the validity of the measure. For example, we do not believe CMS has adequately tested a monthly risk adjustment methodology, nor do we believe that a monthly cost assessment meets face validity. Has CMS examined the impact of this shift on the overall variation of the costs and to what extent those differences are due to scenarios such as a new versus established patient in the practice or seasonality of patient visits (e.g., winter flu cases or snowbirds)? In addition, spending for certain chronic conditions may be distributed over several months while spending for acute conditions will be concentrated in one month. Will physicians who see patients with multiple chronic conditions be fairly and accurately measured against physicians who see patients for acute conditions and vice versa? Further, we are concerned that a physician who is attributed six months of care could be disadvantaged compared to a physician who is able to spread the cost of care across all twelve months. Because of these outstanding concerns, the AMA recommends that TPCC shift back to an annual, rather than monthly, evaluation of costs.

3.1.12 Comment Number 12

- **Date:** 5/17/2024

- **Submitter Name, Credentials, and Organization:** Jennifer Hananoki, JD, American Medical Association
- **Comment Text:**

April 19, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to provide input to the Centers for Medicare & Medicaid Services (CMS) as it reevaluates the Total Per Capita Cost (TPCC) measure included in the Merit-based Incentive Payment System (MIPS) and considers other topics discussed during the March 2024 Physician Cost Measures and Patient Relationship Codes Technical Expert Panel (TEP) meeting. In addition, the AMA reiterates our urgent call for more timely and actionable feedback about the MIPS cost measures, including but not limited to TPCC.

Total Per Capita Cost Re-Evaluation

The current version of TPCC is fundamentally flawed because it attempts to hold physicians accountable for costs associated with medical conditions that the physician did not treat, medical decisions made by another provider, or care that the physician was not involved in. It also includes aspects and types of costs they cannot influence, such as changes in the prices of drugs, or coverage decisions for high priced drugs (e.g., GLP-1s). Furthermore, because the TPCC measure includes all Medicare Part A and B spending, not just the portions of spending that physicians can control, the TPCC measure provides physicians little or no actionable information about how to lower their spending, and it gives patients no useful information about how to lower their out-of-pocket costs or how to select physicians. TPCC does not enable physicians to determine whether they are making referrals to other physicians who order unnecessary tests or procedures or whose treatments result in avoidable complications and adverse events. Nor does the TPCC help a patient determine whether a particular physician will treat that patient's specific health problems more cost-effectively than another physician would. **Because of these fundamental flaws, the AMA strongly urges CMS to remove TPCC from MIPS or, at a minimum, remove it from any MIPS Value Pathway (MVP) in which there is an episode-based cost measure.**

If the TPCC continues to be used, it must be revised so that it is either limited to or focused on the aspects of cost that physicians can reasonably control and so that it avoids creating any incentive for physicians to undertreat patients. We recommend two changes in the TPCC:

1. Excluding all preventive services from the cost calculations, to avoid penalizing primary care physicians for the costs of these services, and
2. Grouping the services and costs in the measure into patient condition categories (e.g., separately calculating the costs of services for cardiovascular conditions, services related to cancer, musculoskeletal care services, trauma care services, etc.), so that it is clear which aspects of costs are more likely to be controlled or influenced by primary care services or by specific types of specialists.

The rationale for the first change is that TPCC currently penalizes physicians for delivering services designed to prevent health problems or treat them at early stages, because it counts the costs of those services but does not account for the savings that will accrue in the future by preventing health problems from occurring or avoiding the higher costs associated with treating more advanced illnesses. For example, patients who enroll in a diabetes prevention program will have higher costs in the performance period but will have lower costs in future periods if they avoid or delay the onset of Type 2 diabetes. Thus, TPCC penalizes physicians for taking actions today that will reduce future spending in the Medicare program. By contrast, in the Maryland Total Cost of Care Model, the Center for Medicare & Medicaid Innovation provides credit in its total cost of care calculations for the estimated future savings from reducing diabetes incidence. It would serve CMS well if its measure development contractor, Acumen, LLC, would develop a method for crediting future cost savings in TPCC. In the short term, the most feasible remedy would be to simply remove preventive services from TPCC.

The rationale for the second change is that the specialty adjustment in TPCC assumes that differences in total cost are based on differences in the specialty of the physician who is providing primary care services rather than differences in the types of treatments the patient needed during the year for their specific health problems. Moreover, the risk adjustment methodology is based only on chronic conditions in a prior year and does not consider current acute conditions or newly diagnosed chronic conditions that are treated for the first time during the current year. For example, a primary care physician who has a higher-than-average number of patients diagnosed with cancer during the year, particularly expensive-to-treat cancers, will be penalized by the TPCC because neither the risk adjustment methodology nor the specialty adjustment addresses this. However, by calculating costs related to cancer as a separate subcategory within TPCC, it would be clear whether the primary care physician's total cost per patient was higher due to those costs, or because that physician provides more services or more expensive services for the health conditions they manage directly. Similar changes are needed for

specialty practices providing "primary care" services; for example, when an oncology practice is attributed a patient under TPCC, it could also be penalized under the current methodology, as research has shown.

In addition, the AMA continues to be extremely concerned with the shift to monthly benchmarking to evaluate a physician's performance on TPCC. We are particularly concerned that this change compromises the validity of the measure. For example, we do not believe CMS has adequately tested a monthly risk adjustment methodology, nor do we believe that a monthly cost assessment meets face validity. Has CMS examined the impact of this shift on the overall variation of the costs and to what extent those differences are due to scenarios such as a new versus established patient in the practice or seasonality of patient visits (e.g., winter flu cases or snowbirds)? In addition, spending for certain chronic conditions may be distributed over several months while spending for acute conditions will be concentrated in one month. Will physicians who see patients with multiple chronic conditions be fairly and accurately measured against physicians who see patients for acute conditions and vice versa? Further, we are concerned that a physician who is attributed six months of care could be disadvantaged compared to a physician who is able to spread the cost of care across all twelve months. **Because of these outstanding concerns, the AMA recommends that TPCC shift back to an annual, rather than monthly, evaluation of costs.**

Adjusting Attribution Rules

The AMA is pleased that CMS and its contractor, Acumen, LLC, are taking steps to address the current problem of attribution to a group practice that exclusively provides specialty care based on billing by nurse practitioners, physician assistants, and clinical nurse specialists within the group practice. We have previously written to CMS expressing our concerns that TPCC was inappropriately attributed to radiologists and hospitalists due to this problem. The AMA is supportive of the proposed refinement discussed by the Physician Cost Measures and Patient Relationship Codes TEP at the meeting on March 13, 2024, which would exclude qualified health professionals (QHPs) in group practices composed of only QHPs and excluded specialists. **CMS should implement this change as soon as feasible and apply the change retroactively to limit any unfair Medicare penalties that result from the current flawed attribution methodology.** It is essential that CMS apply this refinement to the 2023 MIPS performance period to mitigate unwarranted penalties to non-primary care specialists beginning in 2025.

However, CMS must do more to correct the problem of inaccurate attribution due to billing by QHPs, and it must also address other serious attribution problems that were not discussed at the March 2024 TEP meeting. Because the proposed refinement would only prevent inappropriate attribution to QHPs who are part of group practices that consist solely of excluded specialties, it would do nothing to prevent inappropriate attribution to groups that have both included and excluded specialties. This is an even larger group than the group that CMS

would exclude under this refinement. Specifically, there are 6,559 groups (as identified by their tax identification number [TIN]) comprised of QHPs and excluded specialties, which accounts for about ten percent of TINs. However, there are 9,032 groups comprised of QHPs in groups with included and excluded specialties, and this accounts for about 14 percent of TINs. In multi-specialty groups that include both primary care physicians and non-primary care specialists, some or all of the QHPs could be supporting the work of the excluded specialists, yet patients could be attributed to the group solely because of the non-primary care services provided by the QHPs. This would also be inappropriate, and **CMS should identify the types and mixes of services that individual QHPs provide to develop additional ways to eliminate as many inappropriate attributions as possible.**

Refinements to the attribution process related to QHPs are important and desirable, but they do not address the other serious problems with TPCC attribution. Physicians would still have no way to indicate that they are the primary source of care for patients who are healthy and who may not need to be seen for another billable service within the next three months; these patients would not be attributed to the physician under the current methodology. Conversely, there is no way to indicate that the relationship between a patient and physician has ended, and that is also important to address since costs beyond that endpoint would no longer be within the control of the physician. Because all attribution remains retrospective, no physicians would have any certainty as to whether they would or would not be attributed patients until after the performance period ends.

For these reasons, it is essential to modify the attribution rules to include a mechanism for using patient relationship codes and to seek input from physician specialty societies about how to make this new attribution method work effectively. Primary care physicians and specialists, as well as QHPs, should be able to inform accurate attribution of patients and cost measures by including the applicable patient relationship code on their claims. The Medicare Access and CHIP Reauthorization Act provides that "[i]n order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate–(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners" (42 U.S.C. 1395w–4(r)(5)(A)(i)). The statute clearly envisioned that the patient relationship codes would be used for patient attribution of cost measures, and this is particularly important for a cost measure as broad as the TPCC. The current attribution rules merely make guesses, and often inaccurate guesses, about whether a patient's care is being managed by a particular physician. A far more accurate method would be to allow physicians to explicitly describe the nature of their relationship with a patient.

CMS and its contractor, Acumen, LLC, have stated that the reason for not using the patient relationship codes in the cost measure attribution methodology is that very few physicians and

other eligible clinicians report these codes. But this is circular logic. The lack of reporting is due at least in part to the fact that the codes are not currently used in cost measure attribution and do not result in any additional payment or other resources. It is not surprising that busy physicians do not take the extra time to record a code when they know it will have no impact on anything. If physicians knew that their MIPS cost measure attribution would be more accurate and better reflect their clinical practice if they reported the patient relationship codes, the AMA believes many more physicians would report the codes, particularly as the cost measures account for 30 percent of MIPS final scores and MIPS penalties can be as large as -9 percent.

While we recommend that CMS examine approaches to promote and incentivize the use of the patient relationship codes, it is neither necessary nor desirable to mandate the use of patient relationship codes on all claims in order to utilize them to improve attribution. Using the patient relationship codes will require additional time by physicians and changes in their billing systems, and that may not be feasible today for many physicians, particularly those in small and under-resourced practices. If a physician does not report a patient relationship code for a particular patient, the current attribution rules can continue to be used to determine what portion of costs associated with that patient's overall care, if any, should be attributed to that physician.

Adjusting Candidate Event Logic

During the March 2024 TEP meeting, there was also discussion about options to simplify TPCC's candidate event logic. The AMA appreciates that CMS and Acumen are considering ways to simplify the TPCC methodology, which is so complex and opaque that very few physicians could anticipate whether they would be attributed a patient at the time of the patient's visit. **We support the proposed refinements to remove the "+/- three days, Any TIN" rule from the candidate event logic and to add an included specialty check on the confirming claim of the candidate event.**

However, as discussed previously, we believe including the patient relationship codes in the TPCC attribution methodology could do more to simplify and significantly improve the accuracy of attribution and candidate event logic of TPCC, as long as the enhanced methodology is developed in collaboration with the physician specialty societies.

Allowing physicians and other eligible clinicians to prospectively identify their relationship with a patient would provide several benefits, including: (1) improving accuracy of attribution by better distinguishing the relationship between the patient and the physician at the time of the service, (2) remedying flaws in the TPCC attribution methodology by allowing physicians to indicate when their relationship with a patient has changed, and (3) providing physicians greater certainty about which patients will be attributed to them for the MIPS cost measures. Notably, incorporating patient relationship codes into attribution would help resolve CMS' concerns that

simplifying the candidate event logic could exclude healthy patients, because primary care physicians and other specialists managing well-controlled chronic conditions could report that they are the primary source of care for those patients. For example, a physician could be actively managing the care of a patient through patient portal message exchanges and prescription refills that are not captured in claims data, so the only way to know about the actual relationship between the physician and patient would be through the use of patient relationship codes.

Using Cost Measures to Assess Value

During the March 2024 TEP meeting, Acumen presented a concept that would use the existing administrative claims-based cost measure development process to develop a cost measure and a companion quality measure at the same time. Specifically, Acumen presented a case study on how a sepsis mortality measure could be developed using almost all the same specifications of the Sepsis episode-based cost measure.

Though we do not support the approach presented by Acumen for the reasons explained below, we were glad to see discussion about adding measures to MIPS on an information-only basis. The AMA has made this recommendation in the past and been told that CMS does not have statutory authority to include a measure that does not count toward the MIPS score and payment adjustment. For example, the AMA opposes the Psychoses episode-based cost measure that holds inpatient psychiatrists accountable for all services after the patient leaves the hospital, regardless of whether there are community-based supports that accept Medicare. We previously recommended that the measure be implemented on an information-only basis but were told that was not possible given statutory constraints. We are glad that CMS has apparently reevaluated its legal analysis and determined that the agency can adopt measures on an information-only basis. There are some measures that would be helpful to track and to see the data to improve patient care, but not if it means penalizing physicians using measures that are not sufficiently reliable or that can be significantly affected by available community resources and other factors outside of a physician’s control.

Furthermore, we urge Acumen to provide more information about their work on aligning cost and quality measures. For instance, it would be useful to know if Acumen has calculated and evaluated cost and quality measures for the same conditions and episodes and whether they cover the same timeframe, same physicians or eligible clinicians, same panel of patients, and same sets of services.

Identifying and Prioritizing Claims-Based Outcomes

While the AMA believes it is important to align cost and quality in MIPS, that cannot and should not be done using mortality or other “outcomes” measures using administrative claims data. **We strongly urge CMS and Acumen to abandon any further efforts to develop mortality**

measures for physicians and focus instead on quality process measures that are designed to ensure that lower costs are not the result of undertreatment. Adding additional claims-based outcome measures to the program will only exacerbate the ongoing issues with attribution and risk-adjustment that we currently see with claims-based cost measures. Measure developers moved to registry and electronic/digital quality measures because they are much richer and more granular sources of data and allow an accurate determination of which physicians were involved in a patient's care. Claims data cannot do this.

The issue with mortality that *should* be addressed is that under the current cost measures, a hospital or physician is penalized for spending more to keep patients from dying because costs associated with patients who survive are included, but the costs associated with patients who die are not. Acumen's analysis that was presented to the TEP does not address this problem. We also believe Acumen may have misinterpreted the direction of the TEP. The issue that prompted this presentation was a discussion at a previous TEP meeting about whether patients who die should continue to be excluded from cost measures. Rather than simply including or excluding those patients from the current cost measures, the TEP recommended exploring whether it would be possible to create a separate way of measuring costs and quality associated with patients who die. However, Acumen did not propose ways of measuring "episodes ending in death," but instead proposed measuring the rate at which a physician's patients die.

What is worse, the proposed mortality measure did not examine or address the many serious problems that are known to be associated with trying to measure and hold physicians accountable for mortality. The AMA recommends reviewing the two articles below, which provide more information about why it is inappropriate to try and measure performance on mortality at the physician level:

- Fernandez G, Narins CR, Bruckel J, Ayers B, Ling FS. Patient and Physician Perspectives on Public Reporting of Mortality Ratings for Percutaneous Coronary Intervention in New York State. Circ Cardiovasc Qual Outcomes. 2017 Sep;10(9):e003511. Doi: 10.1161/CIRCOUTCOMES.116.003511. PMID: 28893831.
- Salet N, Stangenberger VA, Bremmer RH, Eijkenaar F. Between-Hospital and Between-Physician Variation in Outcomes and Costs in High- and Low-Complex Surgery: A Nationwide Multilevel Analysis. Value Health. 2023 Apr; 26(4):536-546. Doi: 10.1016/j.jval.2022.11.006. Epub 2022 Nov 25. PMID: 36436789.

Aligning Cost and Quality with Measure Specifications

The only way to fairly measure the performance of physicians on cost is to ensure: (1) that the cost measures assess the aspects of cost that physicians can control, and (2) that there are also quality measures that can identify whether reductions in cost are being achieved by delivering fewer of the services that patients need to achieve good outcomes. Although it sounds attractive

to use outcome measures to assess the quality of care, a physician cannot control all the factors that affect a patient's outcome. No risk adjustment methods can adequately adjust for all the uncontrollable factors, and risk adjustment methods based solely on information on claims data will perform particularly poorly. Just as cost measures must be focused on the aspects of cost that physicians can control, quality measures also have to focus on the aspects of care that physicians can control, rather than outcomes that they cannot control.

Cost and quality measures should be developed as a logically related bundle, rather than merely identifying quality measures and a cost measure for the same condition and assuming they are complementary. It would be particularly inappropriate to pair cost and quality measures that are based on different groups of patients and physicians, different time frames, or differences in services or other data elements, because it is then impossible to say for sure whether lower costs are being achieved at the expense of quality for some patients, or whether higher quality is being achieved through spending that is not included in the cost measure. The TPCC measure is already much too broad, and there is no group of quality measures or aggregate measure that could appropriately protect against inappropriately low spending in such a broad measure. This problem is exacerbated under the current approach of monthly benchmarking on costs, which is contrary to how the quality measures are reported. **The AMA urges CMS to refine its approach and implement MVPs that are focused on specific patient conditions and that use logically related cost and quality measures specific to those conditions.**

Assessing Performance with the Companion Metric

MVPs were intended to be a mechanism for aligning cost and quality measures. As a CMS contractor, Acumen should not be developing an additional or different approach. Rather, Acumen should assist CMS to identify and develop more and better episode-based cost measures to replace TPCC. It should also identify the types of services included in each episode-based cost measure where undertreatment of patients could result in lower costs and identify or develop measures of whether cost reductions are being achieved by reducing the number of necessary services delivered.

Lack of Timely Data to Reduce Avoidable Costs for Medicare and Patients

Regardless of how well designed the MIPS cost measures are, an overarching problem is the lack of timely feedback to physicians. Currently, CMS provides physicians with an annual MIPS Feedback Report that includes information about their performance on MIPS measures six to 18 months after they have provided the services to patients. Because only CMS can calculate the cost measures, physicians have no way of knowing at any point during the performance year how they are performing on any of these cost measures. Yet, these measures collectively account for 30 percent of their total MIPS score.

Physicians do not know which cost measures they will be measured on, which patients will be attributed to them, and for what costs or services provided by other health professionals or facilities outside of their own practices they will be held accountable. Without this information, physicians have no way to monitor their current performance, identify opportunities for improving the efficiency of care delivery, and avoid unnecessary costs for the Medicare program and patients. **To drive improvements in cost measure performance and reductions in avoidable spending, CMS should provide physicians with quarterly feedback reports during the performance period about their cost measures. These reports could be similar to the field testing reports that its measure development contractor, Acumen, LLC, provides when cost measures are in development.**

The AMA appreciates CMS' attention to opportunities to improve the MIPS Cost Performance Category and thanks the agency for its consideration of our input on these topics. If you have any questions regarding this letter, please contact Margaret Garikes, Vice President of Federal Affairs, at [*redacted*].

Sincerely,
James L. Madara, MD

3.1.13 Comment Number 13

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Richard Heller, MD, Radiology Partners
- **Comment Text:**

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

No. The current attribution methodology does not exclude non-physician advanced care practitioners (ACPs) who work within excluded specialties, such as radiology. Based on the measure's attribution methodology, diagnostic and interventional radiologists are explicitly excluded from the TPCC measure. However, in its current state, the radiology exclusion only applies to radiologists, not ACPs who specialize in radiology, resulting in candidate events being attributed to a practice that would otherwise be exempt from this measure. If a radiologist in the same practice performed the same pre- and post-imaging consults currently furnished by ACPs, the TPCC measure would not apply. This is not only logically inconsistent, but also counter to the goal of the Quality Payment Program (QPP), since it disincentivizes use of ACPs and may worsen the value of care delivery by adding cost and reducing efficiency.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

Yes, Radiology Partners supports this solution.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

We have no concerns that this would be an issue.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

The attribution methodology could exclude providers according to the billing entity taxonomy code instead of the individual provider HCFA code(s). Taking a step back, the goal should be to exclude providers (both physicians and ACPs) who practice in excluded specialties, including diagnostic and interventional radiology practices.

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

Radiology Partners supports an additional specialty check using the above proposed method, ensuring that excluded specialists are not being inappropriately included.

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

The concerns expressed here are not hypothetical. As an example, a Radiology Partners' affiliated practice, which exclusively provides diagnostic and interventional radiology services, was negatively impacted in MIPS due to TPCC attribution. Specifically, for the 2022 performance year, the practice received 1.45 points out of 10 on the TPCC measure, which is in the lowest benchmark range. Their overall MIPS score ended up slightly above the 75-point performance threshold, at 75.59 score. Had the TPCC measure not been attributed to them, they would have earned a total MIPS score of 84.55, which would have earned them an incentive adjustment. Instead, they barely avoided a penalty. To be clear, ACPs in diagnostic and interventional radiology practices do not furnish primary care services. Their work in radiology practices increases access to care, efficiency and overall value in the healthcare system. While we understand there are appropriate times for ACPs to be considered for TPCC measure attribution, Radiology Partners urges CMS to implement a methodology that properly excludes ACPs who support a specialty that is otherwise excluded from this measure. We appreciate this opportunity to voice our concerns and share a recommendation. We hope that CMS will use its

rulemaking authority to address this problem in the TPCC attribution methodology for the benefit of Medicare beneficiaries and the medical practices that provide them care.

3.1.14 Comment Number 14

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Johnnie Sue Wijewardane, PhD, APRN, FNP-BC, FAANP, American Association of Nurse Practitioners
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

nursing home care, assisted living care, pediatric care, menopause care, preventative care, lifestyle medicine, chronic disease management, transition care, home health care, hospice care, gynecological care for medicare recipients, endocrinology care, some cardiac specialties

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

yes

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

yes

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

no concerns at this time

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

none better at this time

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

yes

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

yes

3.1.15 Comment Number 15

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Fareen Pourhamidi, MS, MPH, American College of Cardiology
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure's intent.]

The TPCC measure aims to promote the delivery high-quality, cost-effective care by holding individual clinicians responsible for their patients' total cost of care, an accepted tactic within most value-based care models. The purported rationale is that TPCC attribution - and with associated rewards or penalties - will spur clinicians to identify areas for improving the efficiency and effectiveness of care delivery. It is postulated that TPCC attribution will drive care coordination and collaboration amongst clinicians and encourage investment in preventive services and wellness programs to reduce long-term costs associated with chronic conditions and preventable illnesses.

The evidence-base for the concept of "assigning individual responsibility will drive system improvement in the cost and efficacy of care" is scant but perhaps strongest when applied to primary care relationships. Prevention and screening, as well as adherence to evidence-based practices for chronic care management, remain cornerstone principles within primary care delivery. Communication and care coordination with specialists should also serve to optimize treatment, reduce complications, and lower costs.

In contrast, the role of the specialist in care delivery typically centers on (1) management of acute episodes of care or (2) longitudinal management of complex patient cohorts whose severity of illness is beyond that which would be reasonably expected to be managed by a primary care practitioner. As such, the costs associated with delivering specialty care are expected to be higher on a per capita basis than the care for a similar disease entity that is managed by a primary care provider. In sum, primary care relationships align best with the measure's intent; specialty relationships do not.

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

Reorganizing the services and costs within the measure into categories based on patient conditions, such as cardiovascular conditions, cancer-related services, musculoskeletal care, and trauma care, would clarify which aspects of costs are more likely to be influenced by primary care services or specific types of specialists. This categorization could provide insight into areas where cost control or influence is most effective.

The current measure adjusts for physician specialty, assuming cost variations stem from differences in primary care services provided by specialists. However, this approach overlooks the complexity of patient needs. For example, heart transplant patients require long-term follow-up to maintain optimal health and transplanted organ function. Additionally, the current risk adjustment method only considers chronic conditions from the previous year, ignoring current acute conditions or newly diagnosed chronic conditions. This could unfairly penalize primary care physicians who manage patients with newly diagnosed, expensive-to-treat conditions like cancer, even if their care is cost-effective. By specifying costs related to specific conditions, the measure could more accurately identify cost drivers.

The shift to monthly benchmarking for assessing physician performance on the TPCC measure raises significant concerns. This change may compromise the measure's validity, particularly in terms of risk adjustment and cost assessment. The fairness of measurement between physicians who primarily treat chronic conditions and those who treat acute conditions is questionable. Physicians attributed care for only part of the year could be disadvantaged compared to those attributed care for the entire year. Therefore, a return to an annual evaluation of costs is recommended to ensure a more accurate and fair assessment of physician performance.

While cardiology is considered “primary care” under the TPCC specialty criteria, the primary care services provided by cardiologists are limited. Cardiologists are medical specialists focused on the diagnosis, treatment, and management of heart and cardiovascular conditions. They possess advanced training in cardiology, which involves expertise in the cardiovascular system, heart diseases, and specialized diagnostic procedures and interventions. In contrast, primary care physicians manage a wide range of health concerns, provide preventive care, diagnose and treat common illnesses, and coordinate care across different specialties when needed. As primary care physicians may refer patients to cardiologists for specialized cardiovascular care, cardiologists usually see patients on a referral basis or when a specific cardiovascular condition requires their expertise. Primary care physicians play a crucial role in overall health maintenance, managing chronic conditions, and addressing the majority of patients' healthcare needs before referring to specialists. Overall, it is not entirely clear other than through the HCFA Specialty list of inclusions as to why Cardiology is included. It appears that there are very few cardiovascular-specific services in the service list (other than ECGs, labs) that would apply as cardiovascular services.

Cardiologists in this measure, however, will be targeted as responsible for the costs of non-primary-care services that they do not provide and cannot control. For example, cardiologists are not conducting preventive services or procedures, such as colonoscopies, breast biopsies, or screening mammograms. We agree with the HCFA exclusions of interventional and surgical cardiology and cardiac EP, for example, but the inclusion of the entirety of cardiology and heart failure specialists remains questionable. While heart failure physicians occasionally provide primary care services, this is likely limited to a very small subset of patients, primarily those with Ventricular Assist Devices (VAD) and transplant recipients. A bigger policy issue points to the fact that due to the ever-increasing shortage of primary care physicians, specialists, like cardiologists or APPs in these practices, are increasingly taking responsibility for primary care services or referrals.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

We are supportive of the proposed refinement discussed by the Physician Cost Measures and Patient Relationship Codes TEP earlier this year, which would exclude qualified health professionals (QHPs) in group practices composed of only QHPs and excluded specialists. With the goal of excluding ACPs in such TINs to more accurately reflect the cost and care delivery dynamics of these specific practices, ACPs, such as nurse practitioners and physician assistants, often have different care patterns and costs compared to physicians, and their inclusion in certain TINs might skew the TPCC results. Excluding them could lead to a more accurate representation of the costs attributed to physicians in these settings. However, the methodology should go further to consider attribution to groups that have both included and excluded specialties. In multi-specialty groups that include both primary care physicians and non-primary care specialists, some or all of the QHPs could be supporting the work of the excluded specialists, yet patients could be attributed to the group solely because of the non-primary care services provided by the QHPs.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

Improvements to the attribution process concerning Qualified Health Professionals (QHPs) are valuable, but they fail to address other significant issues with TPCC attribution. Physicians still lack a method to indicate that they are the primary caregiver for healthy patients who may not require another billable service within the next three months; these patients would not be attributed to the physician under the current methodology. Similarly, there is no mechanism to indicate when a patient-physician relationship ends, which is crucial as costs beyond this point would no longer be attributable to the physician. Since all attribution is retrospective, physicians

have no certainty about whether they will be attributed patients until after the performance period concludes.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

Modifying attribution rules to incorporate patient relationship codes may be a step forward in refining attribution methodology. While we recommend that CMS explore ways to encourage and incentivize the use of patient relationship codes, mandating their use on all claims is neither necessary nor advisable. Clinicians could be given the opportunity to report data on their patient panels, including information on the types of services provided and the complexity of patients' conditions. This would enhance the accuracy of attribution by incorporating clinicians' assessments of their patient populations.

Acumen/CMS could develop specialty-specific rules for attribution that take into account the unique care patterns and costs associated with different specialties. This could help ensure that costs are attributed appropriately based on the type of care provided. Cardiologists' ability to provide primary care depends on factors like time availability and the need for specialized services. It would be an inefficient use of training and skill to defer providing specialized cardiovascular services in favor of primary care. With a projected physician shortage and certain services best delivered by cardiologists, their role in primary care remains uncertain.

The G2211 code, which captures the longitudinal relationship between providers and patients, could serve as a distinguishing factor for primary care providers. In the future, those billing this code may be better positioned to take on patient risk, as it signifies a genuine, ongoing relationship with the patient. This differentiation is essential to ensure that TPCC accurately reflects the roles and responsibilities of different types of providers. Reflecting on the utilization of the G2211 code in a few years will likely complement patient relationship codes and provide a more logical basis for attribution.

In practice, however, many patients, especially those who split their time between different locations, have established relationships with multiple providers. For instance, patients may have cardiologists in both their primary and secondary residences, leading to duplicate care relationships. This complexity makes simple attribution challenging and underscores the need for more precise criteria. CMS currently addresses this by retrospectively analyzing claims to determine which provider delivered the bulk of services. However, this approach can undermine efforts to reduce TPCC effectively. Optimal performance during medical episodes, lowering the cost of ambulatory services, and reducing the need for clinical services are crucial. Implementing these strategies is difficult within Fee-For-Service Medicare without the assurance that value-based dollars will fund necessary investments.

The experience of Pioneer ACOs highlights the difficulty of investing in value-based care without guaranteed returns. Many of these ACOs provided comprehensive care infrastructures to all patients, only to face financial losses when patients were not attributed to them. This experience underscores the importance of precise attribution criteria to ensure that investments in care improvements are sustainable.

[Topic #2 Adjust Candidate Event Logic Q1. Should the measure remove the "+/-3 days, Any TIN" rule from candidate event logic for simplification? If not, please explain.]

We support refinements to remove the "+/- three days, Any TIN" rule from the candidate event logic.

[Topic #2 Adjust Candidate Event Logic Q2. Should the measure add an included specialty check on the confirming claim of the candidate event? If not, please explain.]

Adding an included specialty check on the confirming claim of the candidate event could be a beneficial refinement to the Total Per Capita Cost (TPCC) measure. This check could help ensure that the specialty of the clinician providing the primary care services aligns with the specialties included in the attribution rules for the TPCC measure.

Enabling physicians and other eligible clinicians to prospectively identify their relationship with a patient would offer several advantages. Firstly, it would enhance the accuracy of attribution by clearly delineating the relationship between the patient and the physician at the time of the service. Secondly, it would address shortcomings in the TPCC attribution methodology by allowing physicians to indicate when their relationship with a patient changes. Thirdly, it would provide physicians with greater certainty regarding which patients will be attributed to them for the MIPS cost measures. Incorporating patient relationship codes into attribution would help address CMS' concerns about simplifying candidate event logic, as it could prevent the exclusion of healthy patients. For instance, primary care physicians and other specialists managing well-controlled chronic conditions could indicate that they are the primary source of care for these patients. This approach would account for situations where a physician actively manages a patient's care through patient portal interactions and prescription refills that are not captured in claims data. Thus, using patient relationship codes would be essential for understanding the actual relationship between the physician and the patient.

[Topic #2 Adjust Candidate Event Logic Q3. Please provide any additional comments about simplifying candidate event logic below. For example, would these approaches lead to certain types of care being left out of the measure despite being within the measure's intent?]

Overall, we feel that CMS should consider that the Total Per Capita Cost (TPCC) measure may be redundant, especially in MIPS and with MVPs that already include an alternative episode-

based cost measure. In the 2020 proposed MIPS rule, CMS justified including the revised TPCC measure because there were no other primary care measures available. However, in 2024, this justification is no longer valid, as there are now a number of chronic condition episode-based cost measures either in the program or in development that assess the costs of primary care. Moreover, any MVPs focusing on chronic conditions should encourage investment in preventive services, which are crucial for the shift towards value-based care. Including TPCC in its current form could unfairly penalize physicians who successfully improve the utilization of preventive services. This is because TPCC measures total costs in the same year as services are provided, without accounting for the long-term cost-saving benefits of preventive care. Thus, the current TPCC methodology does not accurately reflect the value of preventive services.

The TPCC measure's use of outdated CPT coding specifications may compromise its reliability and validity, potentially yielding inaccurate results and unintended consequences for physicians and groups. Additionally, the measure's monthly benchmarking lacks meaningfulness and alignment with quality measures, which are scored annually. Concerns also exist about potential double counting of costs within TPCC and other episode-based measures. CMS should offer more detailed information about cost measure overlap in the annual experience report. Exclusions from measures should be made at the specialty, not service, level to maintain voluntary MVP and subgroup reporting. Lastly, MVPs containing preventive services should not be penalized for higher initial costs, as they can lead to cost reductions over time.

Finally, the measure relies on retrospective claims data, which may take months or even years to become available. This time lag limits the measure's ability to provide timely feedback to healthcare providers and stakeholders, hindering their ability to identify and address cost drivers promptly. Real-time or near-real-time data would be more useful for proactive interventions and cost management strategies.

[Additional Comments. Q1. Please provide any additional feedback or suggestions related to TPCC re-evaluation below.]

none

3.1.16 Comment Number 16

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Not Specified
- **Comment Text:**

[Types of Care Relationships to Include Q1. To help guide refinements to the measure, please describe the types of care and care relationships that align with the measure’s intent.]

Physician assistants providing a wide range of primary care services in group practices.

[Types of Care Relationships to Include Q2. Does the current TPCC measure exclusion criteria adequately exclude specialties that do not provide ongoing care management?]

We understand that the inability to recognize PAs by their specialty creates challenges in the attribution process. We agree with the exclusion concept for PA-provided services that are billed under TINs with a high degree of specialty care services. We have some concern with the fact that PAs could be working in multi-specialty practices in where orthopaedics and other specialty care services are being delivered. Even if the PA is providing primary care services the preponderance of services will be "specialty care" services and the PA will be excluded. The data suggests that this scenario would be limited in occurrence. It would be useful if a PA in that type of practice situation could have an option to identify/report their primary care services and avoid the TPCC exclusion.

[Topic #1 Address Attribution Rules Q1. Do you agree with the proposed attribution refinement: exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties? If not, please explain.]

In general, we can support the attribution concept.

[Topic #1 Address Attribution Rules Q2. Are there concerns that the proposed refinement is too restrictive, i.e., providers who only provide primary care are removed under this proposed refinement? Please explain.]

There should be a mechanism for PAs to identify/report the fact that they deliver a preponderance of primary care services within the context of practicing in a TIN that bills a preponderance of specialty services.

[Topic #1 Address Attribution Rules Q3. Are there other approaches to refine TPCC attribution methodology to address the attribution of specialized TINs and/or better identify clinicians responsible for primary care? If so, please elaborate.]

A type of self-attestation process cold also be considered.

3.1.17 Comment Number 17

- **Date:** 5/14/2024
- **Submitter Name, Credentials, and Organization:** Erin Crum, MPH, McKesson and the US Oncology Network
- **Comment Text:**

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

200 Independence Ave SW
Washington, DC 20001

Submitted via online survey

Re: MACRA Cost Measures: Call for Public Comment for Total Per Capita Cost Re-Evaluation

Dear Administrator Brooks-LaSure,

Based on our review of the 2022 MIPS Cost Category results and review of the specifications for the Total Per Capita Cost (TPCC) measure, the US Oncology Network and McKesson are concerned about the unintended negative impact to medical oncology clinician and practice performance. Upon thorough review of the measure specifications, we want to highlight for Acumen and CMS several areas of concern where the attribution and measure methodology may not function as intended; ultimately, this has an unfair, negative impact for medical oncologists and their care teams' ability to achieve high performance for cost measures that are intended to reflect quality, cost-effective care. Below is a summary of our findings, along with recommendations to revise the TPCC measure, to achieve the measure's intended performance objectives.

Total Per Capita Cost Measure (TPCC)

The Total Per Capita Cost measure assesses the overall cost of care delivered to a patient with a focus on the primary care they receive from their clinicians. This is the only cost measure currently included in the Advancing Cancer Care MVP. Effective primary care management can help reduce overall healthcare expenditures and the intent of the measure is to assess clinicians who have an established primary care relationship with the patient. Certain specialty clinicians are automatically excluded based on their Health Care Finance Administration (HCFA) Specialty designation (such as radiation oncologists, dermatologists, and pathologists), as they are unlikely to provide primary care services.

To ensure a focus on primary care, additional clinicians are excluded from attribution if they meet the criteria for one or more service exclusions in the following categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy. Although this methodology intends to exclude clinicians who are providing specialty-specific care, it does not function as expected in actual clinical care settings. Specifically, medical oncology care teams are inappropriately attributed patients who are on active chemotherapy or surveillance.

TPCC Flawed Attribution Logic Negatively Impacts Medical Oncology Practices

Clinicians are excluded from attribution if 10% or more of the clinician's candidate events are comprised of chemotherapy services. However, APPs (NPs and CNSs) are likely to have patients on active chemotherapy attributed to them, where they do not bill chemotherapy under their NPI.

This could result in a group-level score or individual APP score, if MIPS-eligibility and case minimums are met. It is likely that many APPs will be attributed patients that were receiving chemotherapy since it is prescribed by the attending clinician; these events should have been excluded.

In addition to this, many of the "primary care services" that are referenced as part of the trigger for a candidate event may, in fact, be related to cancer care and not primary care. For example,

- A variety of blood tests are included in the list of primary care service codes that may trigger a candidate event indicating a primary care relationship with a clinician. However, these tests may be routinely ordered to monitor a patient's response or tolerance to certain chemotherapy regimens.
    - An example of routine labs ordered by oncology clinicians for cancer patients on active chemotherapy may include: [85004] white blood cell count (WBC); [85007-85008] WBC with manual count; [85013-85014] red blood cell (RBC) concentration or measurement; [85018] hemoglobin (HGB) blood count; [85025-85027] complete blood count (CBC) with or without differential; [85032] manual blood cell count; [85048] automated WBC count; [85049] platelet count; [80053] comprehensive metabolic panel (CMP), and many other pertinent labs for monitoring of chemo-induced or related symptoms of cancer such as anemia, fatigue, risk of infection, dehydration and more.

- Ketone analysis [CPT 82009 or 82010] is one of the primary care service codes that may trigger a candidate event indicating a primary care relationship with a clinician. However, clinicians may order ketone analysis for patients who are diabetic and require steroids during chemo treatment and/or patients who are actively undergoing treatment with a regimen that includes nephrotoxic medication(s).

Many x-rays, procedures, and labs indicative of primary care are often included as part of routine cancer care management for patients on chemotherapy or active surveillance. These services would be unrelated to primary care and inaccurately trigger a candidate event based on the current TPCC methodology.

Lastly, although chemotherapy services include oral and hormonal antineoplastics, the TPCC measure exclusion criteria do not consider oral drugs covered under Part D on the list of trigger codes to indicate receipt of chemotherapy. 40% of anti-cancer treatment today is provided with oral anti-neoplastic agents, and hormonal anti-neoplastic drugs. The measure only references chemotherapy administration codes (billed to Medicare Part B) to assess whether the patient is receiving chemotherapy services. Oral chemotherapy prescriptions candidate events that should be considered when assessing whether a clinician has more than 10% of events tied to chemotherapy treatment that would exclude the clinician from attribution.

Possible Solutions to Correct the TPCC Attribution Methodology

To modify the measure methodology for future MIPS program years, below are several approaches for CMS and Acumen's consideration:

- Exclude Oncology as an eligible specialty for the measure using the HCFA designation (as the exclusion for providing chemotherapy services can be effectively accomplished by excluding Oncology specialists, similar to how radiation oncologists or surgeons are excluded for the provision of radiation or surgical services).
- Exclude APPs who may have attributed patients based on reporting TIN (i.e., exclude APPs in a TIN with a plurality of clinicians who are excluded specialists; APPs may lack a specialty designation, but should be considered under oncology based on their affiliated clinicians within the TIN).
- Consider excluding PATIENTS who are on active chemotherapy from attribution during chemotherapy episodes of care; assume that patients under active chemotherapy will have care focused on the treatment of their cancer, which may confound measure performance which is intended to assess cost of primary care services. Ensure that all infused and oral chemotherapy agents (Medicare Part B and Part D) are considered when assessing whether a clinician has more than 10% of candidate events tied to chemotherapy treatment that would exclude the clinician from attribution.

Thank you for the opportunity to provide feedback. We welcome additional questions or opportunities to provide further input to inform the re-evaluation and refinement of the TPCC measure specifications.

Sincerely,

Erin Crum, MPH
Senior Director, Quality Strategy and Innovation
The US Oncology Network
10101 Woodloch Forest Dr.
The Woodlands, TX 77380
[*redacted]*

3.1.18 Comment Number 18

- **Date:** 5/14/2024
- **Submitter Name, Credentials, and Organization:** Julianna Belelieu, Memorial Sloan Kettering Cancer Center
- **Comment Text:**

May 14, 2024

Acumen LLC
440 First St. NW, Suite 900
Washington, DC 20001

Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Reevaluation of the Total Per Capita Cost (TPCC) measure

To Whom it May Concern:

On behalf of Memorial Sloan Kettering Cancer Center (MSK), I appreciate the opportunity to provide feedback on the design of the Total Per Capita Cost (TPCC) measure. Designed to measure the overall cost of care delivered to a patient with a focus on the primary care they receive from their provider(s), the incorporation of the TPCC measure in the Quality Payment Program (QPP) is intended to incentivize delivery of high-quality primary care services and to reduce avoidable utilization of high-cost settings and services.

As described by the Centers for Medicare & Medicaid Services (CMS), the QPP enables CMS "to reward high-value, high-quality Medicare clinicians with payment increases – while at the same time reducing payments to those clinicians who weren't meeting performance standards." For eligible clinicians who are subject to the QPP, the program presents potential risk and reward with regard to payment rates, but it also impacts clinicians' reputation, because performance scores are publicly reported. Given the high stakes for clinicians, it is imperative that CMS ensure that the measures used to calculate QPP scores, such as the TPCC measure, are well-designed and return valid, meaningful results.

Since the introduction of the TPCC measure, initially as part of Value-Based Payment Modifier Program, CMS has made a number of refinements to the measure specifications to improve its validity. However, additional refinements to this measure continue to be necessary, particularly to ensure that the measure is capturing only primary care services (as intended) and is appropriately excluding providers of specialty care services.

First, MSK strongly supports the proposal to adjust the attribution rules for the TPCC measure to exclude advanced practice providers (APPs), including nurse practitioners (NPs), physician assistants (PAs), and certified nurse specialists (CNSs), who are members of a group with billing tax identification number (TIN) composed entirely of Health Care Finance Administration (HCFA) excluded specialties. The TPCC measure already excludes otherwise eligible clinicians who are members of specialties unlikely to be managing primary care services for Medicare patients, e.g., neurosurgery. However, NPs, PAs, and CNSs who work in practices specializing in these same services are nevertheless captured by the current attribution methodology, because CMS does not have a mechanism to record a specialty concentration for these APPs. Instead, the HCFA specialty codes for these APPs denote only provider type – not the type of care in which

these clinicians may specialize. For example, the code for a PA indicates only that they are a PA (a specialty code included by the TPCC attribution specs), even when the PA works as part of a radiation oncology specialty practice (whose physicians would be excluded from attribution under the TPCC specifications). Additionally, these APPs are benchmarked against other APPs rather than their specialty practice, compounding the cost differential. Excluding clinicians who work in practices with billing TINs that are otherwise composed exclusively of providers from HCFA excluded specialties as part of the TPCC specifications would help to minimize inappropriate attribution of specialty care providers, which analyses suggest will impact 10.1 percent of billing TINs.

At MSK, we have multiple physician billing groups that are organized under TINs made up entirely of HCFA-excluded specialty physicians, as well as APPs, but which were nevertheless scored on the TPCC measure. Presumably, this was due to the presence of APPs in this group, although it remains difficult to verify that without patient-level cost data for this measure. Billing data for MSK's radiation oncology group, for example, shows that APPs billed 28 percent of all E/M visits in this TIN in 2023, which suggests that visits to APPs may be resulting in patients being attributed to this otherwise exempt specialty practice TIN for the TPCC measure. Updating the attribution criteria to exclude specialty services provided by APPs will improve the ability of the TPCC measure to accurately capture the total cost of care for patients managed by primary care clinicians.

Second, and as noted by other commenters, the TPCC measure should be refined to more accurately exclude clinicians caring for a significant number of patients who should be captured by service exclusions. Currently, the TPCC measure excludes clinicians who met the billing threshold for one or more of the following service categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy. However, some APPs may have visits with a significant number of patients on chemotherapy that was ordered by another provider in the same group, e.g., the attending physician. Additionally, the TPCC measure specifications should be updated to capture all patients on chemotherapy, whether provided under the Medicare Part B or the Part D benefit. With a growing proportion (~50 percent) of chemotherapy being administered under the Part D benefit, it is imperative that CMS capture both oral and physician-administered drugs in its service level exclusion criteria.

Again, we appreciate the opportunity to provide feedback on the QPP measures. For the QPP to be a useful mechanism to incentivize efficient, high-quality care delivery, it is critical that CMS create fair and meaningful measures of both cost and quality. The TPCC measure continues to need to be refined as outlined in our comments above in order to meet that bar.

Sincerely,

Julianna Belelieu
Director, Federal Policy & State Government Relations
Memorial Sloan Kettering Cancer Center

3.1.19 Comment Number 19

- **Date:** 5/16/2024
- **Submitter Name, Credentials, and Organization:** Carolyn Millett, American Academy of Physical Medicine and Rehabilitation
- **Comment Text:**

May 16, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G 200
Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine & Rehabilitation (AAPM&R), I write to share our comments regarding the Centers for Medicare & Medicaid Services (CMS) reevaluation of the Total Per Capita Cost (TPCC) measure included in the Merit-Based Incentive Payment System (MIPS). AAPM&R appreciates the opportunity to offer our feedback on this important issue.

AAPM&R is in support of comments submitted by the American Medical Association (AMA) on April 19, 2024, with respect to the TPCC measure. Specifically, and consistent with comments we previously submitted to CMS in 2017 and 2020, **AAPM&R recommends CMS discontinue use of the TPCC measure**. We believe it is inappropriate to use broad measures such s TPCC to evaluate the resource use of individual physicians. Further, as recommended by the AMA: "If the TPCC continues to be used, it must be revised so that it is either limited to or focused on the aspects of cost that physicians can reasonably control and so that it avoids creating any incentive for physicians to undertreat patients."

Thank you for your consideration of our comments. If the Academy can be of further assistance, please contact Carolyn Millett, Director of Reimbursement and Regulatory Affairs, at [*redacted*] with TPCC questions and Beth Radtke, Director of Quality and Registry Initiatives, at [*redacted*] with MIPS questions.

Sincerely,

Matthew Grierson, MD
Chair, Reimbursement and Policy Review Committee

3.1.20 Comment Number 20

- **Date:** 5/16/2024
- **Submitter Name, Credentials, and Organization:** Gina Hoxie, MPH, American Society of Clinical Oncology
- **Comment Text:**

May 17, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20001

Submitted via online survey

Re: MACRA Cost Measures: Call for Public Comment for Total Per Capita Cost Re-Evaluation

Dear Administrator Brooks-LaSure,

I am pleased to submit these comments on behalf of the Association for Clinical Oncology (ASCO) in response to the Total Per Capital Cost Re-Evaluation comment period. ASCO is a national organization representing nearly 50,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. We are also dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans.

The Total Per Capita Cost measure assesses the overall cost of care delivered to a patient with a focus on the primary care they receive from their clinicians. This is the only cost measure currently included in the Advancing Cancer Care MVP. Effective primary care management can help reduce overall healthcare expenditures and the intent of the measure is to assess clinicians who have an established primary care relationship with the patient. Certain specialty clinicians are automatically excluded based on their Health Care Finance Administration (HCFA) Specialty designation (such as radiation oncologists, dermatologists, and pathologists), as they are unlikely to provide primary care services.

In order to ensure a focus on primary care, additional clinicians are excluded from attribution if they meet the criteria for one or more service exclusions in the following categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy. Although this methodology intends to exclude clinicians who are providing specialty-specific care, it does not function as expected

in actual clinical care settings. Specifically, medical oncology care teams are inappropriately attributed patients who are on active chemotherapy or surveillance.

<u>TPCC Flawed Attribution Logic Negatively Impacts Medical Oncology Practices</u>

Clinicians are excluded from attribution if 10% or more of the clinician's candidate events comprise chemotherapy services. However, advanced practice providers (APPs) (nurse practitioners (NPs) and clinical nurse specialists (CNS)) working in oncology care settings are likely to have patients on active chemotherapy attributed to them, as they do not bill chemotherapy under their NPI. This could result in a group-level score or individual APP score, if MIPS-eligibility and case minimums are met. It is likely that many APPs will be attributed patients that were receiving chemotherapy since it is prescribed by the attending clinician; these events should be excluded.

In addition to this, many of the "primary care services" that are referenced as part of the trigger for a candidate event may, in fact, be related to cancer care and not primary care. For example:

- A variety of blood tests are included in the list of primary care service codes that may trigger a candidate event indicating a primary care relationship with a clinician. However, these tests may be routinely ordered to monitor a patient's response or tolerance to certain chemotherapy regimens.
    - An example of routine labs ordered by oncology clinicians for cancer patients on active chemotherapy may include: [85004] white blood cell count (WBC); [85007-85008] WBC with manual count; [85013-85014] red blood cell (RBC) concentration or measurement; [85018] hemoglobin (HGB) blood count; [85025-85027] complete blood count (CBC) with or without differential; [85032] manual blood cell count; [85048] automated WBC count; [85049] platelet count; [80053] comprehensive metabolic panel (CMP), and many other pertinent labs for monitoring of chemo-induced or related symptoms of cancer such as anemia, fatigue, risk of infection, dehydration and more.

- Ketone analysis [CPT 82009 or 82010] is one of the primary care service codes that may trigger a candidate event indicating a primary care relationship with a clinician. However, clinicians may order ketone analysis for patients who are diabetic and require steroids during chemotherapy treatment and/or patients who are actively undergoing treatment with a regimen that includes nephrotoxic medication(s).

Many x-rays, procedures, and laboratory tests indicative of primary care are often included as part of routine cancer care management for patients on chemotherapy or active surveillance. These services would be unrelated to primary care and inaccurately trigger a candidate event based on the current TPCC methodology.

Lastly, although chemotherapy services include oral and hormonal antineoplastics, the TPCC measure exclusion criteria do not consider oral drugs covered under Part D on the list of trigger codes to indicate receipt of chemotherapy. Forty percent of anti-cancer treatment today is provided with oral anti-neoplastic agents, and hormonal anti-neoplastic drugs. The measure references only chemotherapy administration codes (billed to Medicare Part B) to assess whether the patient is receiving chemotherapy services. Oral chemotherapy prescriptions candidate events should be considered when assessing whether a clinician has more than 10% of events tied to chemotherapy treatment that would exclude the clinician from attribution.

Possible Solutions to Correct the TPCC Attribution Methodology

As we have said in previous comments on this issue, immediate action must be taken to avoid unfairly scoring medical oncologists and their extended APP care teams. We recommend modifying the attribution logic going forward for future MIPS program years so that only clinicians responsible for primary care are assessed for the measure.

ASCO recommend adopting the following approaches:

- Exclude oncology as an eligible specialty for the measure using the HCFA designation, as the exclusion for providing chemotherapy services can be effectively accomplished by excluding oncology specialists, just as radiation oncologists or surgeons are excluded for the provision of radiation or surgical services).
- Exclude APPs who may have been attributed patients based on reporting TIN (i.e., exclude APPs in a TIN with a plurality of clinicians who are excluded specialists; APPs may lack a specialty designation, but should be considered under oncology based on their affiliated clinicians within the TIN).
- Consider excluding *patients* who are on active chemotherapy from attribution during chemotherapy episodes of care; assume that patients under active chemotherapy will have care focused on the treatment of their cancer, which may confound measure performance which is intended to assess cost of primary care services. Ensure that all infused and oral chemotherapy agents (Medicare Part B and Part D) are considered when assessing whether a clinician has more than 10% of candidate events tied to chemotherapy treatment that would exclude the clinician from attribution.

While we understand the following is outside the scope of this solicitation for comments, we would like to reiterate the American Medical Association's recommendation to group the services and costs into patient condition categories to clarify which costs are controlled or influenced by primary care versus specialists.

The specialty adjustment in TPCC assumes that differences in total cost are based on differences in the specialty of the physician who is providing primary care services rather than differences in the types of treatments the patient needed during the year for their specific health problems.

Moreover, the risk adjustment methodology is based only on chronic conditions in a prior year and does not consider current acute conditions or newly diagnosed chronic conditions that are treated for the first time during the current year. For example, a primary care physician who has a higher-than-average number of patients diagnosed with cancer during the year, particularly expensive-to-treat cancers, will be penalized by the TPCC because neither the risk adjustment methodology nor the specialty adjustment addresses this. However, by calculating costs related to cancer as a separate subcategory within TPCC, it would be clear whether the primary care physician's total cost per patient was higher due to those costs, or because that physician provides more services or more expensive services for the health conditions they manage directly. Similar changes are needed for specialty practices providing "primary care" services; for example, when an oncology practice is attributed a patient under TPCC, it could also be penalized under the current methodology, as research has shown.

We appreciate the opportunity to comment on the Total Per Capital Cost Re-Evaluation solicitation for comments. Please contact Gina Hoxie ([*redacted*]) with any questions or for further information.

Sincerely,

Everett Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

3.1.21 Comment Number 21

- **Date:** 5/16/2024
- **Submitter Name, Credentials, and Organization:** Samantha Shugarman, American College of Radiology
- **Comment Text:**

May 17, 2024

Acumen, LLC.
Attn: Total Per Capita Cost Measure Development Team 440 First St NW #900
Washington, DC 20001

RE: Recommendation for Updating Total Per Capita Cost (TPCC) Measure Attribution Methodology for Non-Physician Practitioners (NPPs) Servicing Provider Specialties Excluded in TPCC Measures

Dear Acumen, LLC, Total Per Capita Cost (TPCC) Measure Development Team,

The American College of Radiology (ACR), representing more than 40,000 radiologists, radiation oncologists, medical physicists, interventional radiologists, and nuclear medicine physicians, is committed to providing quality services to patients and advocating for radiologic practices participation in equitable value-based payment programs, like the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP). As we previously commented on in response to the Medicare Physician Fee Schedule (MPFS) and QPP final rule for 2024, ACR is troubled by flaws in the Total Per Capita Cost of Care (TPCC) cost measure's attribution method.

Now that the 2022 Merit-based Incentive Payment System (MIPS) payment year is here, we hear from members whose practices were assigned a Cost category score for the TPCC measure, for which they anticipated being exempt from scoring due to their specialty practice status. ACR appreciates that Acumen recognizes this measure's focus on effective primary care management that supports cost savings and that the attribution of this cost measure intends to capture the overall care costs of a primary care service episode based on an index event and attributed to that TIN.

Given that diagnostic and interventional radiology practices are designated by CMS as specialty practices rather than as primary care practices, the TPCC's attribution model provides a specialty-level exclusion for radiologists at the group, TIN, or service level. However, for those radiology practices reporting attribution of the TPCC to their practice for the performance year 2022, there is an oversight regarding the exclusion methodology whereby advanced practice providers (APPs), like nurse practitioners or physician assistants providing advanced care services under a radiology group TIN, are inappropriately attributed the TPCC measure, resulting in their costs attributed to the otherwise excluded radiology TIN.

The growing number of APPs working under the supervision of diagnostic and interventional radiologists plays an essential role in radiology practices. **An APP's employment at a radiology practice limits these clinicians to imaging-specific duties.** ACR agrees with the **Department of Health and Human Services, the Government Accountability Office, and CMS, identifying APPs as integral to expanding affordable healthcare access.**[6,7,8] However, **CMS (through this measure's refinements) must understand that radiology APPs do not furnish primary care services**—an important distinction among other APPs who serve in a primary care

[6] "HHS Secretary Azar Issues Remarks to American Association of Nurse Practitioners" (Mar. 11, 2020). *See also* H. Landi, Fierce Healthcare "HHS to Invest $100M to Train Nurses, Bolster Clinician Workforce" (Aug. 10, 2023) available at https://www.fiercehealthcare.com/providers/hhs-invest-100m-train-nurses-bolster-clinician-workforce (An official from the Biden Administration noted "we know advanced practice nurses can fill…critical gaps" in care).

[7] Government Accountability Office, "Report to Congressional Committees: Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants" (2019) at 1, available at https://www.gao.gov/assets/gao-20-162.pdf.

[8] S. Verma, The Journal of Emergency Medical Services, "Rural Health at CMS: What's Been Done and What's to Come," (Nov. 21, 2019), available at https://www.jems.com/commentary/rural-health-at-cms-whats-been-done-and-whats-to-come/.

role. By including APPs working for specialty practices, like radiology, in the TPCC measure, they are inappropriately held responsible for costs associated with this measure, for which they lack control. As a result, these specialty practices are inappropriately receiving low scores on the measure as a reflection of their APP's billing codes. And subsequently receiving penalties on reimbursement.

CMS communicated its awareness of this problematic attribution issue in the 2019 Medicare Physician Fee Schedule Final Rule, for which the amended TPCC attribution model first began excluding specialty practices. In the rule, CMS declined to solve this matter because it "found that this [issue] occurs infrequently." ACR is troubled by CMS' decision to retain APPs in the TPCC attribution model because they believe it would affect few specialty practices. While it may be true that radiology practices may 'infrequently' be attributed to the TPCC measure, the consequence of inappropriate attribution is significant to these practices and may negatively impact patient care. Most radiology practices are exempt from the MIPS Cost category as their participation in the patient care path is not episode-based. As such, this makes the TPCC measure a TIN's only cost measure for which 30 percent of the practice's final MIPS score is determined.

Under CMS' TPCC measure policy, radiology practices are seeing a significant reduction in their MIPS final scores. As a result, the reduced scores negatively affect the payments for Medicare Part B-covered professional services, diminishing a practice's ability to provide services and patients' access to imaging. **The following illustrates an example of a radiology practice's inappropriate inclusion of the TPCC measure in its MIPS final score calculations.**

- **This practice, comprising 10 percent (six) physician assistants (furnishing imaging service only) and 90 percent (51) radiologists, scored one out of ten (the lowest decile) on the TPCC measure.**
- **Had this measure been removed from the MIPS final score calculations, the practice would have achieved 84.71 percent and received a bonus payment.**
- **However, because the TPCC measure was included in the final MIPS score calculations, the practice was assigned a total MIPS score of 75.13 percent and received a neutral payment adjustment. While this practice is relieved to have acquired enough points to avoid the penalty, 75.13 percent is a poor and inappropriate indicator of the practice's cost management.**
- **It is further notable that due to the financial implications imposed by the measures' inclusion of radiology APPs in this measure, this practice is reconsidering its use of APPs unless the specialty- practice exclusion criterion is revised.**

While it is ACR's position that radiology APP practice scope should contribute to the work of radiologists rather than take on the radiologist's advanced role, we recognize the incredible benefit radiology APPs offer for expanding care access, cost efficiency, and reducing radiologist burnout. As noted in the above example, because of the negative payments imposed on radiology

practices with APPs due to the TPCC measure, radiology practices may reconsider their value to the healthcare business or their participation in an inequitable system. Due to this measure's inappropriate inclusion of radiology APPs, MIPS financial penalties threaten patients' positive health outcomes and the success of healthcare systems by presenting longer patient wait times, delayed diagnoses, and higher care costs.

The current TPCC attribution methodology does not include providers with Health Care Finance Administration (HCFA) codes practicing on behalf of otherwise excluded specialties. These codes are directly related to taxonomy codes, which are reported each time a claim is submitted to Medicare. **ACR urges Acumen to update the attribution methodology to exclude providers according to the billing entity taxonomy code instead of the individual provider HCFA code.** This would ensure radiology-APPs are attributed to the specialty of radiology rather than their title of advanced primary practitioner.

Additionally, we encourage the proposed revision addressed during the Physician Cost Measures and Patient Relationship Codes TEP meeting on March 13, 2024, which would not include APPs in group practices composed of only excluded specialists, like radiologists, and APPs. However, Acumen must correct the problem of inaccurate attribution due to billing by APPs and address other severe attribution problems unaddressed during the March 2024 TEP meeting. Since the proposed changes would prevent inappropriate attribution to APPs who are part of group practices that consist solely of excluded specialties, it would not avoid inappropriate attribution to groups with both included and excluded specialties. In multi-specialty groups that include primary care physicians and non-primary care specialists, some or all APPs could support the work of the excluded specialists. Yet, patients could still be attributed to the group solely because of the non-primary care services provided by the APPs. Such attribution would be inappropriate. Acumen should identify the types and mixes of services that individual APPs provide to develop additional ways to eliminate as many inappropriate attributions as possible.

Explicitly stated in the Medicare Access and CHIP Reauthorization Act (MACRA), patient relationship codes would be used to "to evaluate the resources used to treat patients (with respect to care episode and patient condition groups)," (42 USC 1395w–4(r)(5)(A)(i)), **ACR finds it essential to modify the attribution method to include a mechanism using patient relationship codes.** APPs should be able to inform accurate attribution of patients and cost measures by including applicable patient relationship codes on their claims. Using patient relationship codes is particularly important for broad cost measures like the TPCC. Patient relationship codes allow physicians and APPs to explicitly describe their relationship with a patient, a more accurate method than what is currently used for attributing the measure to the correct clinician. It is hard to ignore the circular reasoning presented by CMS and Acumen (as a CMS contractor), who assert that the reason for disusing the patient relationship codes in the cost measure attribution methodology is that few physicians and other eligible clinicians report these codes. Such a lack of reporting is expected since the codes are not currently used in cost measure attribution and do not result in additional payment or other resources. Unsurprisingly, busy

clinicians do not take the extra time to record a code when it does not provide an effect. If physicians and APPs expect reporting patient relationship codes to effectively reflect clinical practice and improve their MIPS cost measure attribution, more would likely report the codes, particularly as the cost measures account for 30 percent of MIPS final scores and MIPS penalties can be as large as -9 percent.

Though we recommend that CMS examine approaches to promote and incentivize the use of patient relationship codes, it is noteworthy that it is neither necessary nor desirable to mandate the use of patient relationship codes on all claims to improve attribution. We understand that using the patient relationship codes will require additional time by clinicians and changes in their billing systems, and that may not be feasible today for many physicians, particularly those in small and under-resourced practices. Should an APP not report a patient relationship code for a particular patient, the current attribution rules may continue to determine what portion of costs associated with that patient's overall care, if any, should be attributed to that clinician.

ACR views Acumen as an ally for measuring cost-effective, high-quality care delivery. However, we strongly urge Acumen to revise the TPCC attribution model and not hold specialty practices accountable for its negligent decision to retain specialty practice APPs in the measure attribution model. ACR welcomes further discussion with Acumen on revisions to the method that would augment the measure so that it is applied appropriately, thereby protecting its data integrity and fostering participation with the specialty practices that broaden access to high-value care.

Respectfully submitted,

Wiliam T. Thorwarth, Jr., MD,
FACR Chief Executive Officer

cc: Richard Heller, MD, FACR Lauren Nicola, MD, FACR Greg Nicola, MD, FACR Mythreyi Chatfield, PhD Judy Burleson, MHSA Samantha Shugarman, MS

3.1.22 Comment Number 22

- **Date:** 5/16/2024
- **Submitter Name, Credentials, and Organization:** Dyane Tower, DPM, MPH, MS, CAE, American Podiatric Medical Association
- **Comment Text:**

May 16, 2024

Acumen, LLC
500 Airport Blvd., Suite 100
Burlingame, CA 94010

Re: MACRA Cost Measures: Call for Public Comment for Total Per Capita Cost (TPCC) Comprehensive Re-evaluation

Dear Acumen, LLC, and Centers for Medicare & Medicaid Services:

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 related to the Total Per Capita Cost (TPCC) measure during its comprehensive re-evaluation.

Regarding adjustment of attribution rules, while APMA agrees with the current TPCC measure exclusion of podiatrists as they are not providing primary care or other forms of ongoing care management for chronic diseases, **APMA strongly urges CMS to remove the TPCC measure from MIPS because of the fundamental flaws and significant challenges related to appropriate attribution and identifying reasonable influence**. Even though podiatrists are excluded from the TPCC measure, at least 1,200 podiatrists (nearly 10% of the licensed podiatrists in the United States) were attributed the TPCC measure in the 2022 MIPS Performance Year (PY) because of the flawed attribution methodology.

While podiatrists are considered an excluded specialty for the TPCC measure, APMA is in favor of changes to the measure's attribution methodology to identify advanced care practitioners in specialized clinician groups and to better capture clinicians responsible for primary care-type services while preventing attribution of specialized clinician groups. This would help minimize inappropriate attribution of the TPCC measure for podiatrists. **APMA also requests that CMS retroactively apply this revision to prior MIPS PYs to limit inappropriate application of penalties that have resulted from this flawed methodology.**

APMA agrees with the proposed attribution refinement of excluding advanced care practitioners in specialized clinician groups composed of only advanced care practitioners and excluded specialties. **APMA also requests that TINs with included and excluded specialties and TINs with advanced care practitioners, included and excluded specialties be excluded from the TPCC measure** to minimize inappropriate attribution as much as possible.

Regarding the candidate event logic, APMA is in favor of removing the "+/- 3 days, Any TIN" rule from candidate event logic for simplification. APMA is also in favor of adding a specialty check on the confirming claim of the candidate event. APMA supports these steps as they attempt to ensure the accuracy of attribution and add a layer of protection to ensure excluded specialties are not inappropriately attributed the TPCC measure.

APMA requests CMS work with relevant clinical stakeholders to develop ways to more appropriately identify whether a patient's care is being managed by a particular physician and to eliminate inappropriate attributions as much as possible.

Thank you for the opportunity to provide feedback on the TPCC measure. If you require additional information, please contact Dyane Tower, DPM, MPH, MS, CAE, Senior Medical Director, and Director of Clinical Affairs at [*redacted*] or [*redacted*]. Thank you for your time and consideration.

Sincerely,

Lawrence Santi, DPM
President

3.1.23 Comment Number 23

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Kaitlin Miller, MBA, MSN, RN, OneOncology
- **Comment Text:**

May 17, 2024

To: Centers for Medicare and Medicaid Services (CMS)

Re: MACRA Cost Measures: Call for Public Comment for Total Per Capita Cost (TPCC) Measure Re-evaluation

Submitted via the CMS-published survey link:
https://acumen.qualtrics.com/jfe/form/SV_1M7FjrBOi5o41h4

* * * * *
To Whom It May Concern:

OneOncology was founded by community oncologists, for community oncologists, with the mission of improving the lives of everyone living with cancer. Our goal is to enable community oncology practices to remain independent and to improve patient access to care in their communities, all at a lower cost than in the hospital setting. OneOncology supports our platform of community oncology practices through group purchasing, operational optimization, practice growth, and clinical innovation. Our twenty partner practices comprise approximately 1,100 cancer care providers who care for approximately 750,000 patients across 400 sites of care nationwide, including approximately 300,000 Medicare beneficiaries per year (inclusive of Medicare Advantage) and approximately 160,000 traditional Medicare beneficiaries per year.

OneOncology partner practices combine to offer approximately 700 clinical trials and enrolled approximately 2,000 patients in clinical trials annually. OneOncology physician investigators participate in trials beginning at Phase I development of early novel therapies and continuing through late phase trials that lead to new therapies that significantly enhance the lives of patients and families impacted by cancer and blood disorders.

OneOncology acknowledges the importance CMS's ongoing efforts to improve payment policies for cancer care services that better achieve the Quadruple AIM: (1) Access to high quality cancer care for Medicare beneficiaries; (2) Enhancing the patient experience; (3) Minimizing the cost of cancer care for patients and the Medicare Trust Funds; (4) Workforce health among care teams dedicated to the treatment of cancer and blood disorders and whom OneOncology serves.

OneOncology is committed to promoting value-based cancer care and we appreciate CMS's willingness to engage stakeholders in discussions of potential improvements to the technical specifications of the Total Per Capita Cost (TPCC) measure. We further recognize that modifications to the technical specifications are necessary to render these measures more relevant and applicable to the clinical practice of high-quality cancer care and to ensure that cost measures for which community oncologist practices are held accountable will further the Quadruple AIM for cancer care.

Our comments on the TPCC cost measure are noted in the exhibit that is enclosed with this letter. You may contact me at any time with any feedback or questions regarding these comments.

Thank you for your consideration.

Sincerely,

Katie Miller
Director, Clinical Quality
OneOncology
[*redacted*]

3.1.24 Comment Number 24

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** James Haynes, MBA, MSN, RN, Medical Group Management Association
- **Comment Text:**

May 17, 2024

The Honorable Chiquita Brooks-LaSure

Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 445-G 200
Independence Avenue, SW
Washington, DC 20201

Re: Total Per Capita Cost Measure Re-evaluation

Dear Administrator Brooks-LaSure:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) is pleased to provide the following comments in response to the Centers for Medicare and Medicaid Services' (CMS) re-evaluation of the Total Per Capita Cost (TPCC) measure. MGMA has long held significant concerns about the design of the TPCC measure — we urge the agency to remove the measure.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

Structural issues with TPCC necessitate its removal

MGMA urges CMS to cease measuring clinicians on the TPCC measure due to longstanding structural concerns that it incorrectly penalizes providers by holding them accountable for costs outside of their control. TPCC includes all of Medicare Part A and B spending, holds clinicians accountable for patient treatment costs long after the patient has left their care, includes changes in drug pricing, and more. There is a lack of timely and actionable feedback provided to clinicians, and the measure can have a significant negative impact on group practices' Merit-based Incentive Payment System (MIPS) final scores, undermining their financial viability. Taken together, the confluence of issues with the TPCC measure necessitates its removal.

Should TPCC continue to be used as a cost measure, significant changes are needed to more accurately capture costs within clinicians' control and avoid overly punitive scoring. Preventive services, necessary to keep patients healthy and avoid more serious conditions, are included in TPCC calculations and end up harming MIPS scores. Preventive services — that save costs in the long-run — should be removed from cost calculations to avoid incentivizing undertreatment. Additionally, transitioning to monthly benchmarking to evaluate TPCC performance is worrying given the myriad scenarios, such as acute care vs. chronic care, that may negatively impact CMS' ability to accurately conduct risk adjustment and benchmarking. We urge the agency to return to the annual evaluation of costs.

Issues with patient attribution

One of our greatest concerns with the TPCC measure is the issue of patient attribution. MGMA members have shared reports of providers being attributed high-cost patients they saw only a handful of times for inexpensive services. Patient attribution is retrospective which means groups do not know what patients have attributed to them until after the performance period. Further, there is no way to notate that a relationship with a patient has ended, thereby making groups responsible for costs that occur outside of their purview.

We appreciate the recent work CMS and Acumen, LLC, have done to address issues associated with specialty care in group practices made up of qualified health professionals (QHPs) and excluded specialists — the proposed change would exclude QHPs in this setting. We urge the agency to implement this change swiftly and apply it retroactively. Further, CMS should work to address inappropriate attribution issues with QHPs in multi-specialty groups made up of included and excluded specialties. Due to the cross-cutting nature of these multi-specialty groups, QHPs working with excluded specialists may be attributed to the group. The agency should examine ways to address this concern, and work with physician specialties and healthcare organizations to find a workable and accurate solution to patient attribution.

Lack of timely and actionable feedback

The lack of robust feedback on TPCC makes it extremely difficult for clinicians and group practices to understand how cost measurement works and undertake efforts to improve cost efficiency. One of the most common concerns raised by MGMA members regarding the MIPS program is that they have no ability to influence cost measurement and that attribution methodologies are confounding and inappropriate. Members have informed us that despite reviewing the materials made available by CMS and endeavoring to understand evaluation and patient assignment, they struggle to link evaluation with actions they can take to improve cost efficiency.

It is critical that the agency provide timely and actionable specifications regarding not only TPCC, but all cost measures, particularly as methodologies are ever-changing and new measures are being added. CMS makes the annual MIPS Feedback Report available six to 18 months after the clinician has provided services to the Medicare beneficiary. Given that the cost measure accounts for 30% of their MIPS score, a significant portion of a group's score is occurring in a black box where clinicians have no idea on how they are performing. Practices do not know what cost measures they are being scored on, which patients have been attributed to them, and how they can improve.

We encourage CMS to provide comparative information, such as the number of procedures a clinician performs comparative to peers. We have heard from MGMA members that this type of comparative data is helpful in cost reduction, as clinicians can see where they fall on utilization compared to their peers. CMS should provide quarterly reports about performance on cost measures to allow medical groups to understand their performance and make necessary adjustments to save costs.

Conclusion

MGMA thanks CMS for reviewing the TPCC measure and urges the agency to discontinue its use as the measure has intractable issues and results in medical groups being wrongly penalized for costs outside of their control. If you have any questions, please contact James Haynes, associate director of government affairs, at [*redacted*] or [*redacted*].
Sincerely,

Anders Gilberg
Senior Vice President, Government Affairs

3.1.25 Comment Number 25

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Harold D. Miller, Center for Healthcare Quality and Payment Reform
- **Comment Text:**

May 17, 2024

Acumen, LLC
Suite 900
440 First Street NW
Washington, D.C. 20001

RE: Comments on Total Per Capita Cost (TPCC) Measure

To Whom It May Concern:

I am responding to the CMS Call for Public Comment on what is described as the "Comprehensive Re-Evaluation" of the Total Per Capita Cost (TPCC) measure used in the CMS Merit-Based Incentive Program (MIPS).

Although I will respond to the specific questions asked in the Call for Public Comment document, I do not believe that these questions represent a "comprehensive" re-evaluation of the TPCC measure, nor did the questions raised in the Call for Public Comment on TPCC and other cost measures that was issued a year ago. In the comments below, I identify several serious

problems with the TPCC measure and make recommendations for how they should be addressed. I strongly urge you to address *all* of these problems, rather than limiting changes to the small number of narrowly-defined issues you have identified.

The Attribution Methodology in TPCC is Seriously Flawed and Should be Completely Revised

The TPCC Methodology Does Not Identify Primary Care "Relationships"

The TPCC Measure Information Form states that the attribution methodology is intended to identify a "primary care relationship between a clinician and a patient." However, the methodology allows a patient to be assigned to a clinician based on a single Evaluation & Management (E/M) visit with that clinician as long as one additional "primary care service" is also delivered to the patient by the same practice or TIN. This additional "primary care service" can be nothing more than drawing the patient's blood for a laboratory test during the same office visit. Although this one visit *may* represent the beginning of a "relationship," it may also represent a one-time interaction to address an acute concern. Nothing about the methodology attempts to determine whether or not a "relationship" persists for more than a single day. The methodology *allows* the additional primary care service to occur up to 90 days after the initial visit, but it also allows it to occur on the same day. Moreover, the fact that the additional service occurs on a different day does not imply more of a "relationship," since it may simply reflect a delay in receiving the second service (e.g., the need for the patient to fast before drawing their blood).

The TPCC Methodology Attributes Patients to Clinicians Who Are Not Providing Primary Care

The length of the relationship is important because if the patient is assigned to the clinician based on this pair of events, the TPCC methodology assigns the clinician *all* of the costs of *all* services delivered to that patient by *any* other physician or provider for a full *year* following the visit that triggered the attribution. This one-year "risk window" is used regardless of whether the patient and clinician had any intention of maintaining a relationship for that period of time, and regardless of whether the patient has a primary care relationship with a different clinician. Indeed, if the patient has a visit with a clinician in a different practice (i.e., a different TIN) the following week, the next day, or even the same day and if the patient also receives a second "primary care service" from that clinician or its TIN, then *both* the first and the second clinician will be assigned responsibility for *all* of the patient's services and costs for the next year. The methodology does nothing to determine whether the first clinician has any ongoing interaction with the patient after the patient sees the second clinician, and if they do, which clinician is more likely to be providing primary care to the patient versus treating one specific symptom or condition.

The TPCC Attribution Methodology is Not Aligned With Other CMS Attribution Methodologies

Not only is this methodology clearly flawed, it is completely different from the attribution methodology used in other CMS programs that are focused on primary care, such as the Medicare Shared Savings Program (MSSP) and the CMMI Making Care Primary (MCP) model.

- **TPCC fails to identify a single *primary* care practice.** The methodologies in both MSSP and MCP are designed to attribute a beneficiary to a single primary care practice during any given month. Beneficiaries who are not receiving primary care from any practice will not be able to be attributed to any practice, but no patient will be attributed to more than one practice at a time. In contrast, the TPCC methodology can easily attribute a beneficiary to 2, 3, or even more practices/TINs at the same time.
- **TPCC fails to respect the *beneficiary's own choice* of a primary care practice**. Both MSSP and MCP first look to see whether the beneficiary has designated a primary care practice on Medicare.gov, and if so, the beneficiary is attributed to that practice, regardless of whether the beneficiary receives a "primary care" service from a different practice. Only if the beneficiary has not made such a designation, claims data are used to identify the most likely primary care practice. In contrast, TPCC makes no effort to use the beneficiary's designation. As a result, TPCC may attribute the spending on a beneficiary to a completely different clinician or practice than the patient has chosen.
- **TPCC inappropriately categorizes many specialists as primary care providers**. In addition to family physicians and internists, TPCC includes many medical specialists as providers of primary care, including allergists, cardiologists, endocrinologists, gastroenterologists, infectious disease specialists, nephrologists, obstetricians and gynecologists, oncologists, palliative care physicians, pulmonologists, and rheumatologists. Although these specialists often provide longitudinal care for specific conditions, it is unlikely that they will be providing what is ordinarily considered "primary care" to most of their patients. They also provide short-term diagnostic consultations and short-term treatment services which typically start with an Evaluation & Management Services visit and conclude the same day or within a short period of time, and this is not what would ordinarily be considered as "primary care." At the same time, TPCC excludes otolaryngologists, dermatologists, neurologists, etc. even though they treat some of the same types of chronic conditions as the included specialists do.
- **TPCC fails to recognize that primary care practices can only influence the services a beneficiary receives while they are actually providing primary care**. Both MSSP and MCP reassign patients to primary care practices on a quarterly basis. The assigned practice is only viewed as accountable for services delivered to the patients during the quarter that the patient is assigned to them. In contrast, TPCC assigns a primary care practice all of the costs for services the beneficiary receives for a 12-month period, even

if the patient is receiving primary care from that practice for only a small portion of that year.

TPCC Should Use Attribution Methodologies Similar to Other CMS Programs
Although the attribution methodologies used in MSSP and MCP have flaws, they are far superior to the methodology being used in TPCC. There is no obvious reason why TPCC could not use an attribution methodology similar or identical to those used in MSSP and MCP. Doing so would better align CMS payment programs and make it easier for primary care practices to transition from MIPS to MSSP or primary care APMs.

TPCC Should Incorporate the Use of Patient Relationship Codes
In addition, both TPCC and other CMS attribution methodologies should allow physicians to use Patient Relationship Codes to define whether they have a primary care relationship with a beneficiary. In the Medicare Access and CHIP Reauthorization Act (MACRA), Congress required the creation of the Patient Relationship Codes for the purpose of ensuring that attribution of patients in resource use measures could be based on the nature of the care a physician is providing. In particular, the statute specifically stated that one of the purposes of these codes was to identify a physician (or other practitioner) who "considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time."

The Patient Relationship Codes (PRCs) have been available since 2018. As stated on the CMS website, "The purpose of PRCs is to facilitate the attribution of episode-based cost measures to clinicians by making it easier to identify the type of care relationship that a clinician has with a patient." They are not currently being used by physicians because CMS is not using them for cost measures in the way that was intended by Congress. Physicians would be encouraged to use the PRCs if TPCC gave priority in the attribution methodology to a PRC that a physician assigned to a patient visit. Just as the MSSP and MCP attribution methodologies give priority to the primary care practice chosen by a beneficiary if the beneficiary has explicitly chosen a practice, and only use claims-based attribution if a beneficiary has not designated a primary care practice, TPCC could utilize the PRCs when they are assigned to visits in order to determine whether a visit should trigger attribution, and use the MSSP/MCP claims-based attribution methodology in other cases.

TPCC Should Be Revised to Focus on the Costs That Primary Care Can Influence

TPCC Assigns Costs to Physician Practices That They Cannot Control or Influence
The TPCC Measure Information Form states that TPCC measures the overall cost of care delivered to a patient "with a focus on the primary care they receive from their provider(s)." It further states that the measure "specifically focuses on … primary care management," and that "effective primary care management can support Medicare savings in a number of ways, including through improvements in the treatment of chronic conditions…" and that "more

effective primary care management can also direct a greater proportion of patients to lower hospital costs for the inpatient services [sic].”

However, nothing in the definition of the TPCC measure distinguishes the types of services and costs that can be reasonably affected by primary care management. For example, although the TPCC attribution methodology excludes oncologists who administer chemotherapy from being identified as primary care providers, the cost methodology does not exclude chemotherapy from the costs assigned to the patient’s primary care provider, even though it seems obvious that no primary care physician or practice is going to be choosing which type of chemotherapy a patient receives for their cancer. The primary care practice may well be providing other types of care to a patient at the same time that they are receiving treatment for cancer, so it would not be surprising for a cancer patient to be appropriately attributed to a primary care practice, but it would be inappropriate to then assign the costs of their cancer treatment to the primary care practice rather than the oncology practice.

In addition, under the current TPCC attribution methodology, a beneficiary can be attributed to a specialty physician practice if the practice is treating or managing the care of a particular disease or condition, e.g., a cardiologist who is managing care of a patient’s atrial fibrillation or an endocrinologist who is managing care of a patient’s diabetes. The TPCC methodology will attribute the patient to such a specialty practice even if the patient is also receiving more general primary care services from a primary care practice. TPCC will then assign the specialty practice the costs of *all* services the patient receives, even though the specialty practice only has direct control over the services it delivers or orders. TPCC will also assign the costs associated with the specialty practice’s services to the primary care practice, even though the primary care practice is not directly controlling those services and may not have even referred the patient to that practice.

Use of the TPCC Measure in MIPS Could Increase Inequities in Access to Care

Assigning costs to physician practices in this way is a serious problem because TPCC is now being used to affect the payments physicians receive through the MIPS program. A primary care physician could see all of his or her payments reduced (for every service they deliver to every Medicare beneficiary) if their TPCC average increases because some of the patients receiving primary care develop health problems during the year requiring treatment by specialists that involve expensive medications, medical devices, or other services. This would penalize the primary care physician for providing services to such patients, and potentially discourage them from agreeing to provide primary care for those types of patients. This could exacerbate inequities in access to care for patients.

The TPCC Measure Should Be Disaggregated Into Condition-Specific Cost Categories

In order to address this problem, the services a patient receives should be grouped into condition-based categories, and the spending on each of those categories should be tabulated separately. For example, the costs associated with chemotherapy and cancer treatment services should be tabulated separately into an “oncology-related service costs” category, the costs of services for

cardiovascular conditions should be tabulated separately into a "cardiovascular service costs" category, the costs associated with orthopedic procedures should be tabulated separately into an "orthopedic service costs" category, and the costs of services directly provided or ordered by the primary care practice should be tabulated into a "services provided or ordered by the primary care practice" category. Then, spending should be reported as a list of condition-based spending amounts, rather than only as a single undifferentiated "total cost" amount. Rather than comparing physicians based on the average *total* costs for their patients, the physicians can be compared based only on the costs of the services *they order or deliver*. The physician's score under MIPS can then be based either solely or primarily on that subset of costs.

Comments on Changes Proposed by Acumen

The changes proposed by Acumen would not address the most serious problems with the TPCC measure.

#1 Proposed Adjustments to Attribution Rules

Excluding nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) from attribution if they work for practices that are only composed of excluded specialists would certainly reduce the number of cases of inappropriate attribution that are occurring today. However, it would not solve the problem of patients being inappropriately attributed to similar NPs, PAs, and CNSs who work for *multi-specialty* practices. For example, if a physician assistant works with an orthopedic surgeon and sees patients for post-operative care following joint surgery, but the PA and orthopedic surgeon are part of a multi-specialty practice that also includes cardiologists, gastroenterologists, or internists, then visits with the orthopedic physician assistant could still be labeled as "primary care." As shown in Table 1 of the *Call for Public Comment* document, there are far more NPs/PAs/CNSs in practices with both included and excluded specialties than in single-specialty practices, so the proposed change would only address a portion of this particular attribution problem. Unfortunately, it appears that Acumen did nothing to develop alternative methods of identifying NPs/PAs/CNSs that provide excluded-specialty services in multi-specialty practices.

Rather than trying to add more and more rules to try and fix problems with the current attribution methodology, it would be preferable to simply abandon it and utilize an attribution methodology similar to other CMS models, as described earlier.

#2 Proposed Adjustments to Candidate Event Logic

It makes no sense to say that a practice has a *primary care relationship* with a patient simply because a patient makes a visit to that practice and then receives an imaging study or lab test from a separate provider within the next 2 days, without regard to whether the test was even ordered by the first practice. Similarly, it makes no sense to say that a practice is *not* providing primary care simply because the patient did *not* get an imaging study or lab test at all following a

visit to the practice or received the test more than 3 days later. If a patient with difficult-to-diagnose symptoms visits one type of non-excluded specialist practice that immediately rules out a potential diagnosis, and the next day visits a completely different type of non-excluded specialist practice which orders and performs a lab test in order to determine that the patient does not have a second alternative diagnosis, it makes no sense to say that the patient should be attributed to both the first and second specialty practices and that both should be responsible for the patient's costs for the next 12 months, when neither practice was providing "primary care" and neither the practices nor the patient expected to have any ongoing relationship following the negative diagnosis. Since those are the kinds of problematic scenarios that can result from the current "From any TIN within +/- 3 days" rule, the rule should clearly be deleted.

However, this leaves the "From the same TIN within +90 days" rule. It has similar problems as the +/3 day rule, just with a longer timeframe and a single practice/TIN. Acumen has ignored this problem.

Here again, rather than adding and deleting these kinds of arbitrary rules that have no real clinical logic to support them, it would be preferable to simply abandon the current attribution methodology altogether and utilize a methodology similar to what is used in other CMS models.

Lack of Information to Assess the Impact of the Measure

It is impossible to identify all the problems caused by the current TPCC attribution methodology and service exclusions or to accurately assess the magnitude of the problems without having access to data on the types of clinicians who are being attributed patients, the number of other clinicians who are involved with the patient's care, the nature and frequency of the services that the patients are receiving, etc.

As documented in the 2023 *Comprehensive Reevaluation Public Comment Summary Report*, "[s]everal commenters stated that CMS should provide the public with comprehensive analytics regarding the real-world application of these cost measures. Commenters specifically requested information concerning specialties attributed each measure, the average and range of performance on these measures, and number of attributed episodes for each measure. These commenters noted they could not accurately provide input on the measures without such analytics or data."

I urge CMS and Acumen to respond to this recommendation and to release analytical files containing detailed data on TPCC as soon as possible.

I would be happy to answer any questions you have about these comments and to provide guidance or assistance in revising the TPCC measure. You can contact me by email at [*redacted*] or by telephone at [*redacted*].

Sincerely,

Harold D. Miller
President and CEO
cc: Michelle Schreiber, CCSQ, CMS

3.1.26 Comment Number 26

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Erin Grossmann, American College of Emergency Physicians
- **Comment Text:**

May 17, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: MACRA Cost Measures: Call for Public Comment for Total Per Capita Cost (TPCC) Comprehensive Re-evaluation

Dear Administrator Brooks-LaSure:
On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to provide comments on the Total Per Capita Cost (TPCC) Comprehensive Re-evaluation. The Centers for Medicare and Medicaid Services (CMS) seeks feedback regarding the Merit Based Incentive Program (MIPS) Cost Performance category measure as part of its comprehensive re-evaluation process to update the measure's attribution methodology.

ACEP has previously commented that, in its current iteration, the TPCC measure creates confusion and burden for physicians and Medicare beneficiaries. We request that CMS either alter the measure to be more relevant and meaningful to the attributed physician or remove the measure altogether.

Physicians are held accountable for costs associated with medical conditions that they did not treat, medical decisions made by another provider, and/or care that they were not involved in. Per capita costs reflect the total amount billed per patient, not the costs of treatment by the individual provider. Emergency departments (EDs) serve as the entry point for many patients into the health care system, but they may not be responsible for ongoing care management. Patients treated in the ED may receive follow-up care from primary care physicians, specialists, or other providers,

making it challenging and inaccurate to attribute costs accurately to emergency physicians, who have no control over what another physician orders for a particular patient. Thus, the TPCC measure, which is ultimately attributed to the emergency physician, does not accurately represent the actual performance of the emergency physician.

Further, emergency physicians often have limited time to coordinate care beyond the immediate emergency situation. The TPCC measure may penalize emergency physicians for factors such as hospital readmissions or post-discharge complications that are influenced by factors outside of their control.

ACEP is also concerned by the shift to monthly benchmarking to evaluate a physician's performance on TPCC. This decision fails to examine scenarios that regularly lead to spikes and drops in patient visit patterns, including spikes in winter flu and heat stroke in summer months. Additionally, monthly benchmarking could potentially penalize an emergency physician whose patients are highly variable in acuity. As emergency physicians, we are subject to the Emergency Medical Treatment and Labor Act (EMTALA), which guarantees that we provide patients with emergency medical care regardless of their insurance status or ability to pay. Because of EMTALA requirements, EDs care for patients with a wide range of acuity levels, from minor complaints to life-threatening emergencies. The TPCC measure may not adequately account for this variability in patient complexity, leading to unfair comparisons between emergency physicians who treat different patient populations. ACEP strongly supports the patient protections embedded within the EMTALA requirements, and worries this change would disadvantage emergency physicians, who have little control over their practice patterns. ACEP recommends that, if CMS keeps the TPCC measure, they revise the measure back to an annual evaluation of costs.

Scoring emergency physicians on the TPCC measure could create disincentives for providing appropriate care to high-risk or complex patients. Though transfers to specialty care may be medically necessary, emergency physicians should not be held financially responsible for the clinical decision-making of other clinicians outside of the ED-based episode of care. We encourage CMS to continue to develop episode-based cost measures that capture the clinical screening, diagnostic testing, and stabilization work done by emergency physicians before a patient is admitted into the hospital.

Overall, while the TPCC measure may be suitable for assessing the cost efficiency of certain types of health care providers, its application to emergency medicine requires careful consideration of the unique challenges and dynamics of emergency care delivery. CMS should continue collaborating with emergency physicians to develop, implement, and score them on fair and meaningful episode-based measures rather inapplicable alternatives such as the TPCC measure.

We appreciate the opportunity to provide comments and again urge CMS to keep Q487 an optional measure under MIPS. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at [*redacted*].

Sincerely,

Aisha T. Terry, MD, MPH, FACEP
ACEP President

3.1.27 Comment Number 27

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Joshua Lapps, MA, Society of Hospital Medicine
- **Comment Text:**

May 17, 2024

Comments on the Total Per Capita Cost Measure Re-Evaluation

The Society of Hospital Medicine (SHM), representing the nation's more than 50,000 hospitalists, is writing to provide comments on the Total Per Capita Cost (TPCC) Comprehensive Re-evaluation. Hospitalists are physicians who specialize in the medical care of patients in acute care hospitals. Most hospitalists are board certified in internal medicine, but some may also train in family medicine, med-peds, pediatrics or in more limited cases, other specialties. They see patients exclusively in the hospital and are responsible for managing their care throughout their stay and at discharge.

The TPPC measure is intended to assess costs for patients attributed to clinicians with a primary care-type or on-going relationship to the patient. As such, hospitalists generally would not expect to be attributed episodes for this measure or be scored by it in the Merit-based Incentive Payment System (MIPS). However, hospital medicine groups have reported instances where they have received a score for the measure, which has ultimately negatively impacted their overall MIPS Cost category score. Therefore, we do not believe the current measure exclusions, based on specialties, are adequate for targeting the intended clinicians in this measure.

Excluding the Hospital Medicine Team from the Measure

The current attribution methodology excludes hospitalist physicians, identified as such with the HCFA specialty for hospitalists, from the measure. In 2021, there were approximately 16,000 physicians identified as hospitalists in CMS data. SHM estimates that this accounts for only one-third of the physicians who practice as hospitalists – the rest are predominantly identified as

internal medicine, with a significant minority as family practice. Those hospitalists should not have cases attributed to the measure as they are generally not providing potential E/M primary care services defined as candidate events. However, there may be some circumstances where they might bill primary care services and subsequently be attributed cases for the measure. For example, hospitalists may bill outpatient codes in a pre-admission testing clinic or post-discharge clinic. Hospitalists are not the intended clinicians for this measure and we urge Acumen and CMS to explore further refining the methodology to ensure they are not captured by the methodology. We believe a similar approach as for excluding hospitalist NP and PAs could be taken.

Hospital medicine groups who have NPs and PAs in their TINs have also had episodes of the measure attributed to their group and received a score on the TPCC measure. Just like physician hospitalists, there are scenarios such as pre-op clinics where an NP or PA would bill outpatient codes, but would not have the longitudinal relationship intended for this measure. The entire hospital medicine team including NPs and PAs should not be held to this measure, as the patients seen by them are likely to be among the most expensive patients, as they are guaranteed to have a hospitalization.

CMS and Acumen suggest one potential approach to adjusting the attribution rules is to exclude NP and PAs if the rest of their TIN is composed of only HCFA excluded specialties. This would not work for hospital medicine groups, since physician hospitalists may be identified as hospitalists (excluded), internal medicine (included), or family practice (included). Therefore, we strongly encourage CMS and Acumen to develop an approach that more accurately targets the intended clinicians for this measure.

We see two potential pathways to better refine the specialty exclusion rules: a) exclude clinicians who bill a significant majority of claims in the hospital setting; or b) utilizing place of service codes for claims including with the candidate event E/M visit to exclude hospital medicine teams. Using claims analysis could involve excluding NPIs with HCFA specialties of internal medicine, family practice, nurse practitioner or physician assistant if a significant percentage of their claims are otherwise from hospital associated E/M codes.

As an alternative, using place of service codes and a similar threshold to better identify where the clinician is working and determine whether they are hospital based. This could mirror the MIPS facility-based measurement eligibility, which uses a 75% threshold of services in Place of Service 21 (inpatient), 22 (hospital outpatient) and 23 (ER).

It is critical that the TPCC methodology be adjusted to exclude hospital medicine teams. They are not the intended clinicians for this measure, and their incidental inclusion in the measure has negative impacts on their overall MIPS scores. CMS should also strengthen the appeals process

for situations where clinicians who would not reasonably expect to be held accountable to the TPCC receive scores in the measure.

Thank you for your consideration. Please contact Josh Lapps, Director of Policy and Practice Management, at [*redacted*] if you have any questions or need more information.

3.1.28 Comment Number 28

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Jillian Winans, American Academy of Dermatology
- **Comment Text:**

May 17, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
Independence Avenue, SW
Washington, DC 20201

RE: MACRA Cost Measures Call for Public Comment for Total Per Capita Cost (TPCC) Measure Reevaluation

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Dermatology Association (AADA), we write to provide input to the Centers for Medicare & Medicaid Services (CMS) as it reevaluates the Total Per Capita Cost (TPCC) measure included in the Merit-based Incentive Payment System (MIPS).

The AADA is the leading society in dermatological care, representing more than 17,000 dermatologists nationwide. The AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of skin disease.

Total Per Capita Cost & Dermatology

The AADA is pleased to see that CMS and its contractor, Acumen, LLC, are reevaluating the methodologies employed in the TPCC measure in response to concerns raised about inappropriate attributions, which extend to dermatologists despite their exclusion from this measure. We received examples of 2022 MIPS feedback reports where dermatologists were attributed the TPCC measure despite being excluded. Our understanding is that this misattribution may occur when Advanced Care Practitioners (such as nurse practitioners [NPs],

physician assistants [PAs], and certified clinical nurse specialists [CNS]) in a practice bill Medicare directly under the dermatologist's TIN.

In general, the AADA does not support using the TPCC measure in MIPS since it holds clinicians accountable for costs beyond their direct control. While we support CMS' goal of incentivizing better care coordination between providers, a measure targeting total cost of care is more appropriate for a hospital or accountable care organization (ACO), not an individual clinician or group practice.

Adjust Attribution Rules

If CMS is unwilling to remove this measure from MIPS, then the AADA would support the proposed attribution refinement to exclude advanced care practitioners in TINs composed of only advanced care practitioners and excluded specialties. This change would help ensure that dermatologists are not held accountable for costs associated with medical conditions they did not treat, medical decisions made by other providers, or care in which the dermatologist was not involved.

The AADA urges CMS to implement this change as soon as possible and apply the change retroactively to limit any unfair Medicare penalties resulting from the flawed attribution methodology. Additionally, it is imperative that CMS apply this refinement to the 2023 MIPS performance period to mitigate unwarranted penalties to specialists who are excluded from this measure but are being incorrectly attributed.

Adjust Attribution for Multispecialty Practices

The AADA maintains that additional attribution refinements must be made to the TPCC measure to account for scenarios like multispecialty practices that include clinicians who are included and excluded from the TPCC measure since this is a common situation in clinical practice. In multispecialty groups that include primary care physicians and specialists, some or all of the advanced care practitioners could support the work of the excluded specialists; however, patients may be attributed to the group because of the specialty care services provided by the advanced care practitioners. This scenario is equally inappropriate, and **the AADA urges CMS to identify specific types and mixes of services offered by advanced care practitioners to eliminate as many inappropriate attributions as possible. Additionally, we encourage CMS to collaborate with medical specialties to explore alternative methods for accurately attributing patients and costs without adding extra administrative burdens for physician practices.**

Timely Feedback to Help Physicians Reduce Costs

As CMS considers refinements to the TPCC cost measures, the AADA emphasizes the importance of timely feedback to aid physicians in reducing unnecessary costs for Medicare and their patients.

Currently, participants in MIPS face a significant delay in receiving performance feedback, often waiting many months after providing services to Medicare patients. This lack of real-time

feedback hinders physicians' ability to monitor their performance and identify opportunities to reduce costs. **To drive improvements in cost performance and reduce avoidable spending, the AADA asks CMS to provide quarterly feedback reports on cost measures during the performance period. These reports could be similar to the field testing reports that Acumen provides when cost measures are being developed.**

In addition, specialty societies have little understanding of how their members are performing or are otherwise affected by these measures at an aggregate level. As of May 2024, the most current Public Use File (PUF) includes data from the 2021 MIPS performance year. This provides AADA with little insight into the accuracy of these measure methodologies. **The AADA urges CMS to provide more timely aggregate data on MIPS participation and performance trends so that specialties can better understand how more recent CMS policies are impacting their members.**

Conclusion

The AADA appreciates CMS' recognition of opportunities to improve the MIPS Cost Performance Category and thanks the agency for its consideration of our input. If you have any questions regarding this letter, please Jillian Winans, Associate Director of Regulatory & Payment Policy at [*redacted*].

Sincerely,

Seemal R. Desai, MD, FAAD
President, American Academy of Dermatology Association

3.1.29 Comment Number 29

- **Date:** 5/17/2024
- **Submitter Name, Credentials, and Organization:** Rachel Groman, MPH, American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS)
- **Comment Text:**

May 17, 2024

Acumen, LLC
500 Airport Blvd., Suite 100
Burlingame, CA 94010

Submitted via: macra-cost-measures-info@acumenllc.com

SUBJECT: 2024 Total Per Capita Cost Measure Re-evaluation

To whom it concerns:

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 in response to Acumen's effort to re-evaluate the Total Per Capita Cost (TPCC) measure currently in use under the Merit-based Incentive Payment System (MIPS).

Although neurosurgeons, as a specialty, are excluded from the TPCC measure, we are opposed to any measure that creates perverse incentives to undertreat patients. The TPCC is fundamentally flawed because it not only holds physician accountable for costs outside of their reasonable control but is based exclusively on administrative claims data and inadequate risk adjustment methodologies that fail to assess the appropriateness of surgery accurately. As a result, primary care physicians may avoid or delay referring a patient to a surgeon, even when such care is indicated, for fear of getting penalized for the high cost of surgical services. For any given spine surgery, there is tremendous variation in cost. While some might be warranted and some might not, this is impossible to discern from claims data. The TPCC measure inaccurately assumes that surgery is a uniform treatment.

It is critical that cost measures account for the fact that "surgical diagnoses" do not necessarily predict surgical spending. For a given spine diagnosis, there are a number of potential surgical treatments. In other cases, the patient might not even be a candidate for surgery despite having the diagnosis coded. Additionally, diagnosis codes for the spine do not usually indicate the severity of the disease and symptoms, which makes it even more challenging to predict who will have surgery based on diagnosis codes alone. Again, administrative claims data is limited in its ability to discern nuances of care and often results in incomplete and flawed assessments of cost. Risk adjustment methods applied to claims-derived data also perform poorly due to the underlying data's limitations.

On the quality side, measure stewards are increasingly developing registry and electronic/digital quality measures because they offer much richer and more granular sources of data and allow for more accurate determinations of how and why care was provided. The AANS and CNS strongly urge CMS to consider alternative sources of data when calculating cost measures along with more nuanced risk adjustment methodologies. We oppose the use of total per capita cost measures for purposes of physician-level accountability until the accuracy of these analyses and associated perverse incentives have been addressed.

The AANS and CNS thank Acumen for its ongoing work with relevant stakeholders to develop, monitor and refine cost measures to ensure they are clinically accurate and appropriate. We look forward to continuing to collaborate with Acumen on this ongoing initiative. In the meantime, if you have any questions or need additional information, please feel free to contact us.

Sincerely,

Jacques J. Morcos, MD, President
American Association of Neurological Surgeons

Alexander A. Khalessi, MD, President
Congress of Neurological Surgeons

Staff Contact:
Rachel Groman, MPH
Vice President, Clinical Affairs and Quality Improvement
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