2026 Field Testing Feedback Summary Report for 3 Episode-Based Cost Measures:

- Breast Cancer Screening
- Non-Pressure Ulcers
- Parkinsonism Syndromes and Multiple Sclerosis (MS)

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1. Introduction

1.1 Project Title

PCMP Episode-Based Cost Measures: 2026 Cost Measures Field Testing

1.2 Project Background

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

CMS has contracted with Acumen, LLC, to develop new episode-based cost measures for potential use in the Cost performance category of MIPS. This work is under the contract, "Physician Cost Measures and Patient Relationship Codes (PCMP)" (contract number 75FCMC18D0015, Task Order 75FCMC24F0142). Acumen has implemented a measure development process that relies on input from several interested parties, including multiple groups of clinicians affiliated with a broad range of professional societies and Person and Family Partners (PFP), to develop clinically appropriate and transparent measures that provide actionable information to clinicians.

This document summarizes the feedback from interested parties on the three episode-based cost measures that were field tested as part of the measure development process from January 29 to February 27, 2026. Section 1 provides background on the measure development process and the three episode-based cost measures being developed. Section 2 summarizes the feedback Acumen received on the Breast Cancer Screening measure. Section 3 summarizes feedback Acumen received on the Non-Pressure Ulcers measure. Section 4 summarizes feedback received on the Parkinsonism Syndromes and Multiple Sclerosis (MS) measure. Section 5 summarizes feedback received on the field testing process and MIPS program feedback. Section 6 outlines the next steps for potential measure refinement based on field testing feedback.

1.3 Measure Development and Field Testing Overview

The Wave 6 episode-based cost measure development process began in 2023, when Acumen gathered input from interested parties to help inform which measures to develop and determined measures for development. This process continued through 2024, gathering input on measure specifications for the Parkinsonism Syndromes and Multiple Sclerosis (MS) measure (previously called the Movement Disorders) and the Non-Pressure Ulcers measure. Clinician Expert Workgroups were initially convened in June and October 2023 and March 2024 to provide and refine clinical specifications for the Wave 6 episode-based cost measures. Additionally, the Wave 6 measures underwent initial field testing in February and March of

2024. For more detailed information on field testing and the episode-based cost measure development process, please refer to the QPP Cost Measure Information Page.

Following the 2024 Measures Under Consideration (MUC) List and Pre-Rulemaking Measure Review process, CMS continued development efforts for the Wave 6 measures prior to considering implementing the measures for use in MIPS. The Clinician Expert Workgroups were convened again to continue development in July and September/October 2025, where members have considered updates to the measure specifications. Additionally, the Wave 7 process began, where the Wave 7 Breast Cancer Screening Clinician Expert Workgroup was convened in July and October 2025 to develop a breast cancer screening measure in tandem with the continued Wave 6 development.

CMS and Acumen conducted field testing on the updated Wave 6 measures and the Wave 7 measure from January 29 to February 27, 2026. Field testing is a crucial part of the measure development process. It allows clinicians and other interested parties to learn about episode-based cost measures and provide input on the draft specifications.

During field testing, clinicians and clinician groups had the opportunity to view a field test report on the QPP website with information about their performance. Field test reports were available to clinicians and clinician groups who had 20 or more episodes for at least one of the Wave 6 episode-based cost measures during the measurement period (1/1/2024 - 12/31/2024) and at least 10 or more episodes for the Wave 7 episode-based cost measure during the same measurement period. The two Wave 6 episode-based measures undergoing field testing focus on the treatment and management of particular chronic conditions, while the Wave 7 measure focuses on screening for breast cancer:

- Breast Cancer Screening
- Non-Pressure Ulcers
- Parkinsonism Syndromes and Multiple Sclerosis (MS)

Specifically, 691 clinicians and clinician groups downloaded a field test report from the QPP website during field testing. 677 clinician groups (identified by Tax Identification Number or TIN) downloaded a report and 14 clinicians (identified by TIN-National Provider Identifier or TIN-NPI) downloaded a report.

For the duration of field testing, all interested parties were invited to provide feedback on the measures by completing an online survey or submitting a comment letter,[1] regardless of whether they received a report. Acumen and CMS made several materials publicly available for interested parties' review: (i) draft measure specifications, (ii) mock field test reports, and (iii) supplemental documentation.[2] Acumen and CMS also publicly posted the 2026 Cost Measures Field Testing Webinar at the start of the field testing period to provide interested

[1] The survey was previously available online at the 2026 Cost Measures Field Testing Feedback Survey.
[2] Field testing materials are available for download on the QPP Cost Measure Information Page.

parties with details regarding the field testing process and draft measure specifications.[3] Acumen also produced additional publicly posted materials for this field testing period, including At-A-Glance documents and recorded field test report walkthroughs for each measure, which provide a detailed guide on interpreting a field test report.

Additionally, Acumen held 2 specialty society office hours before and during field testing to provide information about field test reports and allow interested parties, including specialty societies who represent clinicians likely to be attributed the measures and Clinician Expert Workgroup members, to ask questions about field testing and the measure specifications.

Acumen also conducted an extensive education and outreach campaign to encourage interested party feedback on the measures undergoing field testing. Acumen initiated over 10 mass email outreach campaigns to the general public, clinician groups receiving reports, specialty society contacts, and other interested parties throughout the field testing period. Acumen attended PFANetwork meetings and coordinated outreach to Person and Family Partners (PFPs) to encourage patient and caregiver feedback.

Acumen received:

- A total of 16 comments through the 2026 Cost Measure Field Testing survey, including 5 letters that were attached to a survey response.
- A total of 23 comments through the PFE Cost Measures Field Testing survey.

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

The next three sections include the measure-specific feedback received on the three episode-based cost measures during the field testing period. The feedback was shared with the Clinician Expert Workgroups prior to the Post-Field Test Refinement (PFTR) webinars in March and April 2026 for their review as they considered potential refinements to the measures.

Each section provides detailed feedback on the Wave 6 and Wave 7 episode-based cost measures. Section 2 summarizes feedback on the Breast Cancer Screening measure. Section 3 summarizes feedback on the Non-Pressure Ulcers measure. Section 4 summarizes feedback on the Parkinsonism Syndromes and Multiple Sclerosis (MS) measure. Section 5 summarizes general feedback about the field testing process and MIPS. Section 6 outlines next steps for measure specification refinements. The list of commenters who submitted feedback during the field testing period is provided in Appendix A. A list of the verbatim comments received during the field testing period is provided in Appendix B.

[3] 2026 Cost Measures Field Testing Webinar materials are available on the QPP Cost Measure Information Page.

2. Breast Cancer Screening

2.1 Definition of an Episode Group

- Several commenters agreed that the measure's trigger code appropriately identifies a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram.
- One commenter recommended shortening the episode window (i.e., 360 days).
- One commenter recommended a 365-day episode window.

The majority of feedback supported the current approach to defining an episode. We appreciate confirmation that the triggering logic is appropriate. To provide additional context on the definition of the episode window, the measure currently has a 360 day episode window (i.e., 12 months of 30 day blocks) to capture patients' screening mammograms and any associated diagnostic care. This 12 month period aligns with the MIPS performance period. The measure uses the 30-day blocks to consistently define months where services are assigned to the measure so that the measure can identify instances of early and late detection of cancer. This methodology allows the measure to assign services differently for episodes where cancer is detected late (i.e., between 9-12 months following an initial screening) than episodes where no cancer is detected or cancer is detected early (i.e., 1-8 months following an initial screening), which is discussed in greater detail in Section 2.4.2.

2.2 Attribution of the Episode Group to Clinicians

- Several commenters confirmed that the measure's attribution methodology is appropriate.
- A few commenters stated that the measure's attribution methodology does not fully capture all clinicians that can reasonably influence costs related to breast cancer screening.
    - One commenter recommended incorporating a shared or multi-specialty attribution model when downstream care drives episode costs.
- Several PFE commenters identified a wide range of clinicians involved in their care team, including radiologists, radiology and x-ray technicians, obstetrician-gynecologists (OB-GYNs), primary care practitioners (PCPs), internal medicine doctors, nurse practitioners, and physician's assistants.
    - Several PFE commenters reported visiting PCPs and internal medicine doctors on a quarterly-basis, radiologists on a yearly-basis, and OB-GYNs once every few years.
    - One PFE commenter also identified breast cancer surgeons, oncologists, and hematologists.
    - Several PFE commenters reported receiving clear and helpful communication from their care team. Some other commenters reported experiences with unclear communication, information asymmetry, and poor care coordination. A few commenters noted that their care team did not heed their concerns with

diethylstilbestrol (DES) exposure, care unrelated to symptoms, and stopping screening past 80 years of age.

The Breast Cancer Screening measure is predominantly attributed to diagnostic radiologists. However, the measure includes the cost of relevant services that are provided to the patient by other providers or specialties, including basic diagnostic services (e.g., breast biopsy, MRI, encounters for screening mammogram) and related ER services (e.g., ER visits for breast biopsy complications). This is to ensure that the measure captures the full scope of relevant care that a patient receives for breast cancer screening and to encourage care coordination and communication that can have cost saving implications, such as reducing redundant testing. The measure is designed to reward providers that provide and manage efficient breast cancer screenings and early cancer detection, if cancer is present, for patients.

The Clinician Expert Workgroup has thoroughly considered the role of the attributed clinician in providing breast cancer screening throughout the measure development process. During the Workgroup Meeting #3 held following field testing, they revisited discussions about what the attributed provider has reasonable influence on for breast cancer screenings and cancer detection. They provided input on what actions are within the attributed providers' control and how those actions impact patient outcomes and measure performance.

2.3 Accounting for Patient Heterogeneity

2.3.1 Sub-groups

- Several commenters agreed that it is reasonable to compare episodes with and without cancer detection separately through sub-grouping due to expected differences in cost.
- A few commenters expressed concerns with the definition of breast cancer detection.
    - One commenter noted that the current claims-based definition of cancer detection may reflect care pathways or coding patterns rather than the actual point of diagnosis, and recommended incorporating pathology-confirmed malignancy codes to improve accuracy. The commenter also noted that the current definition does not account for meaningful variation within both sub-groups, such as episodes involving benign biopsies, high-risk patients, or supplemental imaging.
    - One commenter noted that the current definition does not account for patients diagnosed with breast cancer who do not complete follow-up or treatment.
    - One commenter noted that the current definition could be based on abnormal findings from the screening mammogram.
- A few commenters proposed sub-grouping based on risk of developing breast cancer to better account for increased screening and diagnostic costs among high-risk patients.
    - One commenter recommended using the Breast Imaging Reporting and Data System (BI-RADS) classifications as sub-groups.

2.3.2 Risk Adjustment

- Several commenters proposed additional patient-level risk adjustment variables. These include patients with:

    - Elevated risk for breast cancer, as measured by artificial intelligence (AI) or a statistical model of lifetime risk based on family history
    - A first degree relative that carries deleterious genetic mutation
    - Breast atypia (i.e., atypical ductal hyperplasia and atypical lobular hyperplasia)
    - Lobular carcinoma in situ
    - Changes in breast density
    - Chest/upper abdominal radiation
    - Hormonal therapy use
    - Mental health conditions
    - Prior benign biopsies
    - Prior surgery or implants
- Several commenters suggested adding risk adjustors for location of services (e.g., to account for state-based variation in care patterns) and facility type (e.g., cancer centers, community hospitals, hospitals affiliated with medical schools).
- A couple of commenters expressed support for the current list of risk adjustment variables.
- One commenter recommended further refinement of risk adjustment for underlying patient risk factors to improve fairness and comparability across practices, noting that practices serving older or higher-risk populations will naturally have higher detection rates and downstream costs.
- One commenter recommended more granular age stratifications.
- One commenter requested that the risk adjustment methodology align with standardized breast cancer risk assessment tools (i.e., Tyrer -Cuzick) as environmental or social factors that may affect costs are not easily identifiable in administrative claims data.

2.3.3 Exclusions

- Several commenters supported the current list of exclusions.
    - One commenter noted that male patients are rarely screened and patients under 40 years of age are screened less frequently, often for risk factors associated with higher costs.
- Some commenters proposed refinements to the current list of exclusions.
    - A few commenters recommended that the measure include patients with a strong family history of premenopausal breast cancer. One commenter specified that family history should be limited to a first degree relative.
    - One commenter requested that the measure include all patient sub-populations that can develop breast cancer. They suggested that including these patients can minimize costs for early cancer detection.
    - One commenter recommended that the measure include patients starting at 35 years of age and young patients with a genetic predisposition to breast cancer.

- One commenter recommended replacing the age exclusion with a risk adjustment variable, and explained that excluding patients under 40 years of age does not align with clinical practice guidelines and may discourage screening in this population.

We appreciate the commenters feedback on addressing patient heterogeneity within the measure. Sub-groups are currently defined based on whether cancer is detected during an episode. Each sub-group is then risk adjusted separately for over 100 variables, including standard CMS HCC variables and measure-specific variables (e.g., BRCA carrier status, dense breast tissue, history of abnormal mammograms, or family history of breast cancer) that address situations where patients may be at higher risk. The measure also includes risk adjustment variables for other factors that may be out of a clinician's influence. The current risk adjustment model accounts for many of the commenters' recommendations. The measure also excludes specific patient cohorts that may have a different or more severe disease presentation and progression that is not comparable to the standard population screened for breast cancer. For example, patients with a previous history of breast cancer or who require a screening under 40 years of age are often at an elevated risk of cancer and likely a costlier patient cohort to treat.

During Workgroup Meeting #3, held following field testing, the Clinician Expert Workgroup considered the inclusion of additional risk adjustment variables and the exclusion of additional patient cohorts with the Breast Cancer Screening Workgroup in response to this feedback. They acknowledged that the measure already accounts for some of the variables raised by commenters. However, they voted to risk adjust for breast atypia (i.e., ADH/ALH) separately from the prior presence of dense breast tissue risk adjustor. They also considered how to address episodes that have patients with LCIS, which resulted in Acumen following a conservative approach to exclude these episodes. Finally, Workgroup members voted to modify the exclusion for patients with a history of breast cancer to remove patients with unilateral screenings from the measure.

2.4 Assignment of Costs to the Episode Group

2.4.1 Assignment of Clinically-Related Services

- Several commenters expressed concerns that the measure is holding clinicians responsible for costs that are outside of their reasonable control, such as supplemental imaging that occurs after cancer is detected and informs cancer treatment plans.
  - A couple of commenters questioned the inclusion of evaluation and management (E/M) services in the measure as radiologists typically do not bill these services.
  - Several commenters questioned the inclusion of cancer treatment costs as these services reflect downstream care decisions outside of the attributed clinician's reasonable control.
  - Some commenters recommended the removal of emergency department (ED) services because screening mammograms are rarely associated with ED visits.

    - Some commenters recommended limiting included services to those directly performed by the attributed clinician or tied to the screening mammogram
- Several commenters supported the fixed oncology cost, explaining that it accounts for cost variation that falls outside of a clinician's control and focuses the measure on timely detection.
    - One commenter disagreed and recommended assigning actual treatment costs to account for aggressive cancers that develop after a screening mammogram.
- A couple of commenters recommended additional clinically-related services for inclusion, including breast-specific contrast mammography, positron emission tomography (PET), and computed tomography (CT) scans localization of cancers and lymph nodes prior to surgery.
- One commenter recommended the following refinements to the measure's service categories: (i) separate Magnetic Resonance Imaging (MRI) services into a distinct intermediate diagnostic service category if risk adjustment does not capture breast cancer risk, (ii) add radioisotope scan and function studies to the same service category as MRI, (iii) create a separate service category for laboratory tests performed for early detection of cancer.
- One commenter requested clarification on how costs are attributed to groups that perform both screening mammograms and diagnostic work-up, and expressed concern that these groups would be unfairly penalized compared to screening-only facilities.
- One commenter expressed concern that the measure's terminology for service assignment rule categories (i.e., separating detection episodes into early and late detection) may be confused with cancer staging (e.g., late cancer detection could imply advanced staging or metastasis).
- Several PFE commenters specified which services were the most and least effective their care, reporting the following as the most effective: prompt follow-up services (i.e., supplemental imaging and biopsy), proactive cancer treatment, and services provided in a comprehensive care center. PFEs reported mammograms were less effective at detecting cancer than biopsy and ultrasound.

2.4.2 Influence of Cancer Timing on Service Assignment

- Some commenters noted that 8 months or less is a reasonable timeframe to measure the costs from majority of patients to begin receiving services related to their breast cancer diagnosis.
    - One commenter noted that this timing depends on how the cancer diagnosis is defined, and that the first surgery of chemotherapy treatment would be indicative of a breast cancer diagnosis.
- A few commenters highlighted that some patients undergo supplemental screening 6 months from the screening mammography.
    - One commenter noted that breast cancers detected after a six-month follow-up are often at an early stage and have different clinical features to cancer missed during the screening mammogram.

    - Another commenter suggested that shortening the cutoff used to define early cancer detection to 6 months would adjust for these patients. This commenter noted that registry-level data on method of cancer detection and presenting clinical symptoms could provide additional information.
- Several commenters listed factors outside of the attributed clinician's reasonable influence that may impact the timing of cancer detection. These include patient-level factors (e.g., dense breast tissue, patient anxiety); social and environmental factors (e.g., transportation, affordability of services); and systemic and administrative barriers (e.g., scheduling, access to specialists).
- Several PFE commenters provided input on the timing of services, with most reporting that they waited 1-3 weeks between their first screening mammogram and follow-up test. A few commenters reported receiving follow-up services on the same day or waiting at most a few weeks. Of the PFE commenters that reported receiving treatment, all waited less than one month between their first screening mammogram and being diagnosed with cancer or starting treatment.

The Breast Cancer Screening Workgroup's input informed the services assigned to the measure and the timing that they are assigned. The Workgroup has provided extensive input on services that the attributed provider can influence the frequency, intensity, or occurrence by the care they provide and are clinically relevant to the breast cancer screening process, including instances where no cancer is detected and where cancer is detected based on empiric data and their clinical expertise. These services may be provided by clinicians who are not attributed to measure. This is the framework used for episode-based cost measures to ensure that the measure appropriately captures the cost of care clinically related to a condition or procedure for each patient. For factors that are outside of a clinician's influence that may impact a patient's services, the measure uses other methods, including risk adjustment and exclusions.

During Workgroup Meeting #3, the Workgroup discussed service assignment in detail. They found that the measure should continue to assign ED visits and recommended pairing ED services with additional diagnoses for breast-related postprocedural complications and infections. The Workgroup also revisited discussions on how to define late cancer detection and assign associated services. They reached consensus on using the current 8-month cutoff to define late cancer detection episodes. They highlighted the importance of incentivizing timely follow-up, while not holding providers responsible for factors outside of their reasonable control and voted to only assign the costs of clinically-related services through the cancer detection date for cancer detection episodes. This refinement removes services that are no longer related to the radiologist's role in screening mammography, and that remaining cost variation aligns with clinical expectations. Additionally, they confirmed that the measure's current approach to assign a fixed oncology cost in episodes where cancer is detected late reduces variation that falls outside of the attributed clinician's control, and acts as a mechanism for incentivizing early cancer detection by not assigning treatment services to early cancer detection episodes.

2.5 Alignment of Cost with Quality

2.5.1 Quality Measures

- Several commenters listed quality measure concepts to help assess the value of care, including cancer detection rate, recall rate, positive predictive value, and timeliness and completeness of follow-up.
- One commenter listed specific MIPS quality measures and QCDR measures most applicable to the Breast Cancer Screening cost measure (Measure #112: Breast Cancer Screening, QMM18: Use of Breast Cancer Risk Score on Mammography, QMM28: Reporting Breast Arterial Calcification (BAC) on Screening Mammography, and ACRAD25: Mammography Turn-Around-Time).
- One commenter raised concern about the lack of a paired quality measure for use in MIPS.

2.5.2 Quality of Care

- Several commenters noted that identifying actionable steps to improve measure performance would be difficult, as it is unclear what factors are driving episode costs.
    - One commenter expressed interest in seeing cost comparisons by specialty type.
- A few commenters listed clinical actions which can improve measure performance. These include adopting AI technologies, following clinical practice guidelines, discussing results with the patient in a timely manner, and tracking patient care throughout the episode window.
- One commenter noted that this is a cost measure only and that improving interpretation quality is a separate issue.
- Some PFE commenters reported having false-negative and false-positive mammogram results, and listed the following parts of their care experience that could have been improved:
    - Discomfort during the mammogram
    - Delays in care and redundant testing
    - Speed and access to testing results
    - Concerns with developing cancer and future abnormalities
    - Knowledge and coding of DES exposure
    - Friendliness of staff

We appreciate the commenters' feedback on potential quality measures that may align with the Breast Cancer Screening cost measure. Cost measures are intended to assess costs of care alongside quality measures that capture outcomes of care to provide a comprehensive assessment of a clinician's or group's value of care. We also appreciate the suggestions for steps that clinicians can take to improve their measure performance. During Workgroup Meeting #3, which was held following field testing, the Clinician Expert Workgroup and the measure developer continued to consider what types of actions clinicians can take to improve their measure score as well as ways to appropriately align cost and quality.

2.6 Unintended Consequences

- A few commenters expressed concerns that the following patients may be impacted or discouraged from accessing appropriate care: male patients and younger patients of age with a strong family history, patients with dense breasts, patients with a prior benign biopsy, patients with implants.
- One commenter expressed support for the measure as currently specified, and suggested CMS consider future refinements as unintended consequences become clearer.
- One commenter stated that it is unclear if the measure effectively incentives early cancer detection. They suggested that clinicians would follow-up less frequently if they knew they were going to be attributed, and less cancer would be found as a result because the cancer detection rate is smaller in magnitude compared to the recall rate for most practices.
- One commenter stated that the measure would reward practices that overutilize diagnostic mammography in asymptomatic patients, and recommended a separate measure or mechanism to discourage this.
- One commenter expressed concern that the measure could penalize practices based on geographic variations in care, noting that breast ultrasound is commonly ordered alongside screening mammography in some states.
- One commenter expressed concern that the measure unfairly penalizes private practices in a disjointed health care system, where follow-up care is outside the radiologist's control.
- One commenter raised several concerns related to use of this measure in MIPS, including the broad scope of the measure and the lack of consensus-based entity (CBE) endorsement.

We thank the commenters for their feedback. Current testing has not identified evidence that the measure will have unintended consequences on patients or clinicians. Empiric analysis show that the risk adjustment model accounts adequately for many of the patient characteristics and comorbidities raised. During Workgroup Meeting #3, the Workgroup reviewed evaluation criteria for the Breast Cancer Screening measure, including validity and reliability. They acknowledged that the measure's mean reliability at both the group and clinician levels exceeds the MIPS reliability requirements and is among the highest across cost measures. They also advised on ways that clinicians have influence over measure outcomes that can help improve their performance.

Additionally, CMS monitors any measures once they are in use in a CMS program. If the Breast Cancer Screening measure were to be used in MIPS, it would also undergo a 2-year informational only reporting period before impacting any MIPS performance scores.

3. Non-Pressure Ulcers

3.1 Definition of an Episode Group

3.1.1 Episode Window

- Commenters supported the measure's current trigger window (45 days) and attribution window (90 days), stating that they represent the typical non-pressure ulcer treatment and management timeline, help establish a patient-clinician relationship where clinicians can influence costs, reduce issues with capturing multiple subsequent ulcers in the same window, and capture cost savings potentially associated with exceptional ulcer care.
    - One commenter suggested reducing the attribution window length from 90 days to 60 days
    - One PFE noted their non-pressure ulcer treatment and management timeline lasted one year.
- One commenter asked if the measure takes into account recurrence of non-pressure ulcers, especially as it pertains to the attribution window length.

3.1.2 Episode Triggering Logic

- Commenters supported the current trigger and confirming diagnosis codes used to identify non-pressure ulcers episodes.
- One commenter noted that the trigger and confirming codes should include wound-related diagnosis codes as these also may be used to code non-pressure ulcers.

We appreciate the majority support for the current episode window definition. The current 90 day attribution window was informed by the Non-Pressure Ulcers Workgroup discussion and empiric analyses on the frequency and timing of services relevant to non-pressure ulcers. The Workgroup determined this as an appropriate window reflecting the typical ulcer treatment cycle where a provider can reasonably influence outcomes post-trigger event, and the shortened length naturally limits exposure to post-involvement costs. As a safeguard, if the clinician group does not bill a trigger or confirming claim within the 90-day window (i.e., a reaffirming claim), the episode closes. The measure does capture care related to an ulcer recurrence if it takes place within the episode window, as this is considered care related to the triggering ulcer and would be within the reasonable influence of a provider treating the initial ulcer. However, the measure does account for prior or existing ulcers at the time of an episode beginning through risk adjustment. We will continue to monitor the attribution window to ensure that it is an appropriate length.

3.2 Attribution of the Episode Group to Clinicians

- One commenter expressed support of the attribution's methodology requirements to ensure attributed TIN-NPIs to have billed at least 30% of trigger and confirming codes, and to have provided condition-related care to this patient prior one-year to or on the episode

start date. Another commenter cited concerns about costs possibly being attributed during the condition-related care check's one-year lookback.

- One commenter sought clarification on how attribution would be applied in cases where a physician diagnoses and codes a non-pressure ulcer but refers the patient to another provider for ongoing care, such as a PCP referring a patient to a wound clinic, questioning which clinician would be attributed the episode and associated costs.
- One PFE emphasized the role of internal medicine practitioners, neurologists, and vascular surgeons in their ongoing management of non-pressure ulcers.

We appreciate the commenters that support the current attribution methodology. To provide clarifications on the attribution approach, once an episode has been defined, it is attributed to one or more clinicians of a specialty that is eligible for MIPS. An episode is attributed to the clinician group that billed the trigger event (trigger and confirming claims) for the total attribution window (e.g., relevant outpatient E/M codes with ICD-10 diagnoses codes indicating non-pressure ulcers). The clinically related costs from the total number of assigned days are attributed to that clinician group. An episode is attributed to any clinician within the attributed clinician group that billed at least 30% of the trigger or confirming codes on Part B Physician/Supplier claim lines during the episode. As an additional check, this attributed clinician must also have billed at least one trigger or confirming code within 1 year prior to or on the episode start date. The clinicians or groups that are attributed the episode remain attributed for the duration of the attribution window, regardless of whether a patient is referred to other providers as part of their care.

3.3 Accounting for Patient Heterogeneity

3.3.1 Sub-groups

- Multiple commenters agreed with the measure's existing ulcer type sub-group methodology, stating it accounts for differences in clinical care and cost.
- Several commenters cited concerns with the current sub-group methodology, stating episodes potentially are not being assigned to the correct sub-group.
- One commenter raised concerns about a scenario where wounds could be classified as a non-pressure ulcer.
- One commenter suggested further sub-grouping episodes by severity, depth, and chronicity as these significantly influence resource utilization and cost over time.
- One commenter sought clarification on which sub-group an ulcer coded with a non-specific ulcer code (i.e., L97/L98) paired with a broad disease diagnosis code (e.g., a diabetes diagnosis could) is categorized.
- One commenter sought clarification of the "multiple ulcer types sub-group," and suggested this group may need to be sub-divided according to the types and number of ulcers.

3.3.2 Risk Adjustment

- Several commenters proposed adjusting for additional risk factors, including the following:

    - Acute infections (pneumonia, COVID-19)
    - Anemia
    - Anxiety
    - Autoimmune conditions
    - Cancer and cancer-related wounds
    - Cardiac/heart conditions
    - Chronic obstructive pulmonary disease (COPD)
    - Dyspnea
    - Hypercholesterolemia
    - Hypertension
    - Kidney failure/End-stage renal disease (ESRD)
    - Medication
    - Obesity
- One commenter supported the multiple ulcer instances and ulcer severity risk adjustors. Another commenter cited concerns with the latter adjustor's ability to address multiple instances of ulcers correctly, given that if the ulcers are of the same type, they can be conflated into one code.
- One commenter sought clarification for how a patient's risk is calculated, and whether TINs and TIN-NPIs have average patient risk scores or HCC scores.
- One commenter cited sought clarification for how the measure is specialty-adjusted given that CMS does not have a wound care specialty designation.

3.3.3 Exclusions

- Two commenters expressed support for current exclusions.
- Two commenters proposed excluding patients with:
    - Cancer-related wounds
    - Cancer
    - Chronic obstructive pulmonary disease (COPD)
    - Kidney failure-ESRD (including dialysis)

- Major cardiac events

We appreciate the feedback on how the Non-Pressure Ulcers measure addresses patient heterogeneity. To provide clarification on the current sub-group methodology, the Non-Pressure Ulcers measure sub-groups episodes based on ulcer type, looking at codes submitted from 120 days prior to the episode through the episode start date. Based on discussions with the Non-Pressure Ulcers Workgroup, the measure uses an 80% threshold methodology: if at least 80% of codes during that timeframe reflect a specific ulcer type (i.e., arterial, diabetic, or venous) the episode is placed into that respective sub-group. This accounts for both dual code sets and ulcer-specific codes. Episodes that do not meet the 80% threshold for a specific ulcer type, but where billing patterns still indicate multiple ulcer types, are placed into the "Multiple Ulcer Types" sub-group. Episodes where only L97/L98 codes are billed during the lookback period are placed into the "Non-Specific Ulcer Type" sub-group.

Additionally, the measure includes many risk adjustment variables specific to non-pressure ulcers (e.g., smoking, frailty, site of service, lymphedema, gunshot wounds, radiation, sleep apnea, ulcer instances, and ulcer severity) as well as standard risk adjustors for CMS HCC variables and other comorbidities (e.g., patient age category, disability status, ESRD status, certain cancer, number and types of clinician specialties that a patient has received care).

The Non-Pressure Ulcers Workgroup reviewed existing measure methodology and discussed potential additional risk adjustment and exclusion variables during Workgroup Meeting #3, held following field testing. The workgroup reviewed (i) how the measure identifies the number of ulcers by using ulcer type, location, and severity at the same anatomical site; (ii) how the measure includes a severity risk adjustor per the Workgroup's consensus; and (iii) that a risk adjustor for size could not be used given only 2-3% of relevant claims contain HCPCS/CPT codes specifying size, and size information is unavailable in diagnosis codes. After reviewing the current risk adjustment approach, the Workgroup found that the expected cost variation for episodes with hypercholesterolemia and hypertension were sufficiently accounted for. However, they did reach consensus to risk adjust for cellulitis in response to field testing feedback.

3.4 Assignment of Costs to the Episode Group

- Several commenters expressed concerns with situations where costs may be inappropriately assigned to clinicians' episodes. These include situations where (i) a non-pressure ulcer diagnosis is listed on a claim due to prior care or comorbidities, rather than the ulcer having a clear relationship to the service rendered, specifically for cardiac events, strokes, pneumonia hospitalizations, and skilled nursing facility services; (ii) patients seek care outside of the attributed group or clinician's locality; and (iii) attributed clinicians are no longer involved in the patient's care.
- Several commenters raised concerns about the inclusion of osteomyelitis-related amputations in the measure, noting that the primary distinction should be whether an

amputation resulted from acute trauma rather than a chronic ulcer, and that precise coding is necessary to ensure a clear clinical linkage between the non-pressure ulcer and osteomyelitis-related amputations rather than those driven by other conditions. One of the commenters further noted that DRG selection may not accurately reflect the true reason for an inpatient stay, such as when an osteomyelitis-related amputation is initially coded as a sepsis hospitalization.

- Three commenters cited concerns that claims data cannot distinguish between multiple instances of ulcers occurring in the same location with the same severity, potentially attributing episodes and/or costs of an unrelated ulcer to the clinician treating the original ulcer and making their episode appear disproportionately costly.
- Two commenters sought clarification of whether episode costs reflect appropriate standard of care, noting that higher costs do not necessarily indicate over-treatment nor lower costs under-treatment, and that following standard of care practices may appear to increase costs despite improving long-term outcomes. These commenters also asked whether expected costs are derived from clinical guidelines or peer comparisons, and whether the measure could identify instances where appropriate care was not provided.
- Two commenters requested clarification on which products are assigned to the “Skin Allograft” sub-category under the “DME and Supplies” category within the field test report, with an emphasis on verifying whether skin substitute products (i.e., Q and A service codes) are included.
- One commenter requested a clearer definition of "clinically related services under the reasonable influence of the attributed clinician," and how such influence can be accurately determined from claims data alone.
- One commenter suggested Acumen clarify the Non-Pressure Ulcers Codes List to better define Part D service assignment codes in which some state “No National Drug Code [NDC] description available.”
- One PFE emphasized their most effective services for the treatment and management of non-pressure ulcers being education from a radiologist technician about where their vascular surgery would be conducted and noted that compression socks, while very costly, and medication were their most helpful DME services.
- One PFE noted that they wished they had received better diabetes management at the start of their non-pressure ulcer, which would have led to fewer complications, such as increased neuropathy, damaged veins, and eventual varicose vein surgery.

Episodes are triggered by a group and/or its own clinician, but costs from outside that group and clinician can be assigned. This is intentional again as limiting costs to only those within the group would fail to capture the full scope of care a clinician or clinician group can reasonably influence, including the multidisciplinary care non-pressure ulcers typically require. For instance, groups, especially single-specialty practices, that refer patients to external providers could improve the healing rate of ulcers and the measure is able to capture these outcomes.

Additionally, the Workgroup has extensively discussed how to address patients that present with multiple ulcers simultaneously. Currently, the measure addresses this in two ways. First, the trigger window was shortened to 45 days and the attribution window to 90 days to better isolate individual ulcer occurrences. Second, where multiple ulcers are still present, the Workgroup adopted a "Multiple Ulcer Instances" risk adjustor to prevent clinicians and clinician groups from being penalized for the additional costs these cases carry. The adjustor uses claims data on ulcer severity, location, and type to determine the number of ulcers present and adjust for this accordingly.

During Workgroup Meeting #3, the Workgroup revisited discussions about refining the assignment of inpatient osteomyelitis-related amputations, reviewing empiric data and alternative approaches. They reached consensus to continue using the approach used during field testing (i.e., assigning services identified by MS-DRGs 474-476 (Amputation for Musculoskeletal System and Connective Tissue Disorders) with a principal diagnosis of osteomyelitis (M86)).

3.5 Alignment of Cost with Quality

- Multiple commenters noted that current MIPS quality measures do not fully capture the most relevant aspects of non-pressure ulcer care — including care coordination, timely referrals, and underlying disease management — and that existing measures such as CQM #126 and #127, while tangentially relevant, are limited to diabetic patients and do not directly align with the cost measure.
- Multiple commenters expressed concern that the measure could inadvertently discourage appropriate, evidence-based care — such as vascular evaluation, revascularization, and timely referrals — if clinicians feel pressured to limit interventions to control attributed costs, potentially resulting in poorer outcomes, higher downstream costs, and even avoidance of accurate wound coding when postoperative complications arise.
- Two commenters pointed to the following existing QCDR measures stewarded by the US Wound Registry as the most relevant measures currently available, and strongly encouraged CMS to work with stakeholders to develop additional measures in alignment with the cost measure. However, these commenters also noted barriers to quality measure uptake, noting that many EHRs do not include these QCDR measures on their platforms.
    - USWR 22: Nutritional assessment and intervention for patients with wounds and ulcers

    - USWR 30: Non-invasive arterial assessment for patients with lower extremity wounds or ulcers
    - USWR 32: Adequate compression for patients with venous leg ulcers
    - USWR 33: Diabetic foot ulcer healing or closure
    - USWR 34: Venous leg ulcer healing or closure
    - USWR 35: Adequate off-loading of diabetic foot ulcers
- Two commenters suggested that addressing comorbid conditions and making timely referrals to relevant specialists and proactive surgical interventions could improve measure performance and quality of care, and one expressed concern that the current measure could penalize clinicians for these proactive approaches despite their potential to reduce downstream costs.
- One commenter emphasized the important of quality indicators, specifically for care coordination, and emphasized that its measurement should encourage, not discourage, timely and appropriate referrals.
- One PFE noted a variety of quality actions that improved their wound healing rate and quality of life (e.g., ability to walk, pain management, and a decrease in complications) as they went progressed through treatment and management of their non-pressure ulcer. These included clinician responsiveness, preventative care and follow-ups, supportive behavioral counseling, care coordination, and caregiver education.

Cost measures assess the costs of all care relevant to a specific condition or procedure. They are designed with a safeguard against care stinting, by including the costs of adverse events and downstream costs that may be the result of inefficient care. Cost measures are intended to assess costs of care alongside quality measures that capture outcomes of care to provide a comprehensive assessment of clinician or group care.

We will continue to monitor the available aligned MIPS and QCDR quality measures and take your feedback into consideration. We agree that considering quality alignment during cost measure development is essential. We have worked with the Non-Pressure Ulcers Clinician Expert Workgroup throughout all stages of development to consider the availability of related MIPS and QCDR quality measures. CMS continues to work toward better alignment between cost and quality through MIPS Value Pathways (MVPs), which aim to capturing value of care by pairing most relevant cost and quality measures.

4. Parkinsonism Syndromes and Multiple Sclerosis (MS)

4.1 Definition of an Episode Group

4.1.1 Episode Window

- One commenter expressed confusion about the episode window, stating that there is conflicting information in the materials about whether the follow-up period is 6 months or 1 year. The commenter suggested that greater alignment and clarity in these definitions are needed to ensure consistent interpretation and implementation of the measure.

4.1.2 Episode Triggering Logic

- A couple of commenters provided feedback on the clinical conditions included within the measure.
    - One commenter questioned the clinical relevance and methodological appropriateness of combining Parkinsonism Syndromes and MS within a single measure, as well as the rationale for excluding ALS from the measure.
    - One commenter expressed concerns about the scope of the measure, referencing three included conditions.

Acumen and CMS will consider this feedback when assessing the need for any refinements to the measure. To provide brief clarifications for commenters that expressed confusion or questions, please see additional context about the measure's episode definition below.

The Parkinsonism Syndromes and MS Clinician Expert Workgroup reviewed and contributed to the development of the measure's triggering logic and episode window length. The start or continuation of a clinician or clinician group's management of a patient's Parkinsonism Syndrome or MS is identified by the appearance of a pair of services within 180 days of one another: a trigger code followed by a confirming code. An example of a trigger code could be an Evaluation and Management code paired with a diagnosis of Parkinsonism Syndromes or MS, while an example of a confirming code could be a code indicating rehabilitative services or infusion treatment also paired with a diagnosis of Parkinsonism Syndromes or MS. The confirming code must occur within 180 days of the trigger code. This defines the trigger window for the Parkinsonism Syndromes and MS measure as 180 days. However, once an episode is triggered by this confirming code, the episode window, in which related services are assigned to the attributed clinician or clinician group, can be between 1 year (365 days) and 2 years minus 1 day (729 days), and can vary in length across patients.

Additionally, the Parkinsonism Syndromes and MS Workgroup reached consensus on the removal of ALS from the measure. This was due to distinct prognostic differences that impact timing and trajectory of care as compared to Parkinsonism syndromes and MS. The Parkinsonism Syndromes and MS Workgroup voted for the grouping of both Parkinsonism Syndromes and MS within one measure during initial development as they both reflect chronic, progressive neurodegenerative conditions and display similar patterns of neurological disability, multidisciplinary management needs, and long-term healthcare utilization. Grouping these conditions into one measure additionally supports CMS' goal of streamlining the current measure portfolio and ensures adequate population sizes are maintained. However, the measure does implement two distinct sub-groups for Parkinson's and Related Conditions and MS to assess these patient cohorts separately. Sub-groups are more granular, mutually exclusive and exhaustive groups based on clinical criteria that enable meaningful clinical comparisons.

During the Workgroup Meeting #3, following field testing, the Workgroup reviewed the current methodology and testing and did not have concerns with including both Parkinsonism Syndromes and MS patient cohorts in the measure.

4.2 Attribution of the Episode Group to Clinicians

- PFE commenters identified a range of clinicians involved in their care team for managing Parkinsonism Syndromes and MS, including neurologists, primary care physicians/family doctors, internal medicine providers, physical therapists, and occupational therapists.
    - PFE commenters indicated that neurologists primarily oversee diagnosis and disease management, while primary care clinicians help monitor overall health and

medications, although neurologists and internal medicine clinicians may also oversee medication management.
    - One PFE commenter noted seeing a neurologist approximately every six months, internal medicine every four months, and physical therapy weekly.

We thank the commenters for their feedback. These responses provide insight into the clinicians involved in ongoing care management of Parkinsonism Syndromes and MS.

4.3 Accounting for Patient Heterogeneity

4.3.1 Risk Adjustment

- One commenter stated that the measure must appropriately account for the severity of the disease state, since both Parkinsonism Syndromes and MS are long term conditions in which cost of care varies greatly based on where the patient is in the disease process.

4.3.2 Exclusions

- One commenter suggested excluding MS patients with Intrathecal Baclofen pumps, as they stated that these patients represent a clinically distinct, highly complex population with predictable, non-modifiable costs driven by advanced disability rather than discretionary care decisions. The commenter felt that inclusion of these patients in MS cost measures undermines measure fairness, validity, and interpretability, and may create unintended disincentives for appropriate care. They also stated that exclusion of these patients would better align MS cost measures with their intended purpose and support equitable provider accountability.

We thank the commenters for their feedback. For additional context on the current methodology, the Parkinsonism Syndromes and MS measure uses several different approaches to account for disease severity and patient heterogeneity: sub-groups, risk adjustment, and exclusions. As previously discussed, Parkinson's syndromes patients and MS patients are grouped into mutually exclusive and exhaustive sub-groups based on clinical criteria that enable meaningful clinical comparisons. Additionally, the measure incorporates a robust risk adjustment model, risk adjusting for factors like frailty, dependence on a respirator, wheelchair dependence, and many other indicators of disease severity. The risk adjustment model is also applied separately to each sub-group so that Parkinsonism Syndromes patients are not being compared to MS patients within the measure. Finally, the measure also includes exclusions for patients with conditions like microvascular decompression and spinal cord injury, among others. These methods all work together to ensure that clinicians are being assessed for costs that are related to Parkinsonism Syndromes and MS and are within their reasonable control.

The Workgroup has discussed how to address the use of Intrathecal Pumps (ITP) within the measure and reached consensus to not include ITP costs in the measure methodology. Currently, patients who may receive ITP services are captured by the measure if they represent a relevant patient population with Parkinsonism Syndromes and MS diagnoses, but any ITP service they receive is not assigned. During Workgroup Meeting #3, the Workgroup revisited this topic and they supported the current approach for accounting for patient heterogeneity and for excluding ITP services.

4.4 Assignment of Costs to the Episode Group

- One commenter stated that the service categories included in the measure are appropriate and did not have any recommendations for services that should be added or removed.
- PFE commenters highlighted the importance of rehabilitation services in managing symptoms and maintaining quality of life.
    - PFE commenters described physical therapy, occupational therapy, and structured exercise programs as some of the most helpful services for improving mobility, maintaining independence, and managing symptoms.
    - Some PFE commenters suggested that earlier access to services such as physical therapy or mental health support could improve care for patients with these conditions.

We thank the commenters for their feedback. We understand that rehabilitation services are an important part of managing Parkinsonism Syndromes and MS care. As such, these services are currently assigned to Parkinsonism Syndromes and MS episodes and given specific service assignment requirements.

4.5 Alignment of Cost with Quality

4.5.1 Quality Measures

- One commenter expressed concerns with the lack of available paired quality measures.
- One commenter stated that cost assessments should be balanced with measures of treatment effectiveness and patient quality of life to reflect the clinical value of these therapies and ensure that providers caring for complex neurological populations are not unfairly penalized for delivering appropriate, evidence-based care.

4.5.2 Quality of Care

- PFE commenters discussed care coordination challenges across their care teams.
    - PFE commenters indicated that coordination does not always occur consistently between providers, and that patients may see multiple clinicians who manage different aspects of their condition, making coordination more complex.
    - One PFE commenter suggested that a care navigator or similar support could help patients manage appointments, referrals, and communication between providers.
- PFE commenters described complications and additional care needs associated with Parkinsonism Syndromes or MS.
    - One PFE commenter reported experiencing complications such as overactive bladder that required additional medical attention.
    - One PFE commenter stated that changes in symptoms or complications may lead to adjustments in care plans, such as increasing therapy services or modifying treatment approaches.
- PFE commenters emphasized treatment goals and outcomes that are meaningful for patients living with these conditions.
    - PFE commenters identified the following key goals for monitoring disease progression and maintaining health: reducing or managing symptoms, maintaining mobility and independence, regular follow-up visits, and preventive care.
- PFE commenters described barriers related to accessing services and specialists.
    - PFE commenters reported difficulty scheduling appointments with specialists, and noted that timely referrals to supportive services could improve the care experience.
    - PFE commenters noted referral requirements as part of the process for accessing services such as physical therapy.
- PFE commenters referenced financial considerations related to ongoing care.
    - PFE commenters reported paying out-of-pocket for supportive services, such as exercise or therapy programs, highlighting the ongoing resource needs associated with managing chronic neurologic conditions.

- One commenter expressed concerns about the potential for unintended consequences for patients.

Thank you for your feedback. We will continue to monitor the available aligned MIPS quality measures and take your feedback into consideration. For context, there are currently several MIPS quality measures that assess Parkinson's Disease treatment, including Quality Measure 293: Rehabilitative Therapy Referral for Patients with Parkinson's Disease and Quality Measure 291: Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease. CMS continues to work toward better alignment between cost and quality through MIPS Value Pathways (MVPs).

We agree that cost measures and quality measures should be designed to complement each other, and will take your feedback into consideration. To provide further context, MIPS is designed to assess MIPS eligible clinicians' performance on their quality and cost of care (each performance category score generally constituting 30 percent of a MIPS eligible clinician's final score), as well as improvement activities and promoting interoperability. MIPS thereby holistically assesses MIPS eligible clinicians' performance across various aspects of their practice, including both the quality and cost of their care in generally equal measure. Additionally, cost measures assess clinicians and clinician groups only on costs directly related to the treatment of a specific condition or procedure and are designed to account for patient heterogeneity using methods such as risk sub-groups, risk adjustment, and exclusions.

Finally, we appreciate your feedback on unintended consequences for patients and will take this feedback into consideration. Cost measures are monitored after implementation for potential unintended consequences, such as evidence of care stinting. However, the measure does already safeguard against potential care stinting by including the costs of adverse outcomes.

4.6 Measure Evaluation

- One commenter suggested increasing the case minimum, citing reliability as one of their main concerns with this measure. The commenter was particularly concerned about the 0.571 reliability for the clinician level at the 20-episode threshold.
- One commenter expressed concerns about the lack of consensus-based entity (CBE) endorsement for this measure.
- One commenter stated that without appropriate context, cost measures may incorrectly suggest that these subspecialists deliver unwarranted or inefficient care, for subspecialists, including many neurologists who care for patients with Parkinson's disease and MS, that often prescribe therapies that are inherently more expensive due to the complexity and severity of these conditions.

We appreciate the comments on measure reliability, and will take this feedback into consideration. The Parkinsonism Syndromes and MS measure's reliability is currently considered moderate based on the CMS reliability threshold of 0.4. In finding a balance between reliability and cost measures that have the potential to be impactful, we also consider interested party feedback about the need for clinicians to be assessed under episode-based cost measures. We will continue to monitor this measure's reliability metrics, as we monitor reliability for all cost measures, to ensure that the measure provides an accurate assessment of cost and ensure the reliability of the measures while also guarding against the unintended consequences of excluding clinicians from episode-based measures.

Thank you for your feedback on the CBE endorsement of the Parkinsonism Syndromes and MS measure. To provide further clarification, all cost measures currently undergo a robust 18-month development cycle, where feedback from public comments, persons with lived experiences, clinician experts, and other interested parties are incorporated into the measure's specifications. The measures undergo an iterative testing process, including empiric analyses to inform measure specification decisions and national field testing where extensive information on measure performance is posted publicly for feedback on potential revisions. As a result, the measure has undergone a high level of scrutiny and received varied input throughout its development, despite not having undergone the CBE endorsement process yet. However, CMS understands the value of CBE endorsement for cost measures and may submit the Parkinsonism Syndromes and MS measure for CBE endorsement in the future.

We appreciate the comment that sometimes more expensive care is more appropriate care. Cost measures are designed to incentivize appropriate care by including the costs of adverse events and downstream costs that may be the result of inefficient care. To provide further context, testing indicated that the Parkinsonism Syndromes and MS measure reflects the costs directly related to treatment choices and the cost of related adverse outcomes such as downstream emergency department visits, hospitalizations, or post-acute care. In addition, all costs included in cost measures, including medication costs, are payment standardized to remove non-clinical sources of cost variation. For more information about payment standardization for Part D medications, please refer to this explanation of the CMS Part D payment standardization methodology.

During the Workgroup Meeting #3, following field testing, the Workgroup discussed criteria to evaluate the measure, including reliability and validity. The Workgroup reached consensus that the Parkinsonism Syndromes and MS measure is valid. The majority of members agreed that the scores obtained from the measure as specified will provide an accurate reflection of the costs for episodes of care and can be used to distinguish good and poor performance on cost effectiveness.

5. General Feedback Summary

This section summarizes general feedback received on the episode-based cost measures. Section 5.1 provides feedback on the field testing process. Section 5.2 summarizes feedback on broader concerns about MIPS.

5.1 Field Testing Process Feedback

- Some commenters found a wide variety of the materials helpful, such as the measure specifications, mock field test reports, At-A-Glance documents, and FAQ.
- Some commenters expressed appreciation for the field testing process improvements that Acumen and CMS implemented in 2026, including enhancements to the field test reports.
    - One commenter highlighted improvements to the Service Use and Cost by Medicare Setting and Service Category table (Table 3) and the Top Contributors to Your/Your Group's Part B Physician/Supplier Episode Costs Within and Outside Your Group (Table 4).
    - One commenter found the episode-level CSV file to be one of the most helpful materials.
- Some commenters expressed concerns that the field test reports were complicated to interpret for a typical physician so they can make actionable changes.
    - A few commenters mentioned that the Service Use and Cost by Medicare Setting and Service Category table (Table 3) and the episode-level CSV file were difficult to interpret.
    - One commenter suggested that Acumen and CMS provide a clearer link between the episode-level CSV file and the other field test report materials.
    - One commenter suggested that CMS produce a plain language version of the field test report.
    - One commenter requested that Acumen and CMS provide a list of actionable items in each report so that the clinician or clinician group can take steps to improve their performance.
- Several commenters provided feedback on Acumen and CMS education and outreach efforts.
    - One commenter expressed concerns about the limited opportunity to provide feedback on field test reports and the measures undergoing field testing.
    - One commenter requested public information on the number of field test report downloads and the number of commenters who submitted feedback during the field testing period.
    - Another commenter echoed the above concerns, stating that many clinicians in their practice were unaware of field testing.
    - One commenter expressed appreciation for Acumen and CMS education and outreach efforts and emphasized the need for continued communication.
- Several commenters requested that Acumen and CMS provide more information in the field test reports.

- Some commenters noted that information on laboratory or pathology services was unavailable or insufficient in the CSV file or the measure codes lists.
- One commenter suggested that Acumen and CMS implement historical, geographic, or internal (within the same clinician) benchmark comparisons to better contextualize clinician performance.
- One commenter requested that Acumen and CMS provide further information on expected costs for each clinician or clinician group, and not only observed costs. The commenter requested clarity on how expected costs are calculated.

Thank you for your comments. For 2026 field testing, we implemented improvements to the field testing process based on feedback from the prior round of field testing. These improvements included publicly posting measure-specific field test report walkthrough recordings and At-A-Glance documents. We also provided more detailed guidance within the field test reports, including on how to interpret results and utilize the episode-level CSV file. We appreciate the feedback on how field testing and the field test reports can be improved further, and will consider this feedback for future rounds of field testing.

We understand that one commenter requested public reporting of field test report downloads and survey responses. We refer readers to Section 1.3 of this report for detailed report download and survey metrics, and refer readers to Appendix B of this report for a complete list of verbatim comments we received during the field testing period.

We recognize that some commenters raised concerns about CMS and Acumen education and outreach efforts during the field testing period. We refer readers to Section 1.3 of this report for further information on our extensive education and outreach efforts, such as recurring email campaigns spanning six weeks, dedicated office hours sessions, and recorded presentations and guidance. We appreciate this feedback and will consider further outreach strategies and opportunities for future rounds of field testing.

5.2 MIPS Feedback

- Several commenters requested more timely, actionable, and transparent MIPS performance feedback. These commenters noted that receiving MIPS performance feedback at periodic intervals during the performance period, instead of receiving feedback after the performance period concludes, would be more beneficial and actionable for clinicians.
  - One commenter suggested that more timely performance feedback would allow clinicians to positively adjust their clinical approach during the performance period and better coordinate with other clinicians contributing to their episode costs.
- One commenter suggested that CMS allow for appeals of individual episodes of care within cost measures during the targeted review process and to remove that episode from the measure and cost score calculation if it is found to be inaccurate.

- One commenter requested that CMS further investigate their concerns with the cost measures undergoing field testing during the measures' 2-year informational-only feedback period.

We thank these commenters for their feedback. CMS is continuing to work towards providing meaningful and timely information on cost measures generally and recognizes the importance of providing this information for measures implemented in MIPS. CMS currently provides MIPS Public Use Files and annual MIPS feedback reports with supplemental and patient-level data files to eligible clinicians and clinician groups. MIPS eligible clinicians have episodes of care that begin and end at various times throughout the performance period, so to calculate an accurate comparison across MIPS eligible clinicians, CMS has historically calculated all scores following the end of the performance period. Calculating the MIPS cost measures during the performance period may provide an incomplete indication of how a MIPS eligible clinician is performing. CMS will consider updates to any MIPS program policies, including the timing of performance feedback or targeted review processes, in future rulemaking.

Additionally, the purpose of the 2-year informational-only feedback period for MIPS cost measures, implemented in the CY 2026 PFS final rule, is for clinicians to gain further familiarity with new measures before they affect payment. While CMS monitors all cost measures implemented in MIPS, the 2-year informational-only feedback period is not intended to act as an extension of cost measure development.

6. Next Steps for Measure Specification Refinements

This section outlines the discussion topics that Acumen brought to the Clinician Expert Workgroups during the Workgroup Meeting #3, which is focused on post field test refinement. Acumen identified these topics for discussion largely based on commenters' feedback gathered during field testing and subsequent empirical analyses. The Clinician Expert Workgroups' discussions about these questions directly helped to inform refinements to the measures' specifications.

6.1 Breast Cancer Screening

The following discussion topics were brought to the Breast Cancer Screening workgroup:

- Adjusting the window for defining early/timely cancer detection episodes
- Addressing cost variation due to the month of cancer detection
- Considering the addition of breast atypia as a separate risk adjustment variable

6.2 Non-Pressure Ulcers

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

- Accounting for patient heterogeneity through risk adjustment
  - Additional sub-populations for risk adjustment
- Identifying additional clinically related services
- Assigning osteomyelitis-related amputations

6.3 Parkinsonism Syndromes and Multiple Sclerosis (MS)

The following discussion topics were brought to the Parkinsonism Syndromes and Multiple Sclerosis (MS) workgroup:

- Defining the episode group
  - Rationale for inclusion of both Parkinsonism Syndromes and MS
- Accounting for patient heterogeneity through risk adjustment
  - Using risk adjustment to account for disease severity
- Service assignment and exclusions
  - Rationale for not excluding certain high-cost patients
- Alignment of measure with pre-rulemaking evaluation criteria

Appendix A: List of Commenters

This appendix provides an index of interested parties who submitted a comment during field testing. Patients and caregivers who responded to the PFE survey and commenters who provided feedback and didn't include their name or organization are not included in this table, although their input has been included in this report.

Table A1. Commenters Providing Feedback on 2026 Field Testing

Name	Individual or Representative	Organization
Nima Ramezan-Arab	Representative	Southland Neurologic Institute, A Medical Corporation
Lucian Vlad	Individual	-
Robert Rosenberg	Individual	-
Fang Tong	Individual	-
Debbie Bennett	Individual	-
Maria Benvenuto	Representative	Naugatuck Valley Radiology
Matt Kerschner	Representative	American Academy of Neurology
Brittany L Furr	Representative	Radiology Associates of Venice and Englewood
Jennifer Hananoki	Representative	American Medical Association
Lisa Sheppard	Individual	-
Gail Reese	Representative	American Podiatric Medical Association
David Freedman	Representative	Foot and Ankle Specialists of the Mid-Atlantic/United States Foot and Ankle Specialists
Bethany Niell	Individual	-
Marcia Nusgart	Representative	Alliance of Wound Care Stakeholders
Michael Mabry	Representative	RadNet
Marissa Pearce	Representative	InContext, LLC

Appendix B: List of Verbatim Comments

This appendix includes the verbatim comments received during field testing period. Please note that certain information has been redacted where it may be considered confidential or sensitive information for the commenter, a clinical practice, or a patient.

B1. General Survey Verbatim Comments

This section includes the verbatim comments received through the 2026 Cost Measures Field Testing survey (including attached letters).

Comment Number 1

Date: 1/31/2026

Submitter Name, Credentials, and Organization:
Nima Ramezan-Arab, MD, Southland Neurologic Institute, A Medical Corporation

Comment Text:
[Across these tables, which are the most useful service categories for helping you to understand the cost measure and provide feedback on its clinical validity?]

table 1 and table 2

[Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)?]

table 3 is confusing, perhaps some graphs would help put it in perspective

[How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports?]

it is helpful to have standardized metric so

[Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding the cost measure and how it assesses performance?]

comparison with similar sized groups

[Overview and Measure Score]

figure 1 was not clear as it didn't mark where the practice was compared the average. adding the practice average to the figure helps to have a visual look

[Breakdown of Cost Measure Performance]

table 2 is good, table 3 is very complicated with many metrics, perhaps there more figure could help better intrepret this data

[Episode Costs]

table 5 is clear but figure 2 was hard to make sense in comparison to the practice

[What information was the most useful for helping you to understand the cost measure and provide feedback? Options are listed below.]

Mock field test reports

[What other feedback do you have about the field test reports?]

more figure for physicians to be able to visualize their own practice data compared to national averages

[How did you find out about field testing? Options are listed below: - Selected Choice]

Received CMS email notification

Comment Number 2

Date: 2/1/2026

Submitter Name, Credentials, and Organization:
Lucian Vlad, MD

Comment Text:
[Across these tables, which are the most useful service categories for helping you to understand the cost measure and provide feedback on its clinical validity?]

unsure

[Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)?]

site of service: wound clinic vs PCP office vs surgery office vs in home, etc

[How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports?]

unsure

[Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding the cost measure and how it assesses performance?]

unsure

[Overview and Measure Score]

unsure

[Breakdown of Cost Measure Performance]

E&M versus procedures vs skin subs vs supplies vs DME

[What information was the most useful for helping you to understand the cost measure and provide feedback? Options are listed below.]

At-A-Glance documents

[The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure? Options are listed below. - Selected Choice]

Quick reference specifications, Measure flowcharts, Codes list

[How did you find out about field testing? Options are listed below: - Selected Choice]

Received Acumen email notification

[Please indicate which cost measure(s) that you would like to submit feedback for.]

Non-Pressure Ulcers

[Do the trigger codes and confirming codes appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for patients receiving treatment for non-pressure ulcers? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

the trigger codes must include both wounds and ulcers because there is much confusion about these codes and the appropriate use of them.

[Does the Non-Pressure Ulcers measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to non-pressure ulcer care? Does the trigger window length of 1-45 days appropriately identify a patient-clinician relationship given the typical treatment cycle for a non-pressure ulcer? Please explain your rationale.]

What would happen in the situation when a physician puts in the code and the claim for an ulcer and refers the patient to another physician/ practice. (e.g patient sees his PCP and gets referred to a wound clinic). In this example, the quality measure would be applied to the PCP office or to the wound clinic?

[Does the minimum episode length of 90 days (with extensions for reaffirming claims) appropriately capture the period during which attributed clinicians can reasonably influence the costs of non-pressure ulcer care? Please explain your rationale.]

yes, 90 day is appropriate. does this measure take into account recurrences? Both venous leg ulcer and diabetic foot ulcer have high recurrence rates and can happen simultaneous on the same limb. A patient can have 2 -3 venous leg ulcer on the same leg. Will the measure distinguish the 2 wounds. Many patient have almost continues recurrences of wounds on their limb due to uncontrolled underlying issues. E.g. obesity. uncontrolled venous stasis, uncontrolled lymphedema, uncontrolled diabetes, poorly controlled congestive heart failure, etc

[Is it reasonable to compare episodes according to ulcer type separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Non-Pressure Ulcers episodes? Please explain your rationale.]

Subgrouping can be misleading. E.g. a patient with poorly controlled diabetes that has a coronary event requiring ICU stay for 2-3 days and during the hospitalization he develops skin breakdown posterior heel. Work up reveals PAD with LE arterial occlusions. In this situation, the wound on the posterior heel can be classified as either a pressure injury, or a diabetic foot ulcer or as an arterial ulcer.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for non-pressure ulcer care? Please explain your rationale. Should osteomyelitis-related amputations be assigned to the measure as a clinically related service? If so, should this service be identified as currently specified, or are there other codes that would more accurately identify this service? Are there any other amputations related to non-pressure ulcers that may not be assigned to the measure? Please explain your rationale.]

for amputations it is irrelevant if they inpatient or outpatient and whether osteomyelitis is present or not. Any chronic ulcer can lead to osteo and amputation if the patients are unhealthy. I would dare to say the only issue that matter if whether the amputation is result of acute trauma or not.

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

consider determinants of social health, medication and autoimmune conditions

[Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please explain your rationale.]

cancer related wounds

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Non-Pressure Ulcers measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

Patient comorbid condition, functional status, access and follow up with PCP, access to specialized wound care clinic

[Based on your understanding of the Non-Pressure Ulcers measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

identifying and addressing comorbid condition leading to poor wound healing: medical supervised weight loss, nutrition counselling, diabetes management, etc

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

surgeon that have postoperative complications may not code these as wounds or ulcers if the measure can have negative impact for their practice.

Comment Number 3

Date: 2/5/2026

Submitter Name, Credentials, and Organization:
Robert Rosenberg, Physician

Comment Text:
[The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure? Options are listed below. - Selected Choice]

Measure construction methodology, Measure flowcharts

[Do you have any feedback about the draft measure specifications documentation?]

INADEQUATE DOCUMENTATION OF WHEN THE SCREENING EVENT ENDS AND TREATMENT BEGINS.

[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening

[Does the trigger code appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

Yes Mostly. Some women will have screening MRI after a negative screening mammogram. That would often create the impression that the screening mammogram was a false negative, and therefore the cost of the MRI and subsequent costs would be assigned to the indicidual reading the "negative mammogram" .

[Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.]

Partly. There is a large GAP after cancer diagnosis that may involve significant imaging events. It is unclear who these would be attributed to. They are often requested by treating physicians to better assess the Extent of Disease prior to Teatment. Multicentric disease is common as is the extent of DCIS and Invasive Lobular cancer that may indicate additional imaging and biopsies. Specifically missing from routine patient care are the costs associated with localizing the cancer(s) and lymph nodes prior to surgery.

[Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.]

As noted in question one, "No breast cancer detection" may be inappropriately assigned when the much more sensitive MRI study is done AFTER a screening mammogram. This frequency varies significantly with the patient population, and site of care. The costs of this error would be significant.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.]

ED visits are inappropriate unless they can be tied to the mammography or Biopsy event. Those are Rare for either, but common for the population screened. Advanced diagnostic services also need to be tied to the breast cancer diagnosis or screening event. Treatment services around the timing. of surgery and chemotherapy delivery are more tied to the cancer event but may be unrelated also. I don't know how carefully the available records tie the Services to breast cancer treatment.

[From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.]

Fixed oncology costs seems reasonable, and simplifies the process. The timing to begin receiving services from pathologic cancer diagnosis should be less than 8 months for the vast majority of patients depending on how you define beginning receiving services. First surgery or first Chemotherapy treatment would be definitive. As noted above pre treatment evaluation of extent of disease may take several months as well as scheduling definitive care.

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

I believe there are significant differences in costs depending on location of services provided. Similarly community hospitals and Cancer centers, and medical school affiliated hospitals may also have different costs.

[Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.]

Those are reasonable exclusions. Males rarely are screened and those under 40 less commonly screened, usually for high risk indications, and may have higher associated costs such as fertility preservation.

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Breast Cancer Screening measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

Detection of breast cancer is the main goal of screening and therefore cancer detection rate (CDR) with appropriate adjustments (CDRa)seems the best quality measure at a facility level IF they perform enough screening to make the statistics useful. A combined measure of CDR with recall rate might also be useful - some kind of a weighted combination giving higher value to

CDRa than RR. One other quality measure is documentation of completeness of follow up of abnormal mammograms. This could be either documenting that recommendations of an abnormal initial screen (difficult) happened (or refused/found unnecessary) or that a biopsy recommendation was followed (or refused or otherwise found unnecessary). Timeliness is always useful from a patient perspective.

[Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

This is a cost measure only. Improving interpretation in general is a different issue.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

Yes. As noted above there is a definitions gap of when the initial screening event costs end and treatment begins. This could lead to transfers of costs. The costs of extent of disease evaluation is a potential problem. The current system may either delay or prevent some additional imaging to find and diagnose cancer. Speficic example is whether multiple biopsies are done initially or only a single one. The latter would delay and may under-estimate the extent of disease leading to under treatment or at best delay in treatment to allow those biopsies to be subsequently performed.

Comment Number 4

Date: 2/9/2026

Submitter Name, Credentials, and Organization:
Fang Tong, CPC, COC, CDEO, CPMA

Comment Text:
[Please indicate which cost measure(s) that you would like to submit feedback for.]

Non-Pressure Ulcers

[Do the trigger codes and confirming codes appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for patients receiving treatment for non-pressure ulcers? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

Yes, these are the typical trigger codes one would expect for the majority of the non-pressure chronic ulcer patients.

[Does the Non-Pressure Ulcers measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to non-pressure ulcer care? Does the trigger window length of 1-45 days appropriately identify a patient-clinician relationship given the typical treatment cycle for a non-pressure ulcer? Please explain your rationale.]

The maximum 45-day trigger window is generally reasonable for attributing episodes to clinicians who can influence costs related to non-pressure ulcer care. This timeframe aligns with the typical treatment cycle for a non-pressure ulcer and helps establish a plausible patient–clinician relationship.
However, there are important attribution concerns. ICD-10 coding may not sufficiently distinguish between ulcers at different anatomical locations when they fall under the same diagnosis category (e.g., L97.5, non-pressure chronic ulcer of other part of foot). For example, a patient may initially present with a plantar first metatarsal head ulcer and later develop a plantar fifth metatarsal head ulcer. Although clinically distinct and unrelated, both ulcers may be coded identically. In such cases, costs associated with the new ulcer could be inappropriately attributed to a clinician who treated the earlier, unrelated ulcer.
An additional concern is the attribution requirement that clinicians must have billed at least one trigger or confirming code within one year prior to or on the episode start date. If the episode window is defined as 1–45 days, a one-year lookback may not be clinically relevant. This approach risks attributing responsibility to a clinician for care unrelated to the current ulcer episode, potentially involving a different condition or anatomical site.
In summary, while the 1–45-day trigger window is appropriate, limitations in diagnosis of coding specificity and the extended one-year lookback period may result in inaccurate attribution of responsibility and costs.

[Does the minimum episode length of 90 days (with extensions for reaffirming claims) appropriately capture the period during which attributed clinicians can reasonably influence the costs of non-pressure ulcer care? Please explain your rationale.]

The minimum 90-day episode length raises concerns about whether attributed clinicians can reasonably influence all costs captured within that timeframe. In our review, we have observed that costs unrelated to non-pressure ulcer care are sometimes attributed to the ulcer provider. For example, hospitalizations driven by unrelated conditions such as cardiac events, stroke, or other acute medical issues may be included in the episode, despite having no clinical connection to the non-pressure ulcer.
As noted previously, limitations in ICD-10 coding further compound this issue. Ulcers at different anatomical sites may be reported using the same diagnosis code, even when they are clinically unrelated. If a patient develops a new ulcer at a different location during the episode window, the clinician may be attributed costs for this new ulcer despite not being involved in its development or management.
In addition, ulcer size—an important indicator of clinical severity and resource utilization—is not

reliably captured by available quality measures. The only way to approximate wound size is through debridement CPT codes (97597, 11042, 11043, 11044) and associated add-on codes (97598, 11045, 11046, 11047), which reflect size only in broad ranges rather than precise measurements. As a result, changes in wound size over time, progression or improvement, and distinctions between separate wounds cannot be accurately tracked within a prolonged episode. This limitation makes it difficult to determine whether clinicians meaningfully influenced costs attributed later in the episode, particularly when wound characteristics evolve or new wounds emerge.

While a 90-day episode length is preferable to a 365-day window, it may still be overly inclusive. Given the potential for unrelated medical events, new anatomically distinct ulcers, and the inability to precisely capture wound size and progression, we believe the episode duration should be shortened to no more than 60 days to more accurately reflect the period during which clinicians can reasonably influence costs related to non-pressure ulcer care.

[Is it reasonable to compare episodes according to ulcer type separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Non-Pressure Ulcers episodes? Please explain your rationale.]

It is reasonable—and advisable—to compare episodes by ulcer type using separate risk adjustment models, as different ulcer types are associated with substantially different healing trajectories, treatment intensity, and costs. For example, venous ulcers are particularly challenging to heal and often require significantly longer treatment durations than diabetic or non-specific non-pressure ulcers. Grouping these ulcer types together may obscure meaningful cost differences and lead to inappropriate comparisons.

Additionally, patients frequently present with multiple ulcers that may be at different stages of healing simultaneously. These variations—ranging from superficial wounds to full-thickness ulcers involving subcutaneous tissue—can significantly influence resource utilization and cost over time. Separate stratification by ulcer type would better account for these clinical complexities.

From a coding perspective, use of the L97/L98 ICD-10 series is appropriate for non-pressure ulcer reporting. However, additional claims-based indicators—such as ulcer etiology (e.g., venous versus diabetic), severity or depth, and evidence of chronicity—should be considered when stratifying episodes. Incorporating these factors into risk adjustment models would improve fairness and accuracy when comparing costs across non-pressure ulcer episodes.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for non-pressure ulcer care? Please explain your rationale. Should osteomyelitis-related amputations be assigned to the measure as a clinically related service? If so, should this service be identified as currently specified, or are there other codes that would more accurately identify this service? Are there any other amputations related to non-pressure ulcers that may not be assigned to the measure? Please explain your rationale.]

The listed service categories are appropriate to include in the measure only when they are clinically related to the treatment or complications of a non-pressure ulcer. Services such as inpatient hospital care, procedures, post-acute care, emergency department visits, durable medical equipment, and drug therapies can reasonably reflect a clinician's performance when the non-pressure ulcer is the primary driver of care.
However, attribution becomes problematic when services are included solely because a patient has a non-pressure ulcer diagnosis on the claim, rather than because the ulcer caused or meaningfully contributed to the service. For example, rehabilitation or skilled nursing care following a stroke should not be attributed to non-pressure ulcer care if the stroke was unrelated. Similarly, emergency department visits or hospitalizations for pneumonia, cardiac events, or other acute conditions should not have their costs attributed to the non-pressure ulcer provider simply because the patient also carries an ulcer diagnosis.
This concern also applies to vascular events. While vascular disease may coexist with non-pressure ulcers, attribution should reflect clinical causality. If a vascular event precipitated the hospitalization or intervention—and was not caused by the ulcer—then costs should be attributed to the responsible vascular condition and provider, not to the non-pressure ulcer episode.
With respect to amputations, osteomyelitis-related amputations may be appropriate to assign to the measure when there is clear clinical linkage between the non-pressure ulcer and the development of osteomyelitis. However, attribution should rely on precise coding to ensure the ulcer is the underlying cause. Additional or more specific diagnosis and procedure codes may be needed to distinguish amputations driven by ulcer-related infection from those due to other musculoskeletal, vascular, or systemic conditions.
In summary, the service categories can appropriately capture clinician performance only when stronger clinical attribution criteria are applied. Refining attribution logic to require a clear causal relationship between the non-pressure ulcer and the service—rather than mere co-occurrence—would improve accuracy and fairness of the measure.

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

While the proposed measure-specific risk adjustors are appropriate, additional significant comorbidities should be considered for inclusion. Conditions such as hypertension, hypercholesterolemia, cancer, chronic obstructive pulmonary disease (COPD), kidney failure-ESRD (including dialysis), and cardiac conditions are commonly present at the start of care and can substantially influence overall costs and utilization.
These comorbidities meet the stated criteria for risk adjustment: they are present prior to episode initiation, have a clear clinical relationship with expected costs, vary in prevalence across patients, are not indicators of care provided for the ulcer itself, and are unlikely to be subject to gaming. Importantly, accounting for these conditions would help ensure that care and costs driven by these comorbidities are not inappropriately attributed to non-pressure ulcer care. Including these additional risk adjustors would improve the accuracy and fairness of the

measure by better isolating costs that are truly attributable to non-pressure ulcer management rather than to unrelated or coexisting medical conditions.

[Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please explain your rationale.]

Yes, while the current exclusions appropriately remove ulcer types with distinct etiologies and treatment pathways, consideration should be given to excluding additional episodes involving significant comorbid conditions that can independently drive utilization and costs. Conditions such as cancer, chronic obstructive pulmonary disease (COPD), kidney failure-ESRD (including dialysis), and major cardiac events often result in care pathways that are largely unrelated to non-pressure ulcer management.
When these conditions are the primary drivers of hospitalization, procedures, or post-acute care, attributing associated costs to non-pressure ulcer care may not accurately reflect clinician performance. Excluding episodes dominated by these conditions would help ensure that the measure captures care related specifically to non-pressure ulcers rather than costs driven by separate, complex medical conditions.
Hypertension and hypercholesterolemia, while important comorbidities, may be more appropriately addressed through risk adjustment rather than exclusion. Overall, refining the exclusion criteria to remove episodes in which non-pressure ulcer care is not the primary focus would improve the clinical validity and fairness of the measure.

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Non-Pressure Ulcers measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

Yes, effective care coordination is one of the most relevant quality indicators for assessing the value of care in the Non-Pressure Ulcers measure. Appropriate referral and collaboration with specialists—such as vascular providers when peripheral arterial disease (PAD) is an underlying cause—are critical to achieving optimal patient outcomes and promoting ulcer healing.
Quality measurement should encourage, not discourage, timely and appropriate referrals. If the costs associated with specialist evaluation or intervention are inappropriately attributed to the non-pressure ulcer provider, clinicians may be unintentionally penalized for delivering high-quality, coordinated care. This could create disincentives for necessary referrals that address the root cause of the ulcer.
Additionally, current MIPS quality measures may not fully capture important aspects of care such as interdisciplinary coordination, appropriateness and timeliness of referrals, and shared decision-making across providers. Incorporating indicators that reflect effective care coordination and underlying disease management would better assess the true value of care delivered for non-pressure ulcers.

[Based on your understanding of the Non-Pressure Ulcers measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

Yes, appropriate and timely early referrals become important. Example, for these patients one should include vascular, infectious disease, lab-culturing, radiology and other necessary diagnostic testing. Understanding that all create upfront costs but help reduce the downstream costs, plus reduces the possibility of additional morbidity. Surgery may be indicated, for example, a Charcot procedure or amputation which could improve outcomes with less recurrence with less downstream costs. Being proactive is a positive quality of care, but the current measure seems to penalize the provider who had the non-pressure ulcer attribution.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

Yes, there are potential unintended consequences that should be carefully considered. The measure could inadvertently discourage appropriate care if clinicians feel pressured to avoid referrals, diagnostic testing, or timely interventions in order to limit attributed costs. Delays or omissions in care may reduce short-term spending but can ultimately lead to worse outcomes and higher downstream costs.
For example, preventive interventions—such as vascular evaluation and procedures to improve blood flow—may address the underlying cause of a non-pressure ulcer and promote faster healing. Although these services may increase upfront costs, they can significantly reduce the risk of complications, hospitalizations, or amputations over time. Penalizing clinicians for providing such preventive care may discourage best practices and undermine patient outcomes. Additionally, encouraging more frequent monitoring and preventive services, such as at-risk foot care for vulnerable populations, can help identify issues early and prevent ulcer progression. The measure should be structured to support, rather than disincentivize, proactive and preventive care approaches that improve long-term outcomes and reduce overall costs to CMS.

Comment Number 5

Date: 2/11/2026

Submitter Name, Credentials, and Organization:
Debbie Bennett, MD

Comment Text:
[Across these tables, which are the most useful service categories for helping you to understand the cost measure and provide feedback on its clinical validity?]

Service categories seem reasonable (if I understand question correctly as referring to episode sub-groups).

[Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)?]

Would be helpful to better understand what outpatient E&M services are since these are not typically provided by radiologist in breast imaging center but are being attributed to the radiologist reading screening mammogram.

[How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports?]

Very important.

[Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding the cost measure and how it assesses performance?]

For practice leaders, would be helpful to see this broken down by radiologist as well.

[Overview and Measure Score]

Clear.

[Breakdown of Cost Measure Performance]

Would be good to see the absolute $ amount for each of the episode sub-groups in Table 2.

[Episode Costs]

Table 3 is difficult to interpret. Is the average observed cost based on a per episode basis for each cancer detected? Or for all the episodes in that category? e.g. our observed cost was high for breast biopsy procedures, but we have an overall lower percentage of patients that are receiving biopsy out of our screening population. How would we know if we needed to lower cost or change something else in our practice?

[Additional Information]

Table 4 - top contributors - is this based only on overall volume or on an average per-episode basis?

[CSV with episode-level results]

I opened this file but it contained too much data for me to analyze.

[What information was the most useful for helping you to understand the cost measure and provide feedback? Options are listed below.]

Mock field test reports, Draft measure specifications, At-A-Glance documents, Field testing FAQ

[What other feedback do you have about the field test reports?]

Would be good to understand the impact of these reports from the get-go: is there a financial penalty for higher cost episode care? What are those thresholds?

[The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure? Options are listed below. - Selected Choice]

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

[How did you find out about field testing? Options are listed below: - Selected Choice]

Was notified by specialty society / professional association

[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening

[Does the trigger code appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

Yes, appropriate trigger code. Would suggest 365 day window rather than 360.

[Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.]

Yes, this is reasonable. However, as some of the downstream costs are decided by the diagnostic radiologist that sees the patient after abnormal screening mammogram, it would also be reasonable to have a separate measure that looks at costs associated from diagnostic mammography onwards. E.g., the screening radiologist cannot control whether the diagnostic radiologist recommends a biopsy.

[Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.]

Yes, reasonable to compare episodes separately. However, some patients with breast cancer diagnosed will be lost to follow up and have cancer correctly identified but not return for breast cancer treatment. Current methodology does not account for that.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.]

I would not include ED services in the cost of basic diagnostic services. The term "late cancer detection" is also misleading, in that one would think these categories refer to the stage of breast cancer - early detection (lower stage) vs late detection (advanced stage/metastatic). I believe this category was established to account for interval cancers (those presenting clinically rather than on the screening mammogram). However, this does not account for patients undergoing supplemental screening with MRI that is offset from screening mammography by 6 months and then requires subsequent work-up/biopsy, which could take patients into the 9-12 month time period after their last screening mammogram. Many of these cancers are early stage but would be counted in the "late diagnosis" category even though they are not the same biological cancers as those presenting with clinical symptoms (e.g. lump) after a normal screening mammogram.

[From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.]

A timeframe of 6 months would be appropriate for time of abnormal screening mammogram to initation of treatment for breast cancer. This would address the issue above of patients receiving supplemental screening with another imaging test (e.g. MRI) at the 6 month mark and having cancer diagnosed at that point.

Many practices are now collecting registry-level data on method of cancer detection - screening (mammo, US, or MRI) vs clinical symptom. This might also be a way to get at the data you are looking for.

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

These are appropriate risk adjustors. Could also consider including history of atypia as that would be a separate measure of risk in addition to abnormal mammogram.

[Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.]

Would also exclude transgender patients based on small population size.

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Breast Cancer Screening measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

MQSA outcomes audit data on cancer detection rate, recall rate, and positive predictive value (measure of relationship between CDR and RR) could be a non-cost way to arrive at the same measures of value.

[Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

This would be hard to tease out, because unlike the MQSA outcomes audit, it would be difficult to know whether increased cost per episode was related to too many exams recommended (e.g. recall rate too high), too few cancers detected (CDR too low), or some other factor.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

Yes - I believe that most clinicians would decrease their recall rate if they knew this measure was being counted. That would likely lead to a decrease in the number of cancers found. Because the numbers of cancers is an order of magnitude smaller than recall rate (for most practices), moving the needle on recalls is much easier than moving the needle on cancer detection. But if the main goal is early detection, it's not clear that this would encourage that.

Comment Number 6

Date: 2/18/2026

Submitter Name, Credentials, and Organization:
Maria Benvenuto, Naugatuck Valley Radiology

Comment Text:
[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening

[Does the trigger code appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a

screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

Yes

[Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.]

Yes

[Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.]

Yes, is it reasonable to compare episodes separately. Assigned BIRADs should be considered as an additional indicator because possible cancerous outcomes can increase cost.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.]

In our service area it is rare that screening breast cancer services are performed in the ED. The service list looks complete to capture costs.

[From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.]

Patients should receive services shortly after diagnosis. Other factors that may impact timing is report turnaround time to clinician and confirmed results to clinician and patient. Actual cost should be assigned rather than a fixed cost for late detection because aggressive cancers can develop after a screening episode.

[Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional

patient-level indicators we should account for in risk adjustment? Please explain your rationale.]

The list of variables is appropriate

[Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.]

Male patients with a strong family history and patients under 40 with a strong family history should not be excluded from screening episodes as breast cancers can develop in these cohorts. If these cohorts were included, it can minimize cost with early detection.

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Breast Cancer Screening measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

Timely follow up is most relevant to assess value of care as failure to follow up can increase cost by a missed cancer detection. A numerator code to capture communication to clinician and patient in ensure patient follow up.

[Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

Basically, it would require following a set of patients from time of screening episode through all care for the following 360 days. For a non cancerous episode, it's simple. It gets progressively more complicated for the patients who get called back, get a biopsy, and have a cancer diagnosis. Each episode of care that's reported to CMS needs to be logged, and a cost assigned (compared to national average for that cost). Reporting costs for patient care at an outpatient independent practice during the window is one thing, but tracking a patient through all their other office, ED, and hospital visits is another. This becomes especially complex in our market with the breast surgeons performing biopsies and the fact that we use a different EMRs. The measure is designed to be completed by an academic center or large hospital network versus an independent radiology practice.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

Male population with a strong family history and under 40 with a strong family history can be inadvertently discouraged for appropriate care as they are not included in screening episodes. Failure to detect cancer at an early stage would increase care cost as these populations have been excluded.

Comment Number 7

Date: 2/26/2026

Submitter Name, Credentials, and Organization:
Brittany L Furr, RT(R)(M)(VI)(ARRT)(RCIS), Radiology Associates of Venice and Englewood

Comment Text:
[Across these tables, which are the most useful service categories for helping you to understand the cost measure and provide feedback on its clinical validity?]

the first table that said, based off 2024 numbers, we were in the 95th percentile. We serve an older population that is at higher risk for cancer, and this naturally leads to higher attributed costs that may not reflect the efficiency or quality of our screening practices.

[Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)?]

We need age breakdowns, and rather than being compared to all patients nationally, we should be compared to groups with a similar age mix. This would provide a much fairer assessment of performance.

[How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports?]

very important

[What information was the most useful for helping you to understand the cost measure and provide feedback? Options are listed below.]

At-A-Glance documents, Field Testing Presentation recording, Field Test Report Walkthrough recordings, Measure Testing Forms

[The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure? Options are listed below. - Selected Choice]

Measure construction methodology, Quick reference specifications, Measure flowcharts

[How did you find out about field testing? Options are listed below: - Selected Choice]

Received CMS email notification

[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening

[Does the trigger code appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

While the trigger code identifies women age 40 and older who receive a screening mammogram, we are concerned that the current design does not adequately account for age distribution within that population. Using a broad threshold of ≥40 years may technically define the eligible cohort, but it does not sufficiently adjust for meaningful differences in cancer prevalence, downstream utilization, and total episode cost across age strata.

Our screening population skews significantly older than the national average, with a disproportionately high percentage of Medicare beneficiaries. As age increases, breast cancer incidence rises, which naturally leads to higher rates of diagnostic workup, biopsy, surgical intervention, oncology services, and other downstream care captured within the 360-day episode window. Without more granular age stratification (e.g., narrower age bands) or enhanced risk adjustment, practices serving older populations may appear artificially high cost despite appropriate and guideline-concordant care.

In addition, higher cancer detection rates in an older population may reflect appropriate screening effectiveness rather than inefficiency. Practices with strong true-positive and biopsy-positive predictive values may generate higher downstream costs because cancers are being appropriately identified and treated—not because of overutilization.

We recommend incorporating more refined age stratification and/or improved risk adjustment within the measure methodology to ensure that cost comparisons more accurately reflect differences in patient population rather than differences in clinical performance.

[Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.]

We do not believe the current attribution methodology fully captures which clinicians can reasonably influence the total costs included in a 360-day Breast Cancer Screening episode.

Attributing the entire episode to the clinician (TIN-NPI) who bills the screening mammogram trigger code—most frequently a diagnostic radiologist—places responsibility for a broad range of downstream services that are often outside the radiologist's control. While the radiologist interprets the screening examination and may recommend additional imaging or biopsy,

subsequent services such as E&M visits, surgical consultations, definitive surgical management, oncology treatment, and other related care are typically directed by referring providers and treating specialists.

In many practice settings, including ours, there is no breast surgeon or oncology specialist within the same TIN. As a result, costs generated by independent providers and care pathways are still attributed to the radiology TIN solely because the screening mammogram initiated the episode. This structure assumes a level of longitudinal care coordination and cost control that diagnostic radiologists do not realistically possess.

Additionally, practices serving older patient populations—who have higher cancer incidence and therefore greater downstream utilization—may appear disproportionately high cost due to factors unrelated to radiologist decision-making. This further compounds the attribution issue when combined with limited risk adjustment.

To better align accountability with influence, CMS could consider:

- Limiting attributed costs to services directly ordered or performed by the attributing clinician or TIN.
- Shortening the episode window to better reflect the period during which screening-related diagnostic decisions are made.
- Incorporating shared or multi-specialty attribution models when downstream treatment decisions drive the majority of episode costs.

Without refinement, the current methodology risks holding diagnostic radiologists accountable for costs they do not meaningfully control.

[Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.]

Yes, it is reasonable to compare episodes with and without cancer detection separately, as costs for patients diagnosed with breast cancer are inherently higher than for routine screening episodes. Running separate risk adjustment models is conceptually appropriate to account for these expected cost differences.

However, the current claims-based definition of “cancer detection” may not fully capture clinical nuance. Detection is identified through treatment claims or two E/M visits with a breast cancer diagnosis, which may reflect care pathways or coding patterns rather than the actual point of imaging or pathology-confirmed diagnosis. Incorporating pathology-confirmed malignancy codes, if feasible, could improve accuracy.

Additionally, meaningful variation exists within both sub-groups. Practices serving older or

higher-risk populations will naturally have higher detection rates and downstream costs. In the "no detection" group, episodes involving benign biopsies, high-risk patients, or supplemental imaging (e.g., due to dense breast tissue) may still generate appropriate increased utilization.

Further refinement of detection criteria and enhanced risk adjustment for underlying patient risk factors would improve fairness and comparability across practices.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.]

The overall service categories align with the screening-to-diagnosis pathway; however, several assigned services extend beyond what the attributing clinician—most commonly a diagnostic radiologist—can reasonably influence. Basic diagnostic services are appropriate, but broad treatment services (e.g., chemotherapy, radiation, hospitalizations, durable medical equipment) reflect downstream decisions rather than screening performance. Assigning advanced services and fixed oncology costs based on "late" cancer detection (9–12 months) may also misrepresent screening quality, as timing can be affected by tumor biology, patient follow-up, or access to care.

To better align accountability with clinical influence and improve fairness across practices, we recommend:

- Limit assigned services primarily to diagnostic workup and biopsy-related care directly tied to screening findings.
- Exclude broad treatment services, treatment-related complications, and non-screening-driven hospitalizations.
- Shorten the 360-day episode window to reflect the period during which screening decisions meaningfully impact care.
- Reconsider or clarify the use of "late" cancer detection as a trigger for additional costs to ensure attribution reflects factors the clinician can reasonably influence.

Refining service assignment would better align accountability with services the attributing clinician can reasonably influence and improve the fairness of cost comparisons.

[From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.]

Most patients should begin breast cancer treatment within about 8 months of a screening mammogram, consistent with empirical data. Timing can vary due to factors outside the

screening clinician's control, including tumor biology, patient follow-up, access to specialists, and treatment preferences. Assigning a fixed oncology cost for late detection episodes is reasonable to account for this variability and focus the measure on timely detection.

However, it is concerning that clinicians are being attributed costs for services largely beyond their influence. Even with a fixed cost, the measure still holds screening clinicians accountable for downstream treatment decisions, highlighting a fundamental fairness issue in how costs are assigned.

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

The current risk adjustment variables are appropriate, including CMS-HCC comorbidities and breast cancer–specific factors like BRCA status, dense breast tissue, prior abnormal mammograms, and family history. These capture patient-level variation outside the screening clinician's control and support fair cost comparisons. Consideration could be given to additional baseline indicators that may affect downstream costs, such as prior benign biopsies, changes in breast density, or other high-risk comorbidities (e.g., prior chest radiation, hormonal therapy use), provided they are present at the start of care and clinically relevant.

[Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.]

The current exclusions—male patients, those under 40, and patients with prior breast cancer—are appropriate and align with the measure's intent. No additional exclusions appear necessary.

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Breast Cancer Screening measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

Current MIPS quality measures capture receipt of screening mammography but do not assess radiologist-focused performance, such as interpretation accuracy, recall rates, or positive predictive value. Including these indicators would better align quality assessment with what radiologists can directly influence, complementing the cost measure.

[Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

Because most costs included in this measure—such as treatment, hospitalizations, and late detection management—are outside the radiologist's control, there are very few clinical actions or practice changes that could meaningfully improve performance. Screening clinicians can

focus on accurate mammogram interpretation and timely immediate diagnostic workup, but the majority of cost drivers are determined by downstream care decisions, patient factors, and access to treatment, limiting the measure's usefulness for guiding radiologist behavior.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

Yes. Because most costs in this measure—such as treatment, hospitalizations, and late detection management—are outside the radiologist's control, the measure could send misleading signals about clinician performance without improving care. In general, this could inadvertently encourage other practices to avoid higher-risk patients or overemphasize minimizing immediate diagnostic costs rather than focusing on quality screening. The measure may also misrepresent cost efficiency for radiologists, since downstream care decisions, patient factors, and access largely drive episode costs. Careful consideration is needed to ensure attribution aligns with what screening clinicians can reasonably influence.

Comment Number 8

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
Jennifer Hananoki, JD, American Medical Association

Comment Text:
[What other feedback do you have about the field test reports?]

The AMA is very concerned about the limited opportunity to review and comment on the field testing reports. We urge CMS and Acumen to publicly report the number of comments received in response to field testing, broken down by measure. We also encourage public reporting about the number of clinicians and groups that accessed an available field testing report. Finally, we again encourage CMS and Acumen to continue to make the field tests available to physicians and groups on a permanent basis. These are helpful materials that can be referenced at a later date to better understand and prepare for the use of these measures in MIPS.

[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening, Parkinsonism Syndromes and Multiple Sclerosis (MS)

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Breast Cancer Screening measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

There currently are no quality measures that could be paired with this cost measure. CMS included one from Brigham Women and Children's Hospital on the MUC list this year (Rate of

Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection); however, there are significant concerns with applying it to clinicians and groups rather than at the health system level. The AMA continues to recommend that cost measures be paired with a clinically relevant quality measure to ensure that patients receive complete information about the value of their care and that physicians are able to improve a patient's care.

[Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

It is not clear that there are actionable steps that physicians can take to improve their scores on this measure and that they will not be penalized for seeing more patients who have access-to-care challenges in receiving cancer screenings, whether due to long wait times, long distances and transportation challenges, or socioeconomic factors, such as limited education.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

The primary concern we have heard from radiologists is that it unfairly measures, and may penalize, private practices in a disjointed health care system. The follow-up care is out of the hands of the radiologist who made recommendations for the index exam. Even if it is rationalized that the radiologist should know what ultimately happens to the patient, the information provided in the report (i.e., claims associated with all care that may not be in that radiologist's software system) attributed to that index exam are not available for assessment to determine where there may have been an opportunity to improve the care provided and associated costs. For private practices, it is going to be exceptionally difficult to track all patients who have a positive screening mammography for the following 365 days. The patients may see multiple specialists to determine the best treatment and then pursue that treatment in various locations. There are markets where breast surgeons, rather than the radiologist, perform the biopsies, which will make this especially complex given the physicians use different electronic health records.

[Do the trigger codes appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for patients with Parkinsonism Syndromes or MS? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

We have concerns with the reliability of this measure, which is not a separate question, so I wish to discuss it here. At the 20-episode volume threshold, testing results indicated that the mean reliability for the measure is 0.571 at the TIN-NPI level, and approximately 78.94% of

clinicians meet or exceed the reliability threshold of 0.4. In other words, 20% of clinicians will fall below a 0.4 reliability threshold. The case minimum should be increased to ensure that all clinicians fall above a minimum 0.4 reliability threshold.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

We have several concerns related to use of this measure in MIPS including the lack of a paired quality measure, broad scope of this measure due to the three disorders addressed, lack of consensus-based entity (CBE) endorsement, and the potential for unintended consequences for patients.

Comment Number 9

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
Lisa Sheppard MD, Radiologist

Comment Text:
[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening

[Does the trigger code appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

Should include baseline Screening mammograms at age 35 and High Risk young patients with genetic predisposition or strong family hx of pre menopausal breast cancer in a 1st degree relative ie mother or sister.

[Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.]

yes

[Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.]

High risk patients with no cancer incur more costs for their screening and diagnosis.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.]

Breast specific contrast Mammography, Breast specific PET and Breast specific CT should be added in

[From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.]

Delay diagnosis may not be on the basis of missing caner on the mammogram but not seeing it because of dense breast tissue. Cancer would have been seen on MRI, contast breast mammgraphy or US. which are not always done by patients because there is payment needed for the supplemental screening services. This is unreasonable

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

Add prior high risk biopsy benign diagnosis- ADH, LCIS, LH, Prior surgery, implants.

[Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.]

need to consider those patients with strong family history of pre menopausal breast cancer

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

This measure will impact the screenings of young patients who have hx of early dx family hx, patients with benign hign risk biopsies in the past and patients with dense breasts or implants that supplemental screening routinely.

Comment Number 10

Date: 2/27/2026
Submitter Name, Credentials, and Organization:
Michael Mabry, RadNet
Comment Text:
[Across these tables, which are the most useful service categories for helping you to understand the cost measure and provide feedback on its clinical validity?]

Imaging-related, biopsy

[How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports?]

Allows for comparison

[Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding the cost measure and how it assesses performance?]

Regional; specialty

[Overview and Measure Score]

Reasonable

[Breakdown of Cost Measure Performance]

Reasonable

[Episode Costs]

Reasonable

[What information was the most useful for helping you to understand the cost measure and provide feedback? Options are listed below.]

Mock field test reports, Draft measure specifications, At-A-Glance documents, Field testing FAQ

[What other feedback do you have about the field test reports?]

All in all, the field-test reports were straight-forward.

[The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure? Options are listed below. - Selected Choice]

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

[How did you find out about field testing? Options are listed below: - Selected Choice]

Received CMS email notification, Attended field testing webinar, Was notified by specialty society / professional association

[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening

[Does the trigger code appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

Yes

[Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.]

Imaging supplemental to the initial screening mammogram has to be ordered by the patient's treating physician per Medicare policy, thus the radiologist isn't completely attributable to that care.

[Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.]

Episodes could be constructed based on abnormal findings (as defined by ICD-10 codes) from the initial screening mammogram.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.]

Radiologists typically do not bill E/M codes for screening mammography.

[From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.]

National median treatment cost is less likely to sway the episodes like actual treatment costs; the point of the measure is breast cancer screening.

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

The current risk adjustor variables are reasonable. Race would be another to consider adding.

[Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.]

The current exclusions are reasonable.

[Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

Adoption of AI technologies have been shown to lower recall rates (thus the need for supplemental imaging) and improve suspicious findings characterization and increase cancer detection rates.

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

The measure could potentially penalize practices based on geographic variations in care. For example, breast ultrasound is commonly ordered along with screening mammography in New York, New Jersey, and possibly other states. Also, those practices that utilize breast cancer risk assessment and aggressively follow-up on BIRADS findings (per FDA and MQSA) may be disadvantaged given potentially higher episode costs.

Comment Number 11

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
Marissa Pearce, MHS, InContext, LLC

Comment Text:
[Across these tables, which are the most useful service categories for helping you to understand the cost measure and provide feedback on its clinical validity?]

The tables included in the PDF Field Test report were extremely helpful and the best data CMS has provided to assist clinicians in making meaningful changes to improve performance under a cost measure since the PQRI/PQRS days. All of the tables were highly useful. the most useful was table 3 showing utilization % and average unit cost per episode for the practice compared to National benchmarks. The indicators of 1 or 2 standard deviations were also very helpful for a provider to understand where areas for opportunity exist.

[Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)?]

Even more granular would be helpful. For instance showing utilization and unit cost differences by cost category AND PROVIDER would be helpful. We'd also like to see POS added to the data (both the PDF and the CSV file). As POS of the mammogram and other services can be a driver to high vs. low cost.

[How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports?]

Not very important. It's more important to have the feedback tailored to the measure itself. Show metrics that highlight the cost drivers and identify where the provider/group is significantly different than the National mean/median (benchmarking data). Having common report structure elements is fine - such as always providing cost spend by cost category is very useful but only if the cost categories are applicable to the episode measure being evaluated. We'd rather the data be useful and meaningful rather an just consistent with other measures that are measuring other clinical areas. For example for the Breast Cancer Screening measure the cost category breakouts in the PDF report were highly useful (ultrasound vs. lab vs. E&M, etc.), however, the CSV file seemed to follow the format of other measures and the cost breakout columns in that document were unhelpful and did not tie back the PDF. When we saw that a practice had high utilization and spend in the E&M category for instance we were unable to identify the episodes that included E&M charges, because that cost category was not included in the CSV detail file. How can we understand why these E&M services were rendered if we can't identify the patients that had them?

[Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding the cost measure and how it assesses performance?]

Trending over time. Does a practice always have a higher utilization in a certain cost category for instance? Or was that just an anomaly in one year, because of one or two unusual episode? See performance breakouts over time would be quite useful and also motivating.

Please also add the name of the location of the service. For instance in the CSV file provide the POS code and name of the facility where the trigger code was billed. This can be a driver in cost (high or low) and having that information readily available will allow a doctor to see this as a contributing factor and consider if appropriate care can be rendered in a lower cost setting.

[Overview and Measure Score]

This was displayed well. Suggested improvement would be to add a forecasted point value based on the percentile of performance. This is what is most meaningful to a practice - to see their current performance will fall in the 3rd decile or is only earning them 3/10 points on the cost measure is how they are used to interpreting overall performance.

[Breakdown of Cost Measure Performance]

Very well done. Really like the performance shown by sub-group and in total. No suggestions at this time.

[Episode Costs]

Very well done. No additional recommendations at this time.

[Additional Information]

Overall thought the PDF report was excellent. To include utilization vs. unit cost and most importantly to provide a benchmark for performance and show the spend broken out by meaningful cost categories made this data actionable and will support improvement over time. The explanations and definitions included in the report were also greatly appreciated and made the data easy to absorb and utilize.

[CSV with episode-level results]

This file was vastly better than any we've seen for existing cost measures. Thank you for adding the following useful items: 1) the provider that triggered the episode, the unadjusted cost, the risk adjusted cost, AND the risk adjustment factor, the names of other providers seeing the patient and the hospitals. We greatly appreciate the transparency here and the ability to tie the entire file back to the PDF summary was invaluable (risk adjusted vs. non-risk adjusted. Thank you! We do ask that you PLEASE show the cost spend broken out by the same cost categories you used in table 3 of the PDF. those categories were most useful to identify areas of opportunity for this measure and would allow someone to identify an area of concern with in the PDF and then go to the CSV to investigate at the episode level. Without this all the provider knows is they are high on a certain cost spend category (such as labs or MRI). they need to see which episodes utilized labs or MRI or Ultrasound, etc.

[What information was the most useful for helping you to understand the cost measure and provide feedback? Options are listed below.]

Mock field test reports, Draft measure specifications

[What other feedback do you have about the field test reports?]

We urge CMS to provide at least this level of data to providers once the measure is approved for use in MIPS. The field test reports were the best feedback we've seen thus far under the program and hope they were not just for testing purposes, but will remain that detailed (or more detailed) when the measure is active. We also ask that the CSV files be provided more frequently than annual. Receiving them quarterly so a provider can see how they are trending and where they need to intervene early will make a big difference in cost savings. Thank you for providing such useful, actionable data.

[The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure? Options are listed below. - Selected Choice]

Measure construction methodology, Codes list

[Do you have any feedback about the draft measure specifications documentation?]

No. They are clear and useful. Unlike the feedback reports, having the consistent structure of the measure specification documents across measures has been very useful.

[How did you find out about field testing? Options are listed below: - Selected Choice]

Received CMS email notification, Saw on the CMS MACRA website

[Please indicate which cost measure(s) that you would like to submit feedback for.]

Breast Cancer Screening

[Does the trigger code appropriately identify a patient cohort that reflects the measure's intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).]

Yes, trigger code as presented in the field test data is appropriate.

[Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer

screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.]

Yes attribution logic is appropriate.

[Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.]

Using these two sub-groups to adjust for cost differences would work and is definitely better than grouping all screenings together. Perhaps consider also using sub-groups based on the patient's breast cancer risk rather than relying on risk adjustment to account for that variable. If you do stay with the cancer/non-cancer detection subgroups, we are pleased to see that it will take more than one claim with a cancer dx to consider the episode for the Breast Cancer Detection sub-group. The cancer DX on 2+ claims is important to ensure the accuracy of the assignment between the two sub-groups. If only one claim had been used in the methodology, the sub-groups would not be accurately depicted. Well done.

[Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.]

These service categories are appropriate as long as the workgroup ensures that the risk adjustment for patient's breast cancer risk is complete and adequate enough to hold the provider harmless for having a higher concentration of high-breast-cancer-risk patients. Ultrasound (and to some extent MRI) are important diagnostic tools for detecting cancer early in high-risk patients (such as those with dense breast tissue). We noted Acumen's comments in the risk adjustment section, but are not completely convinced the risk adjustment will be enough to account for the expense of the clinically appropriate US ordered for a high risk patient that ends up screening negative for cancer. Consider building subgroups around breast cancer risk and cancer detection to better account for appropriate costs incurred to screen high-risk patients.

[From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.]

8 months seems fair. Factors outside the clinician's control include: patient's anxiety (leading to procrastination in seeking recommended follow-up recommendations), unmanaged mental health, or social determinants of health preventing the patient from seeking follow-up care (transportation, can't take time from work easily, etc.). We do agree with using a fixed oncology

cost for the reasons stated above - the radiologist has no control over the cancer treatment costs associated with advanced cancer diagnoses.

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

Ensure that the risk adjustment variables are in-line with standardized breast cancer risk assessment tools, such as Tyrer-Cuzick. Consider mental health as a risk adjustor. Mental health can significantly impact patient compliance and thus the time-frame in which the cancer dx is made. Social determinants of health can also play a role, but we understand those elements are not readily known through claims data. But mental health is a variable that can be derived from claims-based data.

[Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.]

No, not at this time. These appear to be appropriate exclusions.

[Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Breast Cancer Screening measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.]

QMM18 - Breast Cancer Risk Scoring and recommendation for appropriate follow-up. This helps the patient and the ordering provider make informed decisions about the modality and frequency of future screenings which can lead to earlier detection of cancer (same goal as this cost measure).
112 - Breast cancer screening mammography - we realize this Primary care quality measure, but does play into this measure (beyond the Radiologist's influence).
ACRAD25 - Mammography Turn-Around-Time - the faster the Mammo. is read the sooner action can be taken if abnormal. This also contributes to reduced patient anxiety. We realize this measure is not in the MIPS program in 2026, but did address an important element.
QMM28 - Coronary Artery calcifications seen on screening mammography plays into improved care coordination and value of care to the patient. Although this measure is more focused on detecting cardiac complications rather than cancer, it utilizes the mammography and involves the radiologist in improving coordination of care for the patient.
Indicator of quality missing - patient experience for patients that require further follow-up after their mammography (whether that be an US, MRI, or biopsy). Since so many false-positives occur it seems important to make sure that the patient felt satisfied with the episode of care. Were they well informed? Where they heard? Was their worry and concern managed? Do they understand the findings? etc.

[Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.]

- Following published guidelines for appropriate follow-up.
- Using most appropriate lowest level of care.
- Bringing patients in to discuss abnormal findings (but not bringing them back in to inform them of negative ones).
- Timely results on screenings, US, biopsies, labs, and all other studies performed to screen/dx a patient. it's better for the patient and leads to earliest possible diagnosis and intervention (if needed).

[Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.]

This seems to be a thoughtfully designed measure. Often times unintended consequences make themselves known over time so we do hope CMS will be willing to make changes to the measure after it is adopted if such concerns arise. At this time we do not see any potential unintended consequences.

Comment Number 12

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
Bethany Niell

Comment Text:
I appreciate that CMS is committed to developing meaningful cost measures. I request the following changes. Without these modifications, this cost measure risks undermining evidence-based, guideline-concordant breast cancer screening and creating barriers to appropriate care for women at elevated risk of developing breast cancer. I strongly urge CMS to incorporate these recommendations before implementing this measure in MIPS.

Recommendation 1: Extend risk adjustment variables to capture additional critical and common factors associated with an elevated breast cancer risk

Rationale: The current list of risk adjustment variables excludes many groups of women known to be at elevated risk for breast cancer. Accurate identification and categorization of women at elevated risk is necessary for meaningful analyses of breast cancer screening cost measures. Risk appropriate supplemental breast cancer screening tests are already profoundly underutilized in US women at elevated risk. If risk adjustment variables are not extended to include risk factors typically recommended for supplemental screening in the United States, this may have the unintended consequence of creating additional barriers to risk appropriate

screening. Based on guidelines from professional organizations such as the National Comprehensive Cancer Network, the American Cancer Society, and the American College of Radiology, at least five additional risk adjustment variable categories should be included as follows:

Woman who is a first degree relative of a known deleterious genetic mutation carrier who remains untested herself

Woman with an estimated lifetime risk of developing breast cancer that meets or exceeds 20% using a validated statistical model based largely on family history

Woman with a history of mediastinal or upper abdominal radiation, such as Hodgkins's lymphoma survivors

Woman with a personal history of lobular neoplasia or atypia on prior breast biopsy

Woman with an elevated estimated risk of developing breast cancer as measured using an emerging artificial intelligence technology, such as mammography-based risk assessment models

Recommendation 2: Magnetic resonance imaging should be separated into its own distinct intermediate diagnostic service category, unless risk adjustment variables are extended to capture other critical and common factors associated with an elevated risk of breast cancer.

Rationale: I understand that CMS does not cover supplemental screening with MRI or ultrasound without cost-sharing. However, most breast MRI examinations in the US are currently performed for screening indications, not for diagnostic indications (e.g. further evaluation of an abnormal mammogram finding, bloody nipple discharge, evaluation of extent of disease after a breast cancer has been diagnosed, etc.).

Inclusion of MRI in the basic diagnostic services category causes the cost of the MRI performed for screening OR diagnostic indications to be included in all breast cancer screening episodes. This approach would adversely impact practices who are appropriately evaluating patients for breast cancer risk and then recommending and performing MRI in women known to be at elevated risk. This approach would also have the unintended consequence of rewarding practices that fail to evaluate breast cancer risk.

I respectfully request that this potentially serious implication be addressed, and I envision three potential possibilities. First, it would be possible to exclude MRI from the basic diagnostic service category and place into its own unique category. Second, it would be possible to move MRI to advanced diagnostic services, although I understand that this would no longer capture costs from MRI performed for supplemental screening indications in women who do not subsequently have a late cancer detection episode. Of note, many practices intentionally perform supplemental screening breast MRI 6 months after screening mammography, so MRI-detected mammographically occult cancers may be captured under the "late cancer detection"

despite being detected earlier than if MRI had not been performed. Lastly, and I believe the most compelling alternative, would be to leave MRI as a basic diagnostic service but appropriately capture risk adjustment variables for women at elevated risk.

Recommendation 3: Eliminate ED services from all breast cancer screening episodes

Rationale: There is no compelling rationale to have costs from ED services linked to a screening mammogram as the trigger. Screening mammograms would not require, nor be associated with, subsequent ED visit(s) or critical care services.

Recommendation 4: Eliminate age exclusion criterion AND include under age 40 as risk variable adjustment category instead

Rationale: I understand that CMS restricts reimbursement for breast cancer screening in women under age 40. However, medical professional organization guidelines in the United States routinely recommend performing mammography and supplemental breast cancer screening tests in women at elevated risk beginning as early as age 25-30. Excluding women under age 40 from the measure entirely fails to capture the costs of guideline-concordant screening in high-risk young women and may inadvertently discourage appropriate early screening in this vulnerable population.

Recommendation 5: Place radioisotope scan and function studies into the same service category as MRI

Rationale: Scintimammography/breast specific gamma imaging/ molecular breast imaging may be used for multiple indications, including supplemental screening or further evaluation of an abnormal screening mammogram finding. Inclusion only under advanced diagnostic services would inadvertently favor practices that perform these types of tests for supplemental screening over practices that perform breast MRI exams for supplemental screening.

Recommendation 6: Include a separate service category for laboratory tests performed for early detection of cancer.

Rationale: Multi-cancer early detection tests are likely to become more widely utilized in the next decade. Placement of laboratory tests under the advanced diagnostic services would exclude the costs associated with these tests in most women who also undergo screening mammography. This approach would inadvertently favor practices willing to perform ONLY multi-cancer early detection tests (which are not concordant with any published medical professional organization guidelines) because a positive multigene test would require diagnostic mammography, so the trigger code for screening mammography would not occur. Although these multi-cancer early detection tests are not yet in widespread use, failure to incorporate them now would render this cost saving measure obsolete in a short period of time.

Recommendation 7: Clarify attribution methodology for practices performing both screening and diagnostic services

Rationale: Many breast imaging practices provide comprehensive care including screening, diagnostic workup, and image-guided procedures. The measure must clearly delineate how costs are attributed when the same practice performs the screening mammogram and subsequent diagnostic evaluation. Without clear attribution rules, practices providing comprehensive breast care may be unfairly penalized compared to screening-only facilities that refer their screening mammography recalls to a different facility.

Recommendation 8: Create a mechanism to track and discourage the use of higher cost annual diagnostic mammography in asymptomatic patients who could have received screening mammography instead

Rationale: Some practices routinely perform annual diagnostic mammography in asymptomatic patients who would be eligible for screening mammography instead. For example, patients with a prior history of atypia or a prior personal history of breast cancer may receive annual diagnostic mammography when they are asymptomatic. However, if asymptomatic, these patients qualify for screening mammography, which is more cost effective and less resource intensive. This cost measure would reward practices incorrectly overutilizing diagnostic mammography in asymptomatic patients, because the screening mammography trigger would not capture the patients receiving unnecessary annual diagnostic mammography. A cost saving measure that decreases the unnecessary overutilization of diagnostic mammography in asymptomatic patients eligible for screening mammograms would be impactful.

Comment Number 13

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
Gail Reese, J.D., American Podiatric Medical Association (APMA)

Comment Text:
On behalf of the American Podiatric Medical Association (APMA), the premier professional organization representing the vast majority of the nation's estimated 15,000 doctors of podiatric medicine, also known as podiatrists or podiatric physicians and surgeons, we appreciate the opportunity to provide input on the draft specifications for the Non-Pressure Ulcers episode-based cost measure currently under development. APMA is also a clinical association member of the Alliance of Wound Care Stakeholders.

APMA sincerely appreciates the significant work undertaken by the Non-Pressure Ulcers Episode-Based Cost Measure Clinician Expert Workgroup (CEW) to improve and refine this measure over the past two years following previous field testing. The cost measure appears substantially improved, with feedback reports that are much easier to understand. However, we still have concerns, particularly about correct assignment of services, especially those delivered by other clinicians, and about the inherent limits of claims data. In reviewing some of the reports shared with our association, there were instances of care episodes we would like to review directly with Acumen to better understand the assignment resulting.

To this end, APMA requests a meeting with Acumen, following submission of these comments.

Draft Measure Specifications

Trigger Codes / Patient Cohort

APMA believes the trigger and confirming codes appropriately identify a patient cohort that reflects the measure's intent.

We did note that some episode start dates are different from the trigger date and ask for clarification as to how that can happen.

Attribution

APMA agrees with the CEW's decision to shorten the trigger window from 180 days to 45 days to better reflect the typical treatment cycle for non-pressure ulcer patients and ensure the measure captures patients with active treatment relationships.

APMA is appreciative of the fact that the measure now imposes an additional check to ensure that TINs and TIN-NPIs are appropriately attributed. Specifically, that the TIN-NPIs that meet the 30% threshold must have billed at least one trigger or confirming code within 1 year prior to or on the episode start date.

APMA maintains concerns about the extent to which clinicians or groups can reasonably influence costs related to non-pressure ulcer care. For example, when the patient triggers an episode of care in one geographical region and subsequently travels to another region without the clinician's knowledge, incurring significant costs outside of the originally clinician's sphere of reasonable influence. Or, a patient sees a podiatrist for a non-pressure ulcer and an episode is opened; however, the patient's primary care provider is the one referring the patient to other, potentially costly clinicians for clinically related services. In this example, costs will be attributed to the podiatrist when they cannot reasonably influence the frequency, intensity, or occurrence of clinically related services.

Recommendation:

APMA recognizes that there are limitations to the underlying claims data and that there is no perfect system to ensure 100 percent accurate attribution and service assignment. However, APMA strongly recommends that clinicians be given the opportunity to appeal any individual episode of care with incorrectly attributed or assigned costs in the targeted review process and have them removed with their cost score adjusted.

Episode Length

APMA believes that the episode length of 90 days is an appropriate length of time, while noting that our concerns about mis-assignment of costs remain. Shortening the episode length from 365 to 90 days attempts to limit previous issues related to subsequent ulcers within the same

window while still being long enough to capture cost savings potentially associated with exceptional ulcer care.

There are challenges with episode length because some patients have multiple ulcers and these concurrent ulcers are not easily/readily apparent based on current billing/coding structure within claims data. While we recognize this is likely a result of the limitations of claims data, and that the field-testing process is testing multiple ulcers in the risk adjustment process, based on real-world clinical experience, we still have concerns about these additional ulcers being part of an episode and/or influencing the costs in a way that isn't captured satisfactorily. We recommend that Acumen evaluate this issue for additional refinement, both before the measure is finalized as well as during the two-year informational period if the measure is adopted under MIPS.

Sub-Grouping

APMA appreciates that CMS, Acumen, and the CEW took our previous comments from field testing in 2024 into consideration, and we agree with the stratification of episodes into five sub-groups based on ulcer types. It is reasonable to compare episodes according to ulcer type separately (i.e., run through separate risk adjustment models) due to expected differences in clinical care and cost, and doing so ensures a more accurate assessment of clinicians treating such patients.

However, as also addressed in the technical specifications section in this letter, APMA is still concerned that not all episodes that could be sub-grouped are being sub-grouped. While there has been improvement since the 2024 Field Testing, the L97/E11.621 concern raised in our previous comments still appears to be an issue. In reviewing one CSV file, APMA identified episodes of care designated as "Non-Pressure Ulcers with Non-Specific Ulcer Type" in the sub-grouping column, but the trigger column included E11.621, indicating the patient has diabetes and a diabetic foot ulcer.

Recommendation

APMA requests that Acumen and CMS investigate if there are any additional ways to ensure these ulcers are grouped together as specifically as possible. Such further refinements are critical to ensure that such episodes are assigned to the correct sub-group, and to ensure that clinicians' costs of care are being accurately assessed and compared. Specifically, if there is a clear diagnosis and/or confirming code in the trigger or confirming visits, that should translate to a correct/clear subgroup designation. In the previously identified diabetic foot example, this means that an episode including the diagnosis code E11.621 should result in the sub-grouping for that episode being identified as a diabetic foot ulcer, not a non-specific ulcer type.

APMA also recommends that Acumen and CMS closely review findings related to this issue during the two-year informational period if CMS adopts this measure for use in MIPS.

Service Assignment

APMA generally agrees with the listed service categories as appropriate to include, but only when clinically related to the treatment or complications of a non-pressure ulcer. For example, if an amputation is due to osteomyelitis, as caused by an infection that would not have been introduced to the patient were it not for the non-pressure ulcer, it would be appropriate to assign these costs to the clinician who triggered the episode of care with the non-pressure ulcer. However, as previously noted, APMA has concerns about accurate service assignment, due in this case to the u(drnderlying limitations of the diagnosis codes and how the clinical cause of such an event may be indicated in the record to ensure that the clinician is appropriately assigned any costs of care occurring in an attribution window.

In one of the reports we reviewed, there was a low percentage of services assigned under the Amputation for Musculoskeletal System and Connective Tissue Disorders with Principal Diagnosis of Osteomyelitis category when the clinician group believes that is a very common occurrence. A concern we have is that a diagnosis-related group (DRG) that is selected/applied to a patient may not accurately reflect the actual reason for their inpatient stay. Their stay may be for an amputation related to osteomyelitis but may be initially selected as some other DRG, like sepsis (before they know there is osteomyelitis). We ask Acumen to confirm that the addition of DRG 474 has borne out the intended outcomes.

Additionally, as identified by other clinicians in their comments, the ICD-10 coding may be insufficiently specific to correctly identify between ulcers at different anatomical locations when they fall under the same diagnosis category (e.g., L97.5, non-pressure chronic ulcer of other part of foot). For example, a patient may initially present with a plantar first metatarsal head ulcer and later develop a plantar fifth metatarsal head ulcer. Although clinically distinct and unrelated, both ulcers may be coded identically. In such cases, costs associated with the new ulcer would be attributed to the clinician who treated the earlier, unrelated ulcer making their episode appear much more costly because they cared for multiple ulcers within the same episode.

Additionally, APMA requests that CMS and Acumen clarify the over 4,500 codes in the Part D service assignment, which all note “No National Drug Code [NDC] description available.” The only identification provided for these drugs is an 11-digit code, with no other information. In order to expect clinicians to meaningfully account for and act on their attributed costs, there needs to be full clarity as all service assignment costs, including drugs. Furthermore, from a practical standpoint, these drugs, which account for over 25 percent of the drugs listed as belonging in the measure, there needs to be confirmation that they do in fact belong in the measure.

Recommendation

APMA recommends CMS provide additional clarity on the drugs in the Part D Service assignment worksheet that are listed as “NDC,” and proactively confirm that those drugs belong in the cost measure and confirming that the addition of DRG 474 is providing intended information.

Risk Adjustment and Exclusions

APMA appreciates that Acumen and CMS have either excluded or risk adjusted for several conditions we previously recommended, to ensure that clinicians are appropriately evaluated given their patients' risk pool. In particular, APMA appreciates the inclusion of the number of ulcers and severity of those ulcers as part of the risk adjustment consideration.

However, APMA would recommend that CMS and Acumen also include both hypertension and hypercholesterolemia in the list of standard and measure-specific risk adjustors, as both of these conditions materially affect healing outcomes, complication rates, and cost of care in a patient being treated for a non-pressure ulcer. Not including these conditions for risk adjustment may underestimate patient complexity and resource utilization, potentially disadvantaging providers managing high-risk vascular populations.

Quality Alignment

APMA agrees that effective care coordination and timely follow-up are the most relevant to the Non- Pressure Ulcers measure to assess the value of care. However, as expressed to CMS previously and through other avenues, APMA remains concerned regarding the lack of meaningful measures for podiatrists, including a lack of meaningful quality measures to link with the proposed Non-Pressure Ulcer episode-based cost measure. While there are quality measures that could be considered relevant to the Non-Pressure Ulcer cost measure, such as CQM quality measures #126 (Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation) and #127 (Diabetes Mellitus:

Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear), there are none directly related to it and would only capture a limited proportion of the episodes (patients must have diabetes to qualify for measures #126 and #127).

It is likely that meaningful measures to evaluate the quality of non-pressure ulcer care have not yet been developed. APMA strongly encourages CMS to work with stakeholders to develop meaningful measures in alignment with this cost measure. There are several QCDR measures stewarded by the US Wound Registry that may align:

- USWR 35: Off-loading of DFUs at every visit
- USWR 32: Compression of VLUs at every visit
- USWR 30: Arterial assessment of all patients with a lower extremity wound or ulcer
- USWR 22: Nutritional screening of all patients with chronic wounds and ulcers
- USWR 33: DFU Healing or closure (risk stratified by the Wound Healing Index- WHI)
- USWR 34: Venous Leg Ulcer healing or closure (risk stratified by the WHI) APMA would like to highlight the continued barriers related to quality measure uptake by electronic health records (EHR).

The above QCDR measures, while potentially in alignment with the Non-Pressure Ulcers episode-based cost measure, are still not currently available widely due to lack of EHR interest

in adding these measures to their platforms. Lack of ability to report these measures contributes to lack of data to benchmark the QCDR measures, which then disincentivizes clinicians to use them or ask their EHR vendor to include the measures in their platform.

Actionability

Within the larger picture of actionability and the ultimate goal of MIPS and cost measures, the timing of when a clinician receives information about their cost score is difficult to ensure meaningful and efficient change within the performance year. Clinicians typically receive their MIPS score information, that would include cost, for the previous performance year in late summer, meaning they are already six to eight months into the current performance year. This leaves little opportunity for clinical and practice workflow adjustments to be made in response to these scores.

If a clinician were to find out their cost score and episode performance in a timelier manner, they could consider changes to their clinical behaviors. They could look at the costliest patients in their episodes and determine if there are processes or efficiencies they could implement. Maybe patients could get labs or testing done prior to their visit with the provider instead of having a visit, then getting labs or tests, and then coming for another visit. A clinician could streamline protocols and processes based on guidelines even more within their practice to create efficiencies. A clinician could identify the top NPIs outside of their TIN and connect with them to coordinate care or to find out what those other providers are doing that are so costly. This could change to whom a clinician refers. If appropriate quality measures were in place, a clinician could determine how the use of costly products impacted outcomes and decide which patients benefitted from the products and which one's didn't. With the scoring/performance being shared so late in the process, it becomes more challenging to effect change.

Clinicians are a good 6+ months into the next performance year when they receive the previous year's reports, which gives little time in the new performance year to turn things around or continue on a good path.

Question 10: Unintended Consequences

APMA appreciates Acumen and CMS's proactive approach in identifying and mitigating possible negative unintended consequences stemming from this measure. APMA's main concern is that this measure may inadvertently discourage appropriate, evidence-based care if clinicians perceive pressure to limit referrals, diagnostic testing, or timely interventions in order to control attributed costs, especially if those other providers are the only ones in the geographic area and are costly. While delays or omissions in care may reduce short-term expenditures, they can ultimately result in poorer clinical outcomes and substantially higher downstream costs.

For example, preventive interventions—such as vascular evaluation and revascularization procedures to restore perfusion—directly address the underlying etiology of many non-pressure ulcers and may significantly accelerate healing. Although these services may increase upfront episode costs, they can meaningfully reduce the risk of infection, hospitalization, limb loss, and

other serious complications over time. Structuring the measure in a way that penalizes clinicians for providing such necessary preventive care could unintentionally discourage adherence to best practices and compromise patient outcomes.

Similarly, promoting more frequent monitoring and preventive services, i.e., at-risk foot care in vulnerable population, facilitates early identification of emerging problems and helps prevent ulcer progression. The measure should therefore be designed to support, rather than disincentivize, proactive and preventive care strategies that improve long-term outcomes and reduce total cost of care to CMS.

Field Testing Questions

Field Test Reports

APMA appreciates the significant strides that Acumen and CMS have taken to make these reports useful and actionable for clinicians receiving them. In particular, Table 2: Group Cost Measure Performance by Episode Sub-Group, is helpful to understand the breakdown by ulcer sub-group to determine if there are billing/coding practices that need to be investigated within a practice. Table 3: Service Use and Cost by Medicare Setting and Service Category, is also helpful for clinicians in providing clarity as to what types of care are driving costs and allows clinicians to assess whether observed cost patterns are clinically appropriate for the patient population being treated. The further clarity as to where a clinician falls both to the national average and the average within their group risk bracket provides better context to a clinician for their cost score. Table 4: Top Contributors to Your Group's Part B Physician/Supplier Episode Costs Within and Outside Your Group provides a starting point for where to work on care coordination. It would be helpful if Table A3: Definitions for Cost and Use by Medicare Setting and Service Category had more examples for the categories. An example is that the DME and Supplies: Skin Allograft line has the following example: (e.g., skin substitute products). There are still questions as to whether all Q codes and A codes, etc. for products that are not all specifically considered, "skin substitutes" fall into this line.

Additional comparison frameworks in the report could improve the interpretability and usefulness of this cost measure. For example:

- Historical comparison, such as performance in prior measurement periods for the same provider, would allow assessment of trends and meaningful improvement over time.
- Peer comparisons within the same practice type or geographic region could better account for local practice patterns, referral networks, and resource availability.
- Internal benchmarks, including comparisons across service categories within a provider's own performance profile, could help identify relative areas of higher or lower cost utilization.

Providing these perspectives would enable clinicians to more effectively contextualize their results and distinguish between actionable performance variation and differences driven by patient population or other external environmental factors.

With regard to the report's presentation, content, and clarity of the sections, overall, APMA finds the feedback report to be significantly improved. In reviewing the materials CMS and Acumen provided, and attending the office sessions, APMA found the following to be the most helpful in understanding and identifying action items for a clinician score on this cost measure:

a) Data dictionary b) CSV file c) The report However, there are a number of areas in the report that could be adjusted to enhance clinician understanding and engagement:

1. Remove pop-up box content in the electronic PDF and incorporate the information into the body of the actual text of the report. Clinicians may not know to hover their mouse over a table or graph, or they may be printing the report into a hard copy. Inserting important information or context into a pop-up obscures it.

2. Ensure any histograms or graphs are sufficiently clear/marked. For example, in one report that APMA examined, the Figure 1: National Distribution of Field-Testing Measure Scores graph, the arrows are indecipherable:

3. Identify a method by which more direct clarity can be given in this report as to why a non-attributing clinician would be listed in the report for any episode of care. APMA believes the episode-level CSV file is helpful for clinicians who are being evaluated under the cost measure. Having access to detailed cost information in all columns allows providers to clearly see how costs were calculated and what is driving them. This makes it easier to review the results, understand their performance better, and act on the information to improve patient care with cost awareness.

4. Include laboratory and pathology codes in the code list. One of the service assignment categories under "Ancillary Services" is "Laboratory, Pathology, and Other Tests," however, these codes do not appear to be in the 2026 Non-Pressure Ulcers Code List. APMA asks that CMS and Acumen provide this information.

5. Under DME and Supplies, in Table A3: Definitions for Cost and Use by Medicare Setting and Service Category, clarify that "skin allograft" includes the range of skin substitute products a clinician might be using, such as xenografts, biosynthetics, flowables, etc. These codes are present in the code list, but it's unclear in the report.

6. Include the expected costs in the materials. The measure is based on the observed to expected ratio and clinicians want to see what CMS is "expecting" to see for a given patient/episode, based on their risk profile.

In addition to the above recommendations, APMA would recommend that CMS and Acumen provide clear, actionable advice in a direct manner at the top of the report. While the call out boxes in each section are helpful, some of the information provided to the clinician in the report preceding the tables might be difficult for the average clinician to understand and use to effectively interpret their results. For example:

The average clinician may not understand what it means for a group's performance to be "more than 1 standard deviation above the average." APMA recommends CMS and Acumen ensure that the language used in these reports for clinicians be sufficiently clear and straightforward – i.e., the clinician reading their report should not need a background in statistical training to understand their report. Making this information accessible is important to ensure that the cost measure accomplishes its ultimate goal:

providing information that a clinician can then take to adjust their own clinical practice and choices for patients to ultimately lower costs and achieve better patient outcomes. The questions our clinicians have are things like, "What does it mean to be 1 or 2 standard deviations above…" "What am I supposed to do with this information?" Somewhat related to the expected costs, APMA has concerns that the measure doesn't look at what the appropriate amount of cost for an episode should be. An example related to non-pressure ulcer would be, are the clinicians with high costs doing too much or are the clinicians with low costs doing too little?

How does one determine where the standard of care/guidelines amount of care is on the continuum of the cost of an episode? APMA recognizes Acumen/CMS relies upon extremely large datasets to come up with the initial estimates of the expected costs. However, if the clinicians in the dataset are doing more or less of any assigned service (such as debridement or imaging studies), how can there be certainty that the costs being used within the episode are the "right" costs? For example, two clinicians may each have episodes of $5,000 but one's costs are all debridement costs and the other had debridement, imaging, and revascularization costs. They both have the same cost for the episode, but which one had appropriate costs? Another example would be that there may be a situation where the standard of care calls for a service that incurs higher costs than options that are considered below standard of care. In a situation like this, we are concerned that our members may be negatively impacted by employing standard of care, ultimately appearing at a higher cost.

Finally, APMA recommends that CMS and Acumen identify a way to tie the reports and the CSV files together in a meaningful way. To ensure meaningful interpretation of the field test materials, CMS should provide a clear bridge between the episode-level data contained in the CSV file and the summarized results presented in the field test report. Without explicit crosswalks or explanatory guidance, clinicians may have difficulty understanding how individual episode records translate into the performance rates reflected in the report. When looking at the report, we can see details as to what categories care falls in to and in looking at the CSV file, we can see episodes for a patient and the costs and providers who cared for the patient, but there is a disconnect or missing link. If a clinician sees in their report that they have a service cost that is 1 or 2 standard deviations above the average for their risk bracket, how are they supposed to know which patients to spot check/audit in their CSV file to figure out if there are changes to their clinical practice they should employ? An example might be that hyperbaric oxygen treatment is high in Table 3 of the report. What is a clinician supposed to do next? If they go into the CSV file, there's nothing there for them to see which patients were part of that hyperbaric oxygen treatment cost.

Technical Specifications

APMA believes that measure flowcharts and codes lists will be of most value to our members, as they clearly illustrate how patients and services are included or excluded and provide transparency into the specific codes driving attribution, service assignment, and cost calculations. However, as previously noted, the codes excel file appears to be missing the labs and pathology codes. APMA asks that CMS address this missing information and ensure that it is available to clinicians. Otherwise, there is no way for a clinician to appropriately address this facet of their costs, which do appear in the summary reports.

Additionally, in the cost measure's technical specifications, there continues to be no clarity to indicate when someone may not be receiving standard of care. Is there an opportunity to use the data to be able to determine if there is a treatment missing from an episode, especially one considered to be standard of care? An example would be related to compression therapy for a venous ulcer. Compression is widely considered to be the standard of care for this condition – is there a mechanism to look at the data points to capture this treatment? If not, why not? Additionally, and similarly, is there a way to identify instances of vascular studies/revascularization for an arterial ulcer? If not, why not? This may be the opportunity to link with meaningful quality measures as mentioned earlier in this letter.

Education and Outreach

APMA appreciates the meaningful and expanded ways in which CMS and Acumen have reminded clinicians about this field-testing period during the measure development process and the various opportunities provided for education on understanding these field-testing reports. Once the measure is finalized for a future performance year, APMA recommends that CMS and Acumen continue proactive engagement with stakeholders and clinicians throughout the two-year grace period to further refine and improve the measure and its attribution and service assignment.

Ongoing outreach (including educational sessions, technical assistance, and structured opportunities for feedback) will be especially important given that many clinicians remain unaware of the non-pressure ulcer cost measure and its potential implications. Sustained engagement will not only increase awareness and understanding, but also allow CMS and Acumen to identify unintended consequences, clarify attribution and methodological questions, and ensure the measure is clinically meaningful, transparent, and actionable for clinicians.

Conclusion

APMA appreciates the opportunity to provide feedback on the Non-Pressure Ulcer Episode-Based Cost Measure. We appreciate all of the work the CEW, Acumen, and CMS have done to refine the measure and ensure that clinicians are able to better understand their score in order to take action on it. However, there are some remaining concerns related to the correct assignment of services under this measure. To that end, APMA requests a meeting with Acumen to review some specific incidents of care episodes, following this comment period. We

look forward to continuing our engagement with Acumen and CMS on this measure and other MIPS-related concerns. If you require additional information, please contact Gail M. Reese, JD, Director of Health Policy and Practice at greese@apma.org or 301-581-9230. Thank you for your time and consideration.

Comment Number 14

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
David J. Freedman, DPM, FACFAS, FASPS, Foot and Ankle Specialists of the Mid-Atlantic (FASMA)/United States Foot and Ankle Specialists (USFAS)

Comment Text:
Foot and Ankle Specialists of the Mid-Atlantic an Affiliate of USFAS received our Field-Testing Scoring and has had a chance to review the future Cost Measure. We appreciate the opportunity to provide input on the draft specifications for the Non-Pressure Ulcers episode-based cost measure currently under development.

Draft Measure Specifications

Trigger Codes / Patient Cohort

From the information provided, we have uncovered concerns regarding this analysis. In reviewing the category “Non-Pressure Ulcers with Non-Specific Ulcer Type”, we discovered when looking at some of our patient records that while the patient may have had initially an L97.- ICD-10-CM diagnosis the next diagnosis right to the right of that with a subsequent diagnosis was E11.621, a diabetic diagnosis, yet you did not always classify that patient in the right subgroup to diabetic ulcer but left it in “Non-Pressure Ulcers with Non-Specific Ulcer Type”.

Another example is where the trigger codes attributed cost to our doctor for an unrelated illness in no way related to their ulcer management. Specifically, 9/1/2023 non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin (L97.421) with Cellulitis of left lower limb (L03.116), last visit 10/6/2023-Patient with significant labored breathing was sent to hospital. The “EPISODE_END_DT” was 1/3/2024. In reviewing the record our doctor got attributed $16,607.51 for the “SNF_COST” when that doctor did not see or treat the patient again for their Pulmonary event unrelated to the ulcer care. We looked at the “OBS_COST” and “OBS_WINZ_COST” which both were $54,115.23, it was nice to see there was a “RA_COST” of $28,378.13, but we feel this example demonstrated an incorrect risk adjusted cost as there was limited cost to our provider that should have been attributed to a just a few office visits regarding the L97.421.

Attribution

In reviewing the CSV file, there are many circumstances where our doctor triggered an episode of care under the non-pressure ulcer cost measure specifications, and the patient later incurs significant costs due to an unrelated health crisis, such as cardiovascular event as stated above. Or, the patient triggers an episode of care in one geographical region, and subsequently travels to another region, incurring significant costs outside of the original doctor's sphere of reasonable influence. An example where the attribution dates do not make sense "TRIG_DATE" for 02/21/2022; 03/31/2022; the primary diagnosis list was E11621. This prompted us to review the medical record. Our documentation started on 6/13/2022 Type 2 diabetes mellitus with foot ulcer (E11.621) located on the left dorsal 2nd toe, then osteomyelitis, Home health multiple visits throughout 2022 left 2nd toe amputation (2022). Then in 2024, left great toe ulcer developed unrelated but on the same foot. The trigger dates had nothing to do with subsequent 2024 care which also involved Nursing: home health care for the patient was provided and an Unna boot was ordered. "EPISODE_START_DT" 5/9/2024 and "EPISODE_END_DT" was 8/6/2024. Our concern was the dates attributed as triggers and the anatomical location is not distinguished which made this care unrelated yet was commingled together.

Although clinically distinct and unrelated, Type 2 diabetes mellitus with foot ulcer (E11.621) were coded identically. With this example case, costs associated with the new ulcer could be inappropriately attributed to a clinician who treated the earlier, unrelated, Type 2 diabetes mellitus with foot ulcer. This is just one example.

USFAS and Foot and Ankle Specialist of the Mid-Atlantic Recommendation: we strongly recommend that our doctors be given the opportunity to appeal to any individual episode of care with incorrectly attributed costs in future targeted reviews and provide a mechanism to allow them to be removed with their respective cost score adjusted.

Episode Length

We believe that the episode length of 90 days is to long and feel that 60 days would be a more reasonable length of time.

Sub-Grouping

We agree with the stratification of episodes into five sub-groups based on ulcer types. It is appropriate to compare episodes according to ulcer type separately due to expected differences in cost, and doing so ensures a more accurate assessment of our doctors treating these ulcer patients. We are concerned that not all sub-groupings are being correctly determined. In our example already provided, the trigger diagnosis code is L97- codes and then E11.621, in our CSV file we saw several episodes of care designated as "Non-Pressure Ulcers with Non-Specific Ulcer Type" in the sub-grouping column, but the trigger column actually included E11.621, indicating the patient had diabetes and a diabetic foot ulcer. The software system is somehow missing this important observation and needs to be corrected before this measure gets instituted across the board.

Hospital Inpatient Services

We reviewed many cases and found issue with “Amputation for Musculoskeletal System and Connective Tissue Disorders with Principal Diagnosis of Osteomyelitis”. When reviewing medical records, it was clear the real purpose for a hospitalization and amputation was misdiagnosed with too many ICD-10-CM codes and only the primary diagnosis code on the specific patient for 5/3/2024 “Other acute osteomyelitis, right ankle and foot (M86.171)” The problem was the secondary diagnosis was assigned in the record which was not necessary or appropriate as a “Non-pressure chronic ulcer of other part of right foot with necrosis of bone (L97.514)” and yes they had Diabetes, then on 5/24/2024 the next note shows they were seen Post-op Foot Toe Amputation. Technically this was a bone infection/amputation case first. It was seen for a new ulcer of the right heel got miscoded as non-pressure chronic ulcer of other part of right foot with fat layer exposed (L97.512). Clearly, this requires provider education, but the medical records show this should not have been included in the cost scoring.

Risk Adjustment

Based on reviewing medical records, there are other more significant issues that these patients possess and recommend that CMS and Acumen also include any condition attributed to shortness of breath (dyspnea) chronic lung diseases (COPD, asthma), heart conditions (heart failure, coronary artery disease), or acute infections (pneumonia, COVID-19) but may also include anxiety, anemia, obesity, as well as consider adding hypertension and hypercholesterolemia in the list of standard and measure-specific risk adjustors, as all of these conditions materially affect healing outcomes, complication rates, and cost of care in a patient being treated for a non-pressure ulcer. Not including these conditions for risk adjustment may underestimate patient complexity and resource utilization, potentially disadvantaging our providers managing especially these high-risk vascular populations.

Actionability -Timely Reporting to Providers by CMS

We are concerned that when we received this most current report for field testing in 2026, but it was for 2024 data. We are requesting that a period of time should be provided to review these extensive CSV files. As a large group practice, we needed time to determine any inconsistencies and need a process in place that allows appealing data inconsistencies. We are concerned that by the time we got these reports disseminated to our practice, we will have missed an ability to address prior performance inadequacies. There is a significant lag time of 9-12 months after we rendered these services and will be penalized without knowing what we could have done to alter our cost associated with non-pressure ulcers.

Unintended Consequences

As a group practice that desires ideal outcomes for our patients, this cost measure could easily influence care by rendering minimal care vs. optimal care. In performing our CSV file review, there appears to be attributed to the cost for services we feel that were not appropriately attributed to our specific care. Seeing this occur to our large group practice, it could easily change practice pathways such that we are forced to reduce attributed short-term expenditures with the result in poorer clinical outcomes and substantially higher downstream costs. An area

of concern is that these patients have co-morbidities that are not due to our practitioner's care. A patient that has Peripheral Arterial Disease (PAD) is one that easily comes to mind and was evident in our CSV file. We saw in several examples a patient was referred to us after a vascular physician did their evaluation and performed a revascularization procedure before we saw that wound. While the vascular doctor did not code the wound as L97.-, but they did refer our doctor the patient and our doctor coded the wound as L97.- on more than one visit ended up having the other providers of care attributed to our cost all in the name of restoring the lack of arterial blood flow. Fact is our doctor did not create the PAD, and we do not want the patient to lose their limb but the notion that a patient that has a non-pressure ulcer global other provider cost gets attributed to us seems totally unfair. We are working diligently to achieve healing. Although these services may increase upfront episode costs, they can meaningfully reduce the risk of infection, hospitalization, loss of limb and other serious complications. Structuring the measure in a way that penalizes clinicians for providing necessary referrals and appropriate interventional care could unintentionally discourage adherence to best practices and compromise patient outcomes.

In our opinion, field testing has taught us there is a gap in coverage for these high-risk patients who possess co-morbidities. Why not promote wellness E/M for this patient population that is covered under Medicare. This would support patients to provide pre-emptive care before they develop a more catastrophic outcome from a non-pressure ulcer.

Field Test Reports

There was not a very clear understanding made by the field test reporting for our group score vs "National Group Average (Mean) Cost Measure Score" and "National Group Median Cost Measure Score". What did ours really mean for our group in this cost measure. If we are below the mean but above the median, will we be penalized? Is there a way to explain the process of rewarding our group if the score was at a certain level, have a neutral adjustment at a certain level or a negative adjustment above a certain level. We really were not sure how our score would have affected our reimbursement due to cost in this measure?

More granular breakdowns within key categories (e.g., separating routine versus high-cost or potentially discretionary services) would help our doctors better understand specific cost drivers and identify areas where practice patterns may differ. Offering the ability to "drill down" from broad categories to more detailed subcategories would support both usability and clinical interpretability without overwhelming the primary tables.

Standardization across measures is very important. Consistent service categories, definitions, and comparison metrics reduce cognitive burden and make it easier for our doctors to interpret multiple reports accurately. Standardized metrics also enable our doctors to compare performance across different cost measures more confidently and to identify systematic patterns in care delivery, rather than attributing differences to measurement methodology

Additional comparisons could enhance interpretability, such as: Historical performance comparisons (e.g., prior periods for the same provider) to assess trends over time. Peer

comparisons within the same practice type or geographic region, which may better reflect local practice norms and resource availability. Internal benchmarks, such as comparisons across service categories within a provider's own performance profile, to highlight relative areas of higher or lower cost. These additional perspectives could help clinicians better contextualize results and distinguish between actionable performance differences and external factors

The overview and measured score section is generally understandable given the number of variables presented. It provides sufficient context to interpret the overall measure results, though clearer explanations of how key variables contribute to the final score could further improve readability and support more informed feedback on the measure specifications.

The cost breakdown is essential for understanding how and where costs are attributed. This section is particularly useful for identifying potential attribution issues, such as costs driven by inaccurate ICD-10 diagnosis coding. Maintaining clear, clinically meaningful service categories strengthens the ability to assess the measure's clinical validity and identify areas for improvement.

The episode cost information is valuable as long as the costs are accurately captured and attributed, as described in the field-testing methodology. When accurate, this section enables providers to evaluate care delivery, identify opportunities to reduce costs when appropriate, and do so without compromising the standard of care.

Other feedback

The episode-level CSV file is very important. Access to detailed cost data across all columns allows providers to fully understand the magnitude and drivers of costs, supports deeper analysis, and improves the ability to provide meaningful feedback on the draft measure specifications. It certainly opened our eyes to costs attributed to our practice and if it were an actual live report, we would have appealed certain lines in the CSV file as costs that were attributed should not have been.

In the pdf report Ancillary Services, "Laboratory, Pathology, and Other Tests" data was provided for our group's episode but when looking in the CSV file there were no lab CPT codes provided thus, we could not validate the percentage assigned to us in the reporting. If a a number is calculated we should be able to cross walk back to the CSV file to verify accuracy of the reporting made regarding our groups non-pressure ulcer costs.

Technical Specifications

Measure flowcharts and codes lists, clearly attempt to illustrate how patients and services are included or excluded, but can this cost measure provide examples of standard of care and how the practice deviated from the expected standard or was this practice within the range of expected care. The specific codes driving attribution and cost calculations need to be demonstrated in the CSV file. There must have transparency so that any physician could look at the file, compare to the medical records and know what was actually billed to validate costs, but

when certain items are missing as was discovered with the “Laboratory, Pathology, and Other Tests”, it creates a level of concern why that data was not present.

Education and Outreach

When we asked colleagues to tell us about their field testing, most colleagues were not aware of the Acumen field testing and that these 2026 reports came out a month ago. The reports are very technical, and it seems one needs a degree as a statistician to understand how all was arrived at to generate our score. The goal is to receive a reasonable cost score and understand where the attributed costs came from during the year. This concern about notification still exists as to how CMS and Acumen will get the word out. Shouldn’t the providers be notified that they may be penalized for their care in the “non-pressure” ulcer area by not reviewing their scoring, learning where the practice had favorable results but also pointing out areas that need improvement. Possibly explaining solutions on how to improve might be useful as well.

We appreciate the opportunity to provide feedback and will be available for any question that arise from this letter.

Comment Number 15

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
Marcia Nusgart, R.Ph., Alliance of Wound Care Stakeholders

Comment Text:
On behalf of the Alliance of Wound Care Stakeholders, Chair Kara Couch, Vice Chair Julie Rhodovi, and I are providing input on the draft specifications for Acumen, LLC’s Non-Pressure Ulcers Episode-Based Cost Measure which is currently under development. The Alliance is a nonprofit multidisciplinary trade association of physician specialty societies, clinical and patient associations, wound care provider groups, wound care clinics and business entities operating in the wound care area. Our mission is to promote quality care and access to products and services for people with wounds through effective advocacy and educational outreach in the regulatory, legislative, and public arenas. These comments were written with the advice of our members who not only possess expert knowledge in complex chronic wounds but also those who are part of the workgroup and those who participated in the field testing.

While the Alliance understands the importance of developing a cost measure relevant to chronic ulcers, the measure needs to be created in such a way to ensure its success. Our own analysis of the complete Medicare dataset a few years back has demonstrated that chronic ulcers affect 16% of Medicare beneficiaries, (Carter MJ, DaVanzo J, Haught R, Nusgart M, Cartwright D, Fife CE. Chronic Wound Prevalence and the Associated Cost of Treatment in Medicare Beneficiaries: Changes Between 2014 and 2019. J Med Econ. 26(1): 894-901, 2023.) an increase of 3% since 2014, (Nussbaum SR, Carter MJ, Fife CE, DaVanzo J, Haught R, Nusgart M, Cartwright D. An Economic Evaluation of the Impact, Cost, and Medicare Policy Implications

of Chronic Nonhealing Wounds. Value Health. 21(1): 27-32, 2017.) and the most conservative estimate of their annual cost is $25 billion but the real cost is likely more than 3 times that number. We offer these comments so that they can be used to further improve the cost performance category of the Merit-based Incentive Payment System (MIPS) and accurately reflect the wound care clinicians' work.

We appreciate the work already undertaken by the Clinical Expert Workgroup in its efforts to improve this measure, however, the Alliance still has concerns with a number of issues including, but not limited to, cost allocation and limitations of claim attribution data. These include the following:

- Costs are still being attributed to clinicians inappropriately as clinicians are still being held accountable for the work of other clinicians. We still have concerns related to how much someone can realistically influence another provider, especially if they don't know the patient is seeing them.
- Costs are being attributed to the clinician simply because they are clinically related to the condition being treated as opposed to "…the attributed clinician's role in managing care during a Non-Pressure Ulcers episode." All costs related to the NPU are supposed to be part of the measure, not just those that fit within the clinician's "role." This issue needs to be addressed so there is no confusion as to cost attribution.

Specific Feedback on Draft Measure Specifications

Trigger Codes

The Alliance continues to agree that the trigger codes appropriately identify the patient cohort based on the measures intent.

Episode

Acumen changed the episode from a 365-day episode to a 90 day-episode. The Alliance agrees with this change.

Attribution

The Alliance is still concerned about correct attribution to the TIN. The revised measure still does not fairly capture the frequency, intensity, or occurrence of clinically related services that are under the reasonable influence of the attributed clinician. None of the costs below are under the reasonable control of the TIN, yet these costs are being attributed to it:

- Costs at hospitals in cities distant from the TIN are attributed to the TIN;
- Costs occurring after the physician is no longer involved in the case are attributed to the TIN;
- Costs of other providers not associated with the TIN are being attributed to the TIN;

- Costs for skilled nursing facility hospitalizations (rarely required specifically due to a chronic non- pressure ulcer). While the Alliance does not have specific examples to provide we are aware that APMA, a member of the Alliance, has some examples that they will be sharing with Acumen.

None of these costs are under the reasonable control of the TIN and yet, these costs are in fact being attributed to the TIN in all the field tests that we have reviewed.

Chronic non-healing ulcers are a symptom of underlying disease(s), not a disease of their own. Research consistently demonstrates that the average patient with a chronic ulcer has at least 8 comorbid conditions and that the severity of their comorbid diseases is greater than the ulcer. (Eckert KA, Fife CE. The Impact of Underlying Conditions on Quality-of-Life Measurement Among Patients with Chronic Wounds, as Measured by Utility Values: A Review with an Additional Study. Adv Wound Care (New Rochelle). 12(12): 680-695, 2023.) Conditions such as congestive heart failure, diabetes (in patients with all ulcer types), atrial fibrillation, COPD, depression, ischemic heart disease and renal disease all have a high prevalence rate. These conditions are managed by numerous specialists following the patient simultaneously. The physician caring for the wound has no influence over the care required for these other medical conditions, and yet the current cost measure attributes many such costs to the wound care practitioner. What is clear is that with patients as complex as those with chronic ulcerations, the broad range of services included in a 90-day episode are NOT all related to the ulceration.

Furthermore, non-pressure ulcers often require a multi-disciplinary approach, as evidenced by the number of NPIs rendering care. Therefore, it is possible that referrals and/or care coordination efforts are being led by a clinician who is different from the clinician/TIN being attributed the costs. This is raised to highlight why there may be problems with cost attribution including the limitation of using claims data.

The Alliance requests that Acumen answer the following questions:

- How will this measure appropriately attribute episodes to clinicians or groups who can “reasonably influence” costs related to non-pressure ulcer care?
- The Alliance requests Acumen to define what is meant by “clinically related services that are under the reasonable influence of the attributed clinician.”
- What does Acumen consider reasonable influence? How can that actually be measured? How does Acumen believe this information can be gleaned accurately from the claims data?

We believe that perhaps by better understanding this information we can work together to ensure that cost attribution is allocated correctly.

Variability

The Alliance is concerned that risk adjustment based on the number of ulcers will be difficult to assess as a result of the fact that claims data has limitations. Additionally, the Alliance raises the following issues:

- Wound number
    - A decade of data from the US Wound Registry, who has the largest wound care QCDR, has shown that the vast majority of patients have more than two ulcers. (Fife CE, Eckert KA, Carter MJ. Publicly Reported Healing Rates: The Fantasy and the Reality. 7(37): 77-94, 2018.) We are concerned that if the ulcers are of the same type, they are conflated into one code and thus CMS is unable to know when multiple ulcers exist of the same type. A risk stratification was developed to predict the likelihood of healing in order to report healing rates to CMS under MIPS. Also, research on the Wound Healing Index demonstrated that the statistical likelihood of healing one wound is inversely proportional to the total number of wounds present, so accurate risk stratification requires insight into the total number of wounds/ulcers present. (Horn SD, Fife CE, Smout RJ, Barrett RS, Thomson B. Development of a Wound Healing Index for Patients with Chronic Wounds. Wound Rep Reg. 21;823-832,2013)
- Wound type(s)
    - When these ulcers are of different types, we are not sure that a category of "multiple ulcers" sufficiently captures the resource use. For example, a patient with both a diabetic foot ulcer and a venous ulcer would need both off-loading and compression, but a patient with a different combination of ulcers would need a different set of services. Thus, even the category of "multiple ulcers" would need to be subdivided according to the types and the number of ulcers. As we raised in the cost attribution area, this also highlights another limitation of claims data. Thus, the Alliance requests that Acumen address this issue and help to explain how multiple ulcers will be addressed accurately using claims data.
    - Variations in the use of dual code sets mean that the apparent "type" of an ulceration may change from one provider to another even though the patient is being seen for the same problem. How will Acumen be able to flag this issue so that the correct attribution is assessed?
- Codes
    - There are no ICD-10 codes for a "diabetic foot ulcer." An ICD-10 code exists for "diabetes with an ulceration" but this is a code for diabetes. Thus, capturing a diabetic foot ulcer requires two codes to be used, one for a chronic ulcer on the foot and the other for diabetes. We do not understand how this was handled in the cost measure but it is important to address the fact that two codes are required. How will Acumen address this issue?
    - Similarly, there is no ICD-10 code to capture an arterial ulceration and we are not clear how the necessary combined codes were handled.

- We certainly agree that resource use must be evaluated for each ulcer type separately but are not sure how this can be done in the absence of needed ICD-10 codes or with multiple different types.
- With the exception of venous ulcers, non-pressure ulcers are always coded with 2 codes - the anatomic location of the wound as well as the wound type. However, depending on the payer, some clinicians code the underlying condition first (as it should be done) while others code with the ulcer first as required by the payer in their jurisdiction. However, unless both codes are accepted together there will be inaccurate subgroupings – as seen in the field testing - which will continue if not addressed.

We are not sure how this can be managed given the lack of needed codes, but it clearly impacts the ability to crate reliable risk categories. This needs to be addressed.

Quality Measures

No organization has worked harder for the development of national MIPS measures that are relevant to chronic ulcer patients than the Alliance. We first began working with the relevant organizations (e.g., National Quality Forum) in 2009 but found no support for such measures, despite the fact that 16% of Medicare beneficiaries have a chronic wound or ulcer. Due to the unwillingness of national quality organizations to support the development of wound/ulcer relevant measures in MIPS, the Alliance partnered with the US Wound Registry, which is a CMS recognized Qualified Clinical Data Registry (QCDR) to develop a suite of relevant QCDR measures. (Fife CE, Walker D, Thomson B. Electronic Health Records, Registries, and Quality Measures: What? Why? How? Adv Wound Care. 2(10): 598-604, 2013.) Since wound care is not a specialty, CMS agreed (after much advocacy and education on the part of the Alliance) to allow the Alliance of Wound Care Stakeholders to act as a de-facto specialty society. These measures were first approved by CMS in 2015. The 2026 CMS approved measures can be found here: https://uswoundregistry.com/quality- measures/ The most relevant QCDR measures are:

- USWR 22: Nutritional assessment and Intervention Plan in Patients with Wounds and Ulcers
- USWR 30: Non-Invasive Arterial Assessment of patient with lower extremity wounds or ulcers for determination of healing potential
- USWR 32: Adequate Compression at each visit for Patients with Venous Leg Ulcers (VLUs) appropriate to arterial supply
- USWR 33: Diabetic Foot Ulcer (DFU) Healing or Closure
- USWR34: Venous Leg Ulcer (VLU) Healing or Closure
- USWR 35: Adequate Off-loading of Diabetic Foot Ulcers performed at each visit appropriate to location of ulcer

The MIPS program is woefully lacking in relevant quality measures. Some measures are tangentially relevant such as Measure #001: A1C control in diabetic patients with ulcers, but

since this measure is limited to diabetics, the measure is not relevant to at least half the patients with non-pressure ulcers.

One of the Alliance members, the American Podiatric Medical Association (APMA) has two measures specific to diabetics WITHOUT active ulcers, specifically:

- #126: Diabetic Foot and Ankle Care, Peripheral Neuropathy — Neurological Evaluation
- #127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear Diagnosed neuropathy is an exclusion for measure # 126, and since all patients with an active DFU have neuropathy, that measure is not relevant to diabetic patients with active DFUs. Additionally, the purpose of measure #126 is to identify diabetics “at risk” for a DFU so that interventions can be implemented in hopes of preventing DFUs. This is a laudable goal for patients before an ulcer develops but is a moot point among diabetic patients who already have an active ulcer.

Measure # 127 can be performed in diabetics with an active ulcer, but the measure is aimed at preventing a DFU by ensuring that patients have appropriate protective footwear, a moot point when an ulcer has already occurred and when other forms of off-loading must then be implemented. Both of the APMA measures are gradually being “topped out” by CMS due to the high-performance rate of reporting clinicians. Thus, in addition to questions about the relevance of these measures in patients with active DFUs, their future availability within MIPS is in question.

At this time, the QCDR measures developed jointly by the Alliance and the USWR remain the most relevant measures with which to understand the quality aspect of care among patients with non-pressure ulcers. However, there are barriers to their use and their survival. Some of the reasons for this include:

- many EHRs do not place these measures in their platforms
- clinicians can cherry pick the measures they report and are not incentivized to use these measures While the above measures are the most relevant measures, they do not fully align with the cost measure being developed. The Alliance recommends that more meaningful measures are developed to align with this cost measure and EHR vendors be required to add them to their platforms.

Feedback Related to the Presentation of the Report Materials

The Alliance is fortunate to have members who are experts in the area of billing and coding. However, we do not think it is possible for the typical practicing physician to make use of their Field Test report. Recognizing that even scholarly organizations like the Cochrane Collaboration provide “plain language” summaries of their findings, we strongly urge Acumen and CMS to create a plain language explanation of the report. While Acumen has significantly improved the field-testing report, there is still a lot of technical language contained in the report and there could be more clinician-lay person language to make the process and the report itself easier to understand. The Alliance suggests/recommends the following from feedback received:

- Include information on what types of care are driving cost.
- Provide more clarity regarding the national average, the average within a clinician group risk bracket and where the clinician fits within both of these categories. This will help contextualize the clinician cost score.
- Provide peer comparisons in a geographic area and also within the same practice type.
- Provide historical comparisons for a clinician so trends can be seen allowing for possible improvement over time.
- Any graph provided needs to be clear so there is no ambiguity. There are some graphs in which arrows are placed within the graph but the clinician cannot make out what the arrow is pointing to making it difficult to understand what was being relayed.
- Regarding skin substitutes, codes are provided in the code list but Acumen should make clear in the report that "skin allografts" include the wide range of skin substitute products clinicians use as it is currently unclear.
- The report needs to be tied to the CSV file so that clinicians can better understand the field test information. There are no cross walks or any explanatory guidance currently making it difficult for clinicians to understand how individual episode records translate to the performance rates identified in their report.

Additional Feedback/Questions

The Alliance has other concerns and questions which we believe are important to raise because answering them will improve the success of any cost measure including but not limited to the following:

TIN and Attribution

1. How can Acumen ensure that the services being provided are being attributed correctly to the right TIN? As stated above, we still have serious concerns about this issue.

2. Why are wound care practitioners being compared to doctors in the same specialty? Since wound care is not a specialty, how is the measure specialty-adjusted? For a clinician who has a specialty of Family Medicine or Internal Medicine, but practices primarily wound care, how would that clinician be adjusted based on specialty when there isn't a wound care specialty? Comparing by specialty is not fair to those in the wound care space as their costs will be widely different than others in the same specialty and will be unfairly held accountable. We emphasize that the family practitioners, internists, emergency medicine practitioners and preventive medicine practitioners are not simply providing wound care services occasionally within their primary specialty but are actually practicing "wound care" full time. The single exception to the above rule may be podiatry in which wound care services may sometimes be provided within the specialty.

Field Test Participants

1. What clinicians are being chosen to participate in the field study. We are aware of MIPS-eligible clinicians who would have had more than 20 relevant episodes, but who found no Field

Test Report on the QPP website. Can you help us understand why some wound care clinicians would NOT have found a field test report despite having relevant episodes?

2. One of our members that provided all the information for the field study could not run their report. If this happened to one clinician, it is likely that this was the case for many others. While this member has reached out to Acumen, others will not take the time to do so and their information will not be available to review which hampers the ability of Acumen to accurately identify issues with the measure.

DFU Coding

1. Diabetic foot ulcer coding: What will happen when a clinician uses L97422: Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed and follows that ulcer code with an ICD-10 code for diabetes, e.g. E11.621.?

a. Will the ulcer in the scenario above be sub-grouped as “non-specific ulcer type” or “diabetic ulcer type?” Is there’s a way for the measure to be categorized based on trigger/confirming codes as well?

b. How many ICD-10 codes are used to place a non-pressure ulcer into one of the distinct sub-groups?

Cellular and/Tissue Based Products for Skin Wounds (CTPs) or Skin Substitutes and Skin Related Questions

1. The Alliance is deeply concerned that Acumen CTPs and other similar products are part of the Skin Allograft line in the report under DME and Supplies. These products are not DME and should not be listed within that section. It is confusing to clinicians and miscategorized these products. These products are not surgical dressings. Can Acumen please provide an explanation as to why these products were placed in this category and not separately identified?

Risk Scoring

1. We find the information regarding risk scoring unhelpful. How is it calculated? How does it related to HCC, a concept which many physicians do understand? Do physicians have an average of patient risk scores like they have with an HCC score?

More Information or Clarification Needed

1. Expected versus observed costs is a big issue for our members. In the field test, providers were scored on a ratio of observed to expected costs, and only the observed costs were provided in the feedback. Acumen needs to either provide the expected costs in addition to the observed costs, or provide the ratio that applies to each patient or episode. This is the only way clinicians can know which patients/episodes are considered higher-than-expected cost, since there is no way for a practice to know CMS’s expected cost values for any patient/episode. Furthermore, our specific question on this issue - what is Acumen using as the "Expected" costs

for any of the subgroup ulcer types? The Alliance would appreciate more information being provided on this topic to help better understand what are “expected” costs. Acumen compares observed costs to expected costs but where do the expected costs come from? Do they come from any guidelines or care by peers? How does Acumen determine what is the "right cost?"

1. Similarly, we are concerned that correctly implementing the standard of care can actually increase total cost over the one-year time horizon, such as referring a patient for revascularization. Long term, these interventions likely decrease the risk of amputation. However, given the slow progression of vascular disease, early diagnosis may appear to increase costs rather than decrease them. Again, Acumen compares observed costs to expected costs but where do the expected costs come from? Guidelines or care by peers?

2. Conversely, we wonder if there is a way to determine when appropriate care has not been provided. For example, all patients with VLUs should have charges for compression bandaging. Is this something that can be addressed?

3. How can a physician use the report to inform specific actions in order to improve their performance in the cost measure? The report does not provide any “actionable” information. The Alliance recommends that Acumen provide a list of actionable items in the report in an easily identifiable format.

The Alliance would appreciate having a dialogue to discuss these questions/issues as well as a written response from Acumen.

Conclusion

Thank you for the opportunity to provide feedback on the revised Non-Pressure Ulcers episode-based cost measure. We appreciate the hard work that went into the crafting of the latest version of the cost measure for non-pressure ulcers. The Alliance continues to have some concerns with the measure and hope that information provided in our comments is meaningful to help resolve them.

In addition, the APMA, an Alliance member, has submitted its own set of detailed comments. The APMA received more information from its members on the field testing. As such, the Alliance supports and agrees with the issues raised in the APMA comment letter. We urge Acumen to carefully review the comments being provided to them along with the issues of concern. The Alliance is hopeful that the information/feedback provided will help Acumen to refine this cost measure so it is effective and accurate.

Should you have any questions or need any additional information please do not hesitate to contact Marcia Nusgart marcia@woundcarestakeholders.org or our health policy advisor Karen Ravitz karen@woundcarestakeholders.org

Comment Number 16

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
Matt Kerschner, American Academy of Neurology (AAN)

Comment Text:
The American Academy of Neurology (AAN) is the world's largest association of neurologists and neuroscience professionals with 44,000 members and the leading voice on brain health. The AAN's mission is to enhance member career fulfillment and promote brain health for all. A neurologist is a doctor who specializes in diagnosis, care, and treatment of brain, spinal cord, and nervous system diseases. These neurological diseases and disorders affect one in two people in the United States and include Alzheimer's disease, stroke, concussion, epilepsy, Parkinson's disease, multiple sclerosis, peripheral neuropathy, and migraine.

The AAN supports CMS's goal of advancing value-based care. However, for cost accountability to be fair, meaningful, and effective, CMS must ensure that clinicians are provided with transparent, timely, granular, and clinically actionable information. Without these elements, cost-based accountability risks becoming retrospective and punitive rather than a driver of improvement.

The AAN believes that if clinicians are held accountable for costs, they must be able to see the actual cost components attributed to them. Currently, clinicians often lack access to clear, usable cost data, even when cost performance affects quality or payment. Neurologists require visibility into which aspects of care are driving costs and which changes in care delivery would make a meaningful difference.

Trigger Codes/Patient Cohort

The AAN requests clarification regarding the rationale for removing amyotrophic lateral sclerosis (ALS) from this cost measure. In addition, the AAN has identified inconsistencies in the terminology and specifications related to claims inclusion and episode length. While the background materials indicate that patients must be seen within six months, a timeframe that is clinically appropriate for these conditions, the measure specifications elsewhere reference a one-year period. Greater alignment and clarity in these definitions are needed to ensure consistent interpretation and implementation of the measure.

Attribution

Subspecialists, including many neurologists who care for patients with Parkinson's disease and multiple sclerosis (MS), often prescribe therapies that are inherently more expensive due to the complexity and severity of these conditions. Without appropriate context, cost measures may incorrectly suggest that these subspecialists deliver unwarranted or inefficient care. The AAN believes that cost assessments should be balanced with measures of treatment effectiveness and patient quality of life to reflect the clinical value of these therapies and ensure that providers caring for complex neurological populations are not unfairly penalized for delivering appropriate, evidence-based care.

Episode Length

Parkinsonian syndromes and MS are long term conditions in which cost of care varies greatly based on where the patient is in the disease process. The AAN believes that a cost measure such as this requires appropriate accounting of severity of disease state.

Sub-grouping

Parkinsonian syndromes and MS are clinically distinct diseases, and the cost of treatment varies substantially based on the specific condition, disease stage, and severity. Given these significant differences, the AAN questions the clinical relevance and methodological appropriateness of combining Parkinsonian syndromes and MS within a single measure. Furthermore, the absence of a clear clinical or conceptual linkage between these conditions makes it difficult for the AAN to understand the rationale for excluding ALS from this measure.

Service Assignment

The AAN believes that the service categories included in the measure are appropriate and does not have any recommendations for services that should be added or removed.

Exclusions

Patients with MS who require intrathecal baclofen pumps represent a clinically distinct, highly complex population with predictable, non-modifiable costs driven by advanced disability rather than discretionary care decisions. Inclusion of these patients in MS cost measures undermines measure fairness, validity, and interpretability, and may create unintended disincentives for appropriate care. Exclusion from these patients would better align MS cost measures with their intended purpose and support equitable provider accountability.

Quality Alignment

The AAN believes that cost assessments should be balanced with measures of treatment effectiveness and patient quality of life to reflect the clinical value of these therapies and ensure that providers caring for complex neurological populations are not unfairly penalized for delivering appropriate, evidence-based care.

Unintended Consequences

Without regular access to understandable cost data, and clarity on how clinical decisions influence cost outcomes, providers cannot reasonably be expected to manage financial performance embedded within CMS quality programs. The AAN encourages CMS to continue refining its cost measurement and reporting frameworks to better support clinician-led improvement and patient-centered care. Specifically, the AAN believes:

- Cost performance data must be provided during the measurement period, not solely after it concludes. Timely feedback allows clinicians to assess performance trends and adjust

within the same performance year. Retrospective reporting limits the ability to improve and reduces the value of cost-based accountability.

- Data must be sufficiently detailed to support clinical decision-making. CMS should provide cost and utilization data at the TIN-NPI and patient level, along with appropriate risk adjustment and regional benchmarks. This level of granularity is necessary to distinguish patients with true opportunities for improvement from those whose costs reflect clinical complexity.
- While cost measurement is inherently complex, CMS should strive to make cost data clinically actionable. Providers need support identifying specific patients and management options that align with evidence-based care. Advanced analytics and emerging AI tools may help compare individual patient care to guidelines, highlight potential alternatives (e.g., medication or imaging choices), and translate cost data into meaningful changes.

The AAN supports CMS's efforts to advance value-based care, however, meaningful accountability requires that clinicians be equipped with transparent, timely, granular, and actionable information.

On behalf of the AAN, our 44,000 members, and their patients, we greatly appreciate your willingness to gain feedback. Please don't hesitate to contact Matt Kerschner at mkerschner@aan.com with any questions.

Thank you for your consideration.

B2. PFE Survey Verbatim Comments

This section includes the verbatim comments received through the 2026 Person and Family Engagement (PFE) Cost Measures Field Testing survey. 23 survey respondents submitted 26 comments. All respondent names have been redacted for privacy purposes.

Comment Number 17

Date: 1/30/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

My PCP and the imaging center

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Internal medicine and I see him every 3 months

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes. He is very involved in my complex care needs

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes, both the imaging center and my PCP released records with complete information

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes, for breast cancer screening. Some other health care things are more silo'd

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

I would think it would have the possibility of spreading and that could leave me pretty unhappy

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Said there was cancer once, but it was determined that it was not. It was worrisome, but moved very quickly to get a complete answer

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

Side effects of the treatment can sometimes be much harder than what they are treating.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

I just had to go back for a follow-up ultrasound

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes, my doctor can speak in very laymen terms

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

Less than a week

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

n/a

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

n/a

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

n/a

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

n/a

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

I love that the screening center is right next to my doctors office. The screening center sends yearly reminders which is helpful.

[What parts of your care experience could have been improved?]

The front staff isn't always super friendly, but I have noticed that the screening center is working on that.

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Anything negative is a win!

[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

n/a

[Who is part of your care team in treatment and management of non-pressure ulcers?]

n/a

Comment Number 18

Date: 1/30/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Doctor, Nurse Practitioner and other health care staff

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Nurse Practitioner, the primary provider before screening and testing every 3-4 months. After screening and testing and every 1-2 months. Diagnostic radiologist twice.

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes, however had we known that screening and testing should continue past 80. We would have insisted on screening and testing. We was told by my provider that it was not necessary. I believe that my Mother's outcome would have possibly been different.

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

We received clear and helpful information after the screening and test results. We believe that due to age and other health issues that her provider was focusing on, we were not given clear and helpful information that my Mother should and could receive a screening if so desired.

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes, the care team communicated and work together about about my Mother's care. We experienced professionalism and kindness.

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No complications

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

My Mother felt a lump that lead to screening and testing. So, if it was missed that would have caused false relief, sense of security and delayed treatment We were worried, hoping and praying for it to be benign however it was cancer.

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

If screening suggested cancer but cancer was not actually found after follow up test, that would be a relief but raise questions about the screening .

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

It could cause physical toil on the body and emotional turmoil for someone to go through the process of treatment even though it would have caused no harm.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

follow-up tests, biopsy, referral to specialist

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes, she took the time to explain and waited for any questions and we were encouraged to call/email if any further questions.

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

Fist screening was completed in less than a day, follow-up test was done the next morning.

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

Screening/testing/follow-up testing/biopsy/referral/treatment was done at a breast cancer center. The treatment started one week after first screening

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

Follow-up test and biopsy was done in the same day.

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

No barriers. I believe that because everything thing was under one roof including radiologist, pathologist oncologist, pharmacist, nurse case manager, and prior authorization staff, treatment started quickly without difficulty moving forward.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

We did not experience this. I could imagine it would be frustrating and inconvenient.

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Having all services in one center including clergy and social worker. The center was very organized and care focused.

[What parts of your care experience could have been improved?]

Dealing with the insurance company and off campus pharmacy regarding non formulary medication. Medication that were not for cancer took longer even though the cancer treatment side effects were the cause for needing these medications.

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

I believe that there is a need for clearer guidelines regarding breast cancer screening for women over 80. The guidelines are not standardized. This causes confusion for the doctor/patient/caregiver, lead to delayed diagnosis and an elder woman going through treatment for breast cancer who has other health issues is different than an 40-50 year old woman going through cancer treatment with other health issues.

Comment Number 19

Date: 1/30/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

my primary care physician, radiology Technician, Attending and Resident for Radiology for reading

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

I see primary care MD quarterly. the diagnostic radiologist only when screened or rescreened as indicated which is at least once a year. This year an OB/GYN Nurse Practitioner performed a breast exam

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

My primary care MD and the Nurse Practitioner took my care quite seriously. I do not get to see the Radiologists, they are behind the scenes. When I have a questionable positive test and required retesting at a higher level, I supervisor came out and review the tests. My Primary Care called me that night and went through the details and plans forward

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

The initial results by the supervisor were not helpful but she tried. When I asked to speak to radiology she stated they were not available. My primary care MD was the super star. She took the time to explain the results, impact on my health and how we were going to go forward. This was done on the phone, At my quarterly meeting we then discussed results.

[Does your care team communicate and work together about your care? How did this affect your experience?]

My radiology tech who took the tests the second time was outstanding. When I came in for the second round of testing she asked me how I was doing, put the year before test and the previous test I had, She showed me what was different and what they would focus on. Primary care was also great. I know when they originally found something wrong on scanning, the technician that day went immediately to the radiologist to discuss before releasing me.

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

The only problem I have is in the process of placing the breast correctly, I sometimes have skin breakdown

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

I think I am highly sensitive to abnormalities of my breast since this experience. Unfortunately, my experience has not been positive related to getting a MD hands on breast exam. It has been deferred for years with primary care, OB GYN etc. When I got a new OB/GYN this year and asked her, she said absolutely and performed the exam. As a diabetic with peripheral neuropathy, my tips of my fingers are numb and I would not feel a lump unless it was really big

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Since there was no biopsy of the site of concern, this is still a concern that the breast was not read correctly and a cancer could be growing

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

I think once diagnosed with breast cancer or frankly any cancer, your life changes for the rest of your life. You become hypersensitive to any change in your body, your lifestyle changes because sometimes your insurance drops you or charges more and co payments and deductibles can impact your finances. Also it becomes hard to change insurances. No one wants you

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

I received 3 D mammography initially, followed by a higher level Mammography and then ultrasound. A decision to avoid a biopsy was made.

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes by my primary care. The notes in my medical record were not helpful.

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

Originally, they told me it would be 4-6 weeks due being maximally scheduled out. I was put on a wait list and got in in 4 weeks. The longest 4 weeks in my life.

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

I did not have treatment, MDs decided it did not appear to be a cancer.

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

not applicable

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

the barrier was getting the second mammogram and ultrasound. Our institution has 4 separate mammography sites and you can't get in.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

I have never had that experience. We can get copies of our tests sent to other insitutions.

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Manual breast cancer check up by a medical professional needs to be a standard of care annually. If high risk, quarterly or twice a year. Folks who are diagnosed with a positive test should be tested within 2 weeks, delay in testing or biopsy if placing the patient at risk, and ultimately costing the government more money with more intensive treatment

[What parts of your care experience could have been improved?]

Timely initial mammogram. Annual mammograms are usually scheduled 3-4 months out due to lack of equipment and staff.

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Timeliness of testing and clear explanations by MD. If AI is used at any time(which happened to me). I need to be informed what it said and that a second read was done and confirmed by a medical professional.

[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

N/A

[Who is part of your care team in treatment and management of non-pressure ulcers?]

n/a

Comment Number 20

Date: 1/31/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

admin, technologist, rediologist

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

yes - they are thorough

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

onkywhen forther steps were needed, like follow up mammogram

[Does your care team communicate and work together about your care? How did this affect your experience?]

no idea

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

no

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

delays in getting accurate screening, diagnosis, treatment lead to excruciating frustration and anxiety with little help in care rapid, effective care coordiation

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

concerns that something was missed

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

preferable to not knowing and not treating. no way to know if ca would not have caused harm so worry could be ongoing.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

additional screening mammogram

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

yes - with the help of AI

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

not sure

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

na

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

na

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

na

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

na

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

rapid information, explanation, follow up

[What parts of your care experience could have been improved?]

access and speed of results and any follow on care

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

access, accuracy, speed of results and follow on care; inclusion of the care partner.

Comment Number 21

Date: 2/1/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Health system notifications, mamogram tech, radiologist, office staff, PA

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

PA 1 time per visit

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

On this issue it is known I have dense breasts- My PCO are respectful

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

yes- no problems here

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes - though I have had false negatives that can create overuse of radiology testing and my time

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

false negatives

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

Lawsuits, cancer could metastisize, radiologist could lose there job

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

more unneccessary tests

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

up to each individual- though it is up to each person to do their job! Radiologists need to eb trained sometimes I really believe

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

repeat uneeded tesing

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

yes though appointments are not in our portal

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

on site same day one time- one time two years later sttaed they could not do a mamogram as I had not come in for ultrasound even though this was never shown or asked for in my integrated practices in my HMO

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

n/a

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

n/a

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

n/a

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

n/a

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Proimpts in medical record / after visit summaries/ and written reminders (only for breast screenings) with dates when preventive services are due

[What parts of your care experience could have been improved?]

My Patient Portal does NOT LIST UPCOMING SCHEDULDED MAMOGRAMS- they post when the screening is scheduled to be done by - alerts in summaries when mamogram is due and post info

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Effective communication, transparency and living up to HiPAA

[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

N/A

[Who is part of your care team in treatment and management of non-pressure ulcers?]

N/A

Comment Number 22

Date: 2/3/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Mammography Tech and Physician

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Diagnostic Radiologist

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes. Listen to my comments on DES Exposure and took the Educational Pamphlet I provided him in Diethylstilbestrol Exposure

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes. Meeting with the radiologist was very important

[Does your care team communicate and work together about your care? How did this affect your experience?]

Meeting with the radiologist was very important

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

At high risk for breast cancer due to my in-utero DES Exposure so I am always anxious

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Anxiety would be there but worth it is indeed this was a false positive.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

Mammogram and meeting with diagnostic radiologist

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

I only have diagnostic mammograms due to my increased risk due to exposure to Diethylstilbestrol in utero.

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

The diagnostic mammogram.

[What parts of your care experience could have been improved?]

Staff need to be more knowledgeable about Diethylstilbestrol exposure and the anxiety of DES exposed patients. I should not have to write DES Daughter each and every time I go for a mammogram.

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Staff need to be more knowledgeable about Diethylstilbestrol exposure and the anxiety of DES exposed patients. I should not have to write DES Daughter each and every time I go for a mammogram.

Comment Number 23

Date: 2/4/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

It was too long ago to remember.

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

OB/GYN and multiple times over several years

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

I did at the time.

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes, because I had uterine cancer at the same time.

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes they did and it made my experience very effective.

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

Yes

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

I have had to have further testing after each mammogram. I wish they would start out with further testing from the start because I am always worried about breast cancer.

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Over testing happens when a mammogram suggests multiple further tests.

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

I think patients worry about the word cancer and when isn't treated they worry even more. Do you treat the cancer and prevent psychological harm or live with the harmless harm.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

I have had diagnostic mammograms, ultrasounds, CT scans, MRIs, and biopsies multiple times.

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Unfortunately no. I was told it was need to get a diagnosis.

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

Usually weeks to as long as months.

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

NA

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

Several weeks

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

I had to go several hospitals and clinics to receive diagnosis because I live in a rural area. Scheduling is always a problem because you have to wait for them to call you, you can't call them.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

This just happened to me last week. Imagining I had in September, they couldn't find. I had to pull up the information in my portal. They still repeated the tests. I am having second set of biopsies because they never got the results from my October biopsies.

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Most effective is biopsies Less effective is mammograms

[What parts of your care experience could have been improved?]

All of them.

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

I know I am going to end up with a biopsy and that is the outcome that matters to me.

Comment Number 24

Date: 2/5/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:

[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

I only had a mammogram and my results are all clear. There was an X-ray with the X-ray tech. I had to be referred through my primary physician.

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

I would see my obgyn ever two years, my family practice physician every few months due to health follow up.

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

No and because they have informed me that they can only treat the symptoms and if the symptoms are out the scope it gets noted, maybe.

Comment Number 25

Date: 2/11/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Gyn, Radiologist, Breast Cancer Surgeon, Oncologist, Hematologist, other doctors, nurses, medical professionals

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Yearly for screening

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes, they share their knowledge and are very experienced so they seem to be taking things seriously

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

No family members were part of my care

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes, fortunately, they all share the same EMR and can review test results and notes to save from me having to remember dates

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

Not other than positive results and further testing

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

Hopefully would catch on the next breast exam and/or diagnostic test

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Unnecessary worry and stress

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

The treatment is sometimes worse than the diagnosis, depending on both

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

Mammogram, ultrasound, biopsy, referrals, surgery, radiation therapy, follow up visits

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

The mammography and ultrasound team were not very clear and did not provide a lot of answers but the surgeon who performed the biopsy (and ultimately the surgery) was very direct and clear about everything

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

After mammogram showed something positive, the ultrasound was the same day, then a week later was the biopsy

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

Less than a month?

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

Just the unknown and the waiting for the biopsy to come back

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

none

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Biopsy and ultrasound were most effective; felt like the mammogram is not as effective

[What parts of your care experience could have been improved?]

communication in the beginning of the diagnosis

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Rapid results, quick communication, and complete transparency

Comment Number 26

Date: 2/11/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

Sibling

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Internal Medicine, Nurse Practitioner, Neurologist, Physical Therapist, Physician Assistant, Cardiologist)]

Family medicine internal medicine neurologist

[If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle?]

Ms internal medicine and neurologist

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

I'm not sure they have adjusted my sister treatment because of age

[Does your care team coordinate with each other about your care? How does that affect your care?]

I think they do from what I observe

[What complications or side effects have you experienced? Which one(s) required medical care?]

Not sure with medication change it appears possible blood in stool

[What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications?]

Discuss thoroughly possible complications

[Did your care plan change after you experienced these complications?]

It did because frequency of treatment changed

[What is your experience in accessing non-procedural medical care, such as physical therapy, occupational therapy, or mental health care?]

Ok

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

It's sometimes difficult because my sister requires a open MRI

[Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)?]

Transportation sometimes

[Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare?]

Wheel chair might need to be reevaluate

[What were the barriers, if any, to complementary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complementary interventions are services that are usually not a part of standard care and may not be covered by Medicare.]

Transportation

[What treatment outcomes matter most to you and your caregivers?]

Improving in balance and using safer measures

[Have you experienced any difficulty obtaining medications? If so, why?]

New MS infusion

[Do you have any concerns about adhering to your medication dosage or frequency?]

Not a present

[How do you and your care team decide which medications you should take?]

Discussed with my sibling who is receiving care

[Which clinician(s) oversee(s) your medications?]

MS neurologist and internal medicine physician

[Have you experienced any side effects from your medications? If so, did any require medical care?]

Not sure

[Have you experienced any difficulty being referred to additional clinicians? If so, why?]

No

[During times when navigating care, coverage, or services was particularly challenging, would having a care navigator or similar support have been helpful? Why or why not?]

I think so

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

Regular MsS treatment

[What aspects of your care experience could have been improved?]

Change of amount of treatment

[How is your current treatment affecting your current lifestyle?]

To early to tell just change

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Somewhat

[What treatment outcomes matter most to you and your caregivers?]

Better balance and safer environment

Comment Number 27

Date: 2/11/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

PCP, screening clinic

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Every 3 months

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes. He is very engaged with my health

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes, from PCP and clinic

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

That I could progress and actually get into your bones

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Biopsies that didn't need to be performed

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes

[What parts of your care experience could have been improved?]

None

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Negative everything

Comment Number 28

Date: 2/11/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

N/A

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

N/A

[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

PCP, Neurologist, Physical Therapist, Massage Therapist, Neuropsychologist

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Internal Medicine, Nurse Practitioner, Neurologist, Physical Therapist, Physician Assistant, Cardiologist)]

Family Practice every four months, Neurologist twice a year. Physical therapist 4-6 visits 1-2x/year

[If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle?]

Massage therapy and PT. I spend about $3000 out of pocket annually for massage 1-2x/month but should be seeing them weekly

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Absolutely they take me seriously.

[Does your care team coordinate with each other about your care? How does that affect your care?]

Not really. The massage therapist communicates with the PT but it is not reciprocal. Neither MD communicates with the other.

[What complications or side effects have you experienced? Which one(s) required medical care?]

hypogammaglobulinemia from MS med that was picked up by PCP who did not respond to labs in portal and needed three phone calls over the course of a month from me to address the issue.

[What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications?]

Communicate

[Did your care plan change after you experienced these complications?]

Yes. Labs were added on a schedule and I became more focused on communicating with both physicians via the patient portal. I also initiated stopping IVIg at $25, 000/month when labs came back into normal range. I initiated stopping DMT and switching due to lab shift and starting another DMT even though it meant out of pocket expenses to do so.

[What is your experience in accessing non-procedural medical care, such as physical therapy, occupational therapy, or mental health care?]

Often has extended wait times for appointment. PT can take 1-2 months to access. Mental health care can take 4-6 weeks.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

While an inpatient, I have had copious redundant labs and imaging done despite having recently had them done from Provider's office. They were not able to access results. They also were unable (seemingly) to access prior tests done in their facility in the prior 5 years so repeated MRI, CT scan, Ultrasound and X Rays when recent results could have been accessed had they tried.

[Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)?]

I have had in the past but not in the most recent 5 year period.

[Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare?]

N/A

[What were the barriers, if any, to complementary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complementary interventions are services that are usually not a part of standard care and may not be covered by Medicare.]

Out of pocket costs for necessary intervals to obtain relief. Medicare only covers a teaching visit for diabetics to Nutritional support and does not cover anti-inflammatory dietary practices needed to reduce central nervous system inflammation causing increased symptoms and prolonged slide into disability. Medication costs have the potential to be reduced (symptom management) if you provided the basic nutritional support and education. Physical therapy should not have a cap, nor should Chiropractic for MS patients (if those modalities are helpful to the individual) but they do. I have to purchase TENS UNIT and Massage Gun to treat areas I have trouble reaching because of limits to visits to PT and cost of massage therapy.

[What treatment outcomes matter most to you and your caregivers?]

Pain reduction and restorative sleep. When you are "almost there" in getting relief, the visits stop because of Medicare guidelines regarding goals met or unmet. Then the pain syndrome ramps back up and we have to start a whole new treatment cycle. It is a seasaw that makes functioning difficult, increases discomfort, decreases quality sleep and so much more. The patient and the therapist need to be making those decisions and not a clerk in an office who does not feel the pain or experience the spasticity that makes walking more difficult and falls more likely.

[Have you experienced any difficulty obtaining medications? If so, why?]

Yes. The copays are too high for self administered disease modifying therapies. Prior to the 2024 cap on out of pocket copays being instituted, the copays for MS Disease modifying therapies that were oral or injectable were around $2000 to $3000/month so we were relegated to getting more costly ($40K to $80K) every 6 months which then triggered, in some of us, complications that necessitated IVIg at $25K/month. These higher cost infusible therapies are covered by Medicare but you could save $ by covering the cost of self administered medications with a lower side effect profile if a patient was well managed on them prior to being covered by Medicare.

[Do you have any concerns about adhering to your medication dosage or frequency?]

Not any more.

[How do you and your care team decide which medications you should take?]

Yes, but within the limitations set by Medicare and that limits "best options" in many cases.

[Which clinician(s) oversee(s) your medications?]

I am the primary overseer and both PCP and Neurologist have input at the visits with me.

[Have you experienced any side effects from your medications? If so, did any require medical care?]

Yes. Hypogammaglogulinemia which resulted in several COVID infections despite masking and vaccines. It also resulted in colitis and UTIs. That would not have happened had Medicare paid for a lower efficacy med without a $$2700/month out of pocket cost for me. I have now had nearly 3 years of treatment with IVIG at $25, 000 per month and 2 years of Pemgarda infuisions at $37, 000/ quarter because you do not cover the lower or medium efficacy disease modifying therapies without huge out of pocket costs.

[Have you experienced any difficulty being referred to additional clinicians? If so, why?]

No

[During times when navigating care, coverage, or services was particularly challenging, would having a care navigator or similar support have been helpful? Why or why not?]

Not for me personally since that was one of my responsibility for others throughout much of my nursing career but so many people just cannot navigate this....especially when they do not feel well. There are times, in the past, when I have asked for a navigator's help and ended up with people who clearly were following a script that denied rather than facilitated care to keep costs down. These people were clearly not from a medical background and did not have a working knowledge of the condition they were there to navigate me through.

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

Physical therapy and massage therapy are the most valuable and Physiatry was the least valuable. As a rule, I find the referrals to specialists to not be helpful.

[What aspects of your care experience could have been improved?]

At the moment, we are in a good and stable place in the management of my MS and all of the other comorbidities.

[How is your current treatment affecting your current lifestyle?]

I am able to manage my husband's plan of care (early Alzheimer's) and my MS and other conditions and still be able to meet social, community and professional responsibilities with a work load of 20-25 hours/week.

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Yes

[What treatment outcomes matter most to you and your caregivers?]

Functionality without moderate to severe pain. Restorative sleep. Fall risk minimized.

[Who is part of your care team in treatment and management of non-pressure ulcers?]

N/A

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Podiatrist, Internal Medicine, Physician Assistant, Vascular Surgeon, General Surgeon)]

N/A

Comment Number 29

Date: 2/11/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

doctor, imaging technician

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

ob/gyn, 1x/yr

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

yes

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

yes. I always receive a written letter with results, and received a phone call to let me know I had breast cancer. Communication was clear and helpful.

[Does your care team communicate and work together about your care? How did this affect your experience?]

As far as I can tell, yes.

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

Years ago I was on the table getting ready for an ultrasound guided breast biopsy. The doc said lets just keep an eye on the spot instead. 10 years later it was breast cancer.

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

Cancer eventually is diagnosed at a latter stage, with more treatment required.

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Undue worry.

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

?

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

ultrasound, biopsy, surgery, radiation. referral to other providers.

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

All of my providers were very comprehensive in their explanations, and I was able to understand.

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

two weeks

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

three weeks until diagnosis, surgery 4 weeks later

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

I suppose lack of providers impacted how soon I was able to receive diagnosis and treatment.

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Expert professionals (MDs, RNs, imaging) are the most effective component.

[What parts of your care experience could have been improved?]

I wish that the biopsy had been done years ago, before the cancer had spread.

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Correct diagnosis.

Comment Number 30

Date: 2/11/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

Myself, my Husband, Neurologist, Physical Therapist

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Internal Medicine, Nurse Practitioner, Neurologist, Physical Therapist, Physician Assistant, Cardiologist)]

Neurologist--annually and as needed.
PT-As needed based on symptoms, approximately annually for the last 5 years.

[If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle?]

Physical Therapy, possible in-home ADL support. I am already in a progressive care community in anticipation of increasing needs as my husband and I age.

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes--But as my disease has progressed very slowly over the last 40 years, the approach has been more conservative.

[Does your care team coordinate with each other about your care? How does that affect your care?]

I have multiple medical conditions and regularly seek out consults with each appropriate medical provider to assure everyone is in agreement with a change to the plan of care. I, however initiate these collaborations, not individual providers or clinical services.

[What complications or side effects have you experienced? Which one(s) required medical care?]

Chronic ringing of the ears, paresthesias, generalized muscle weakness, especially to one leg requiring therapy and more recently bracing and use of a cane or walker for stability

[What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications?]

Nothing. I feel very fortunate to have had so many (40) years of relative health with my MS. I will continue to work with my care team to maintain/improve the quality of my life.

[Did your care plan change after you experienced these complications?]

Minimally, it's a complex situation at this point in my disease progression involving multiple clinical disciplines and clinical conditions.

[What is your experience in accessing non-procedural medical care, such as physical therapy, occupational therapy, or mental health care?]

Good. Available on site at my current living facility as well as nearby health facilities.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

I focus the majority of my care with 1-2 healthcare sites. Both have access through shared electronic medical records.

[Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)?]

I have not needed/receive acute care services for MS. I've been very fortunate.

[Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare?]

So far, it's not been a problem. I've only used the services minimally for MS concerns.

[What were the barriers, if any, to complementary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complementary interventions are services that are usually not a part of standard care and may not be covered by Medicare.]

I have paid out of pocket for over 30 years to receive regular massage therapy for MS-related muscle spasm, etc. It's expensive, but the benefits are worth the cost and we choose to pay. Would absolutely endorse Medicare-approved financial support for this service. I do not use/need chiropractic or nutritional services at this time

[What treatment outcomes matter most to you and your caregivers?]

QUALITY OF LIFE. I'm willing to put in the work (PT), shoulder the expense as needed, negotiate clinical services, modify my lifestyle, navigate complex rules and any other barriers if I get that result.

[Have you experienced any difficulty obtaining medications? If so, why?]

No, but due to my specific situation, I have not needed/do not qualify medically for MS-influencing drugs.

[Do you have any concerns about adhering to your medication dosage or frequency?]

As above.

[How do you and your care team decide which medications you should take?]

Based on my overall health situation. I have a medical condition that, for all intents and purposes, precludes me from using the "typical" MS-moderating drugs. Thankfully, my MS is relatively stable over time. Should that change, I may be facing a rather difficult treatment dilemma.

[Which clinician(s) oversee(s) your medications?]

Primary decisions for MS treatment plan is through my neurologist. Other clinical specialties manage my other long-term health concerns.

[Have you experienced any side effects from your medications? If so, did any require medical care?]

N/A for MS drugs

[Have you experienced any difficulty being referred to additional clinicians? If so, why?]

No

[During times when navigating care, coverage, or services was particularly challenging, would having a care navigator or similar support have been helpful? Why or why not?]

Haven't had that experience.

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

PT given the relatively benign nature of my MS course.

[What aspects of your care experience could have been improved?]

No issues

[How is your current treatment affecting your current lifestyle?]

I/my neurologist are handling issues as they arise. Currently things are relatively stable.

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Yes

[What treatment outcomes matter most to you and your caregivers?]

Increasing (or at least maintaining) quality of daily life.

Comment Number 31

Date: 2/12/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Registration, mammography tech, Mammogram Radiologist

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

See the Radiologist at the time of my diagnostic mammogram

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

All unaware of my high risk of breast cancer due to my in utero exposure to Diethylstilbestrol (DES)

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes. Radiologist was great to visit with and was pleased to receive the DES Pamphlet

[Does your care team communicate and work together about your care? How did this affect your experience?]

Hard to tell

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

A missed cancer, would expect a recall for more in depth screening

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Delay in diagnosis and delay in treatment which would then be considered a Sentinel Event

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

It would have caused harm

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

Diagnostic mammogram is the only test

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

N/A

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

N/A

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

N/A

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

N/A

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

N/A

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Lack of knowledge on the high risk of DES Exposure

[What parts of your care experience could have been improved?]

Increase knowledge and appropriate coding of my DES Exposure

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

That they are knowledgeable about my high risk of breast cancer due to DES Exposure

Comment Number 32

Date: 2/13/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

DNurse oract

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

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[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

NA

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

8 NLR 3

[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

Primarily family practice 4-5 mons, Movement Specialist 3-6 mons, opthomologist 6 mons-one year

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Internal Medicine, Nurse Practitioner, Neurologist, Physical Therapist, Physician Assistant, Cardiologist)]

PT bi-wkly, endocrinologist yearly

[If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle?]

Prescribing medication for health and mental health issues, podiatrist, transportation to doctors, pt and exercise classes

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes, before visiting clinicians I document issues I have and bring any documentation needed to explain my needs

[Does your care team coordinate with each other about your care? How does that affect your care?]

Fortunately the doctors have access to my files online with notes from staff/doctors and I come prepared with questions and answers to my needs

[What complications or side effects have you experienced? Which one(s) required medical care?]

I had an upper respiratory infection went to an ER clinic and my first case of sciatica went to ER hospital with USC

[What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications?]

It would have been helpful for the doctor's staff contact me for an update. The first medication for upper respiratory was primarily over counter and I needed to return to clinic two weeks later for more medication for respiratory.

[Did your care plan change after you experienced these complications?]

I shared my up-to-datie medical problems and needs to my family in case I couldn't speak for myself

[What is your experience in accessing non-procedural medical care, such as physical therapy, occupational therapy, or mental health care?]

PT has been a bit difficult as they may not have openings but it is also a burden if I have to submit billing for this therapy. Much easier to pay a co-pay and not to have to produce bill/ledger

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

No, I have not had that problem.

[Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)?]

I try to know which clinics and/or services have access to my provider. It is difficult, when you are ill to remember specific information that is in my patient file. I have printed out some info and carry with me for verification of illness.

[Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare?]

I find that others or older patients have not thought about DME and are not aware of the different models of walkers, etc. It would be helpful to be able to go to a room where you can find the different items. My insurance co. Aetna appears not to provide much help or advice until the doctor has prescribed an Rx. Waiting until the last min re what equipment is needed and provided by insurance; should be common information for patient. But, insurance won't even give out information to patient (who wants to prepare) for equipment. wouldn't hurt for insurance co to have a site where patient can see recommended DME.

[What were the barriers, if any, to complementary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complementary interventions are services that are usually not a part of standard care and may not be covered by Medicare.]

Have not encountered these interventions. But I must say I try to think ahead of needing thsei interventions because I don't feel confident that insurance company will inform me of this practice.

[What treatment outcomes matter most to you and your caregivers?]

Pt is important and so far I have been able to drive to facility. many of my friends do not drive or can drive during treatment available. Transportation to and from is so important and determines if any help will be offered

[Have you experienced any difficulty obtaining medications? If so, why?]

No problems but when I called insurance company to find out cost of medication orthopedic is suggesting I can not get information from Aetna. Its cost will determine if I will agree to meds. I was told the dr must approve before I inquire.Patient should have access to that information anytime so we can dec discidei if we want or have the funds to purchase meds. I believe my med may be needed daily or weekly and will be in hundred of dollars. Most seniors are unaware of Rx cap and may not take meds for lack of funds.Info should be readily available.

[Do you have any concerns about adhering to your medication dosage or frequency?]

Just today tried to get info re meds for osteoporosis from Aetna. Staff nice but I can get any info until it is required by doctor then Aetna will access information. This procedure may stop someone from the meds without knowing all the information on expense.

[How do you and your care team decide which medications you should take?]

My daughter and sister know my finances and we discuss my needs

[Which clinician(s) oversee(s) your medications?]

Family doctor

[Have you experienced any side effects from your medications? If so, did any require medical care?]

no problems

[Have you experienced any difficulty being referred to additional clinicians? If so, why?]

No other than PT I pay for my gym out of pocket as Aetna no longer oncludes

[During times when navigating care, coverage, or services was particularly challenging, would having a care navigator or similar support have been helpful? Why or why not?]

I try to keep information to assist me when necessary and I share info with others. I learn from what others have come across in their needs.

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

PT is helpful when body aches

[What aspects of your care experience could have been improved?]

it would be helpful to be able to go to a room with resources to look what is available.Would have a resource person available to help explain info.Would also be helpful to have access to computer to view videos with help from attendant. As we get older computers/software and cell phones are more difficult with less help for us. Workshops like AARP had to help senior understand cell phones and videos

[How is your current treatment affecting your current lifestyle?]

Very good. My Movement Specialist reminds me what symptoms to be concerned and asks me to keep in tying when needed

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Would be helpful for all medical institutions have list of support programs. I found a Parkinson gym twice a week and have a Hawaiian dance class that I enjoyed before Parkinson. I wake up and stay in touch with friends.

[What treatment outcomes matter most to you and your caregivers?]

Ability to walk and care for myself.

Comment Number 33

Date: 2/15/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who is part of your care team in treatment and management of non-pressure ulcers?]

Northwestern Medicine - Internal Medicine, Vascular Surgeon, Neurologist

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Podiatrist, Internal Medicine, Physician Assistant, Vascular Surgeon, General Surgeon)]

Internal Medicine: Every 3 months; Neurologist: Every 6 months; Vascular Surgeon: As Needed

[How long did your care team provide ulcer-related treatment for (i.e., how long did it take your ulcer to heal)?]

1 year

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes, my symptoms have decreased over time.

[Do you feel your family/caregivers receive appropriate and comprehensive education to aid wound care? Why or why not?]

Yes, my family members helped me heal post-surgery and provided transportation to my care team.

[Does your care team coordinate with each other about your care? How does that affect your care?]

Yes, they are all part of the EPIC system and receive the same reports.

[What complications or side effects have you experienced? Which one(s) required medical care?]

Right leg/feet required more care because my neuropathy and vein vascular issues had more damage compared to the left.

[What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications?]

Initially, I needed better diabetes management. It wouldn't have progressed as quick as it did.

[Did your care plan change after you experienced these complications?]

Yes, first I controlled my diabetes and then had Laser Varicose Vein Surgery.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

No, I was in one healthcare system and it was around the same location.

[Please share any information about the impact of preventive care or follow-ups after wound closure. Has it had an impact on wound recurrence?]

No, I haven't had any further complications as of now.

[If applicable, what durable medical equipment (DME) (e.g., orthotic footwear, bandages, wheelchairs) do you think was the most helpful to improve or maintain your current lifestyle?]

Yes, I had follow-up appointments and was provided with compression socks, medication, and other tools to manage.

[If you've experienced wound care at a wound care clinic facility and at home, what was the difference in care for these settings (e.g., the type of care provided, the quality of care, the resources provided)?]

No, I received treatment only at [redacted].

[If applicable, what was your experience like receiving home health?]

N/A

[Do you have any concerns regarding the frequency of home dressing care provided by any caregivers? If so, what are they?]

N/A

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

Most effective treatment/service was having a team in one area and a radiologist technician showing scans to me and outlining problem veins/where surgery will be conducted.

[What aspects of your care experience could have been improved?]

Having to purchase compression socks on my own due to not being covered by Medicaid. Would have been better to be provided the tool by the facility conducting the surgery.

[How is your current treatment affecting your current lifestyle?]

I'm able to walk better on my feet and I'm now able to manage my pain/diabetes.

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Yes, I receive support through behavior counseling at [redacted].

[What treatment outcomes matter most to you and your caregivers?]

Being able to stay active in my children's lives and take more care of myself by moving.

Comment Number 34

Date: 2/18/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

[Redacted]

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

[Redacted] family clinic 2 times a month

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes, the experience been great

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

It could spread

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

More testing could be done

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

Other side effects

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

Follow up tests

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes, she was very nice and informative about my test

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

About 2 weeks

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

2 weeks

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

No biopsy was done

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

No

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

No

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Diagnosis

[What parts of your care experience could have been improved?]

Treatment

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Treatment

[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

No one

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Internal Medicine, Nurse Practitioner, Neurologist, Physical Therapist, Physician Assistant, Cardiologist)]

[Redacted] family clinic

[If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle?]

Physical therapy

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes

[Does your care team coordinate with each other about your care? How does that affect your care?]

None

[What complications or side effects have you experienced? Which one(s) required medical care?]

None

[What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications?]

None

[Did your care plan change after you experienced these complications?]

No

[What is your experience in accessing non-procedural medical care, such as physical therapy, occupational therapy, or mental health care?]

Physical therapy and occupational therapy

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

No

[Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)?]

No

[Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare?]

No

[What were the barriers, if any, to complementary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complementary interventions are services that are usually not a part of standard care and may not be covered by Medicare.]

Physical therapy

[What treatment outcomes matter most to you and your caregivers?]

Walking correctly again

[Have you experienced any difficulty obtaining medications? If so, why?]

No

[Do you have any concerns about adhering to your medication dosage or frequency?]

No

[How do you and your care team decide which medications you should take?]

Talking about my medicine and medical issues

[Which clinician(s) oversee(s) your medications?]

[Redacted] family clinic

[Have you experienced any side effects from your medications? If so, did any require medical care?]

No

[Have you experienced any difficulty being referred to additional clinicians? If so, why?]

No

[During times when navigating care, coverage, or services was particularly challenging, would having a care navigator or similar support have been helpful? Why or why not?]

Yes because I could call her anytime

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

Physical therapy help and occupational therapy didn't

[What aspects of your care experience could have been improved?]

Occupational therapy

[How is your current treatment affecting your current lifestyle?]

A lot

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

No

[What treatment outcomes matter most to you and your caregivers?]

My medication

Comment Number 35

Date: 2/18/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Doctors, nurses and X-ray technicians

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Every 6 months to 1 year

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Only about half of them that related to me and my case.

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes 50 percent of the time; staff was busy or unconcern about follow up conversations and appointments.

[Does your care team communicate and work together about your care? How did this affect your experience?]

No they do not work together as they should and could. This makes my complex health matters challenging.

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No but I would always have to reach out to the staff to get my results or check my EMR.

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

I think at 55 years old with no living parents or grandparents and and all 11 aunts and uncles dead; I could be too . Therefore, it is vital I know what is happening to my body.

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

I would live a good life quality of life and enjoy it and be thankful.

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

I would be relieved.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

Yearly mammograms and physical examinations of breast tissue.

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes it was in laymen's terms.

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

2-3 weeks

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

Did not have to start treatment; no cancer diagnosis.

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

Did not require a biopsy

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

Distance to the comprehensive care center is 1 hour and 45 minutes.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

This has happened before so now I go to a comprehensive healthcare center MUSC that does most of my care even though it is 1 hour 45 minutes.

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Mammogram I feel; physical breast examine by drs.

[What parts of your care experience could have been improved?]

Screening preparation

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Correct, compassionate and whole-person centered care even though my breast are the main areas cared for at the time.

[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

N/A

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Internal Medicine, Nurse Practitioner, Neurologist, Physical Therapist, Physician Assistant, Cardiologist)]

N/A

[If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle?]

Comprehensive and effective healthcare team

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Sometimes and other times they are overwhelmed with their own competing interests.

[Does your care team coordinate with each other about your care? How does that affect your care?]

Not as frequently as I would like them too but getting better.

[What complications or side effects have you experienced? Which one(s) required medical care?]

A medication that caused me GI trouble and Acute kidney injury years ago.

[What do you feel your care team could have done (if anything) to help avoid or reduce the severity of these complications?]

Improved communication between family doctor, internal medicine doctor, GI specialist and nephrologist.

[Did your care plan change after you experienced these complications?]

Yes it did and I changed hospital systems.

[What is your experience in accessing non-procedural medical care, such as physical therapy, occupational therapy, or mental health care?]

It has been good.

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

Yes I did not like having to repeat services or care I knew I had. It is time consuming and wasteful of many resources.

[Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)?]

Normally have extensive travel .

[Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare?]

No

[What were the barriers, if any, to complementary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complementary interventions are services that are usually not a part of standard care and may not be covered by Medicare.]

Home health needs in rural South Carolina.

[What treatment outcomes matter most to you and your caregivers?]

Having the best quality of life possible with 2 rare diseases and 3 chronic illnesses.

[Have you experienced any difficulty obtaining medications? If so, why?]

No.

[Do you have any concerns about adhering to your medication dosage or frequency?]

No

[How do you and your care team decide which medications you should take?]

EMR communication

[Which clinician(s) oversee(s) your medications?]

Pharm D

[Have you experienced any side effects from your medications? If so, did any require medical care?]

Yes, Acute Kidney Injury and significant GI upset

[Have you experienced any difficulty being referred to additional clinicians? If so, why?]

No

[During times when navigating care, coverage, or services was particularly challenging, would having a care navigator or similar support have been helpful? Why or why not?]

Yes care navigating would make so many processes easier!

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

Surgery, medication, good nutrition and tolerated exercise.

[What aspects of your care experience could have been improved?]

Whole- person centered care

[How is your current treatment affecting your current lifestyle?]

Helping me maintain it.

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Yes

[What treatment outcomes matter most to you and your caregivers?]

To be functional as possible with all my complicated health needs.

Comment Number 36

Date: 2/18/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Nurses

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

They are taking my concerns seriously

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

We got helpful information

[Does your care team communicate and work together about your care? How did this affect your experience?]

They worked together as a team, it was satisfactory i must say

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

No worries

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

Treatments and follow up test

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes, it was easy to understand

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

Not at all

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

None i think

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Finding out what the problem is and getting the right treatments

Comment Number 37

Date: 2/18/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Health care staff

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Gyn office routine yearly visits

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Not as much as I am

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

N/a

[Does your care team communicate and work together about your care? How did this affect your experience?]

All providers seemed disconnected and slid while placing the burden on me to insure providers were updated and included in care plan

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

Where I was differently diagnosed with dense breast, I am no longer in this monitoring screening because morning was noted in my must recent screening after over a decade.

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

Screened and followed, chipped and monitored for dense breast and family history, I'm no longer a candidate.

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

Not knowing why there's a difference in results

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

N/a

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

In the past, biopsy and chip. Currently only routine mammogram

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

Quickly

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

Person centered care, consistent information across providers and congruent proactive reatment plan

[What parts of your care experience could have been improved?]

Consistent messaging across providers, without having to piece mail it all and with patient portals that don't communicate and sync.

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Consistent messaging for provider team, patient and family.

Comment Number 38

Date: 2/25/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Doc [redacted]

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Family Practice

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes!

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes

[Does your care team communicate and work together about your care? How did this affect your experience?]

Yes

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

Not any physical at all. However I did have to repeat scan but it was out of caution and I appreciate that

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

I feel it’s perfectly acceptable considering the alternative

[What problems or worries do you think could happen — or did happen — if breast cancer was found and treated even though it would not have caused harm?]

Not sure

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

I had to have a follow up

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes every reasoning and step

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

Within 2 weeks I believe?

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

No wait AT ALL! Wonderful

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

None

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

I've had thesdd reds exams for years.. from a mobile trailer to a hospital however my experience that I was not looking forward to completely change my view. I was in and out for both exams! Barely sat 5 min both times

Comment Number 39

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes, my sister received and I received clear and helpful information during her care. My brother situation was too late; however, his provider was helpful with suggestions.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

my sister receives great care and she was referred to a specialist for reconstruction surgery.

[What treatment outcomes matter most to you and your caregivers?]

Understanding and taking into consideration the patient's desire.

Comment Number 40

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

All of the above were involved in my sister and brother's care.

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes. however, my brother cancer was at a stage that only the cancer team was involved.

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes

[Does your care team communicate and work together about your care? How did this affect your experience?]

The team still care for my sister.

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

None.

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

My brother cancer was not detected by healthcare providers.

[What problems or worries do you think could happen — or did happen — if a screening mammogram suggested cancer but cancer was not actually found after follow-up tests?]

For my sister, her cause probably would have been more serious.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

She is receiving all of the above on a yearly basis.

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

yes.

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

n/a

[If applicable, how long did you wait between your first screening mammogram and being diagnosed with breast cancer or starting treatment?]

n/a

[If applicable, how long did you wait between your first diagnostic follow-up test and having a biopsy?]

n/a

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

n/a

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

No. She received and moved forward within a month for the next process as she had to consider the care for her husband.

[What services are the most effective in your breast cancer screening and diagnosis? Which of these were least effective?]

n/a

[What parts of your care experience could have been improved?]

n/a

[What outcomes matter most to you and your caregivers when undergoing screening for breast cancer?]

Early diagnosis.

Comment Number 41

Date: 2/27/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who is part of your care team in treating and managing a parkinsonism syndrome or MS?]

Neurologist, Internal Medicine, Physical Therapist

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Internal Medicine, Nurse Practitioner, Neurologist, Physical Therapist, Physician Assistant, Cardiologist)]

Neurologist-6 months, Internal Medicine-4 months, Physical Therapist-every week

[If your needs increase over time, what services do you believe will be most useful to help maintain your lifestyle?]

Physical Therapist

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes, I have improved in some of my symptoms

[Does your care team coordinate with each other about your care? How does that affect your care?]

Not always. No impact as of yet

[What complications or side effects have you experienced? Which one(s) required medical care?]

overactive bladder

[Did your care plan change after you experienced these complications?]

yes, scheduled physical therapy sessions

[What is your experience in accessing non-procedural medical care, such as physical therapy, occupational therapy, or mental health care?]

i need referral which has been approved

[Can you speak to your experience or perspective on redundant services, such as getting an imaging or lab work service elsewhere because a facility cannot access the previous one?]

No experience

[Do you have any barriers to accessing chronic outpatient care after receiving acute care services (inpatient and urgent care)?]

None

[Do you have any concerns about your current Durable Medical Equipment (DME) (e.g., wheelchairs, oxygen supplies, hospital beds, ventilators, and walkers) covered by Medicare?]

not applicable- no DME needed

[What were the barriers, if any, to complementary interventions (e.g., massage therapy, chiropractic care, nutritional support)? Complementary interventions are services that are usually not a part of standard care and may not be covered by Medicare.]

None

[What treatment outcomes matter most to you and your caregivers?]

Eliminating the symptoms or reducing the severity

[Have you experienced any difficulty obtaining medications? If so, why?]

None

[Do you have any concerns about adhering to your medication dosage or frequency?]

None

[How do you and your care team decide which medications you should take?]

The neurologist makes a recommendation and patient makes final decision.

[Which clinician(s) oversee(s) your medications?]

Internal Medicine and neurologist

[Have you experienced any side effects from your medications? If so, did any require medical care?]

None

[Have you experienced any difficulty being referred to additional clinicians? If so, why?]

None

[During times when navigating care, coverage, or services was particularly challenging, would having a care navigator or similar support have been helpful? Why or why not?]

Yes, patient had difficulty securing appointment with previous MS specialist as patient had to supply proof of MS diagnosis

[What treatment or services are the most effective in helping you feel better? Which of these were least effective?]

Most effective-customized Physical Therapist, Least effective-general dietician

[What aspects of your care experience could have been improved?]

Physical therapy and mental health sessions early on at the onset of the MS diagnosis.

[How is your current treatment affecting your current lifestyle?]

None

[Do you feel supported in other aspects outside of physical care (e.g., behavioral, community, employment support, etc.)?]

Yes

[What treatment outcomes matter most to you and your caregivers?]

Preventative and follow up check ups

Comment Number 42

Date: 3/1/2026

Submitter Name, Credentials, and Organization:
[Redacted]

Comment Text:
[Who was part of your care team during breast cancer screening and testing? This may include doctors, nurses, or other health care staff.]

Nurse

[If the following types of clinicians were part of your care team, when and how often would you see them? (Family Practice, Nurse Practitioner, Diagnostic Radiologist, OB/GYNs, Internal Medicine, Physician Assistant)]

Internal medicine

[Do you feel like your clinicians are taking your concerns seriously? Why or why not?]

Yes, I actively participate in my health care

[Did you and your family or caregivers get clear and helpful information about breast cancer screening, test results, and what to do next? Why or why not?]

Yes

[Does your care team communicate and work together about your care? How did this affect your experience?]

No. Oftentimes, they forward the results to your primary care physician.

[Have you experienced any complications in your screening or diagnostic process for breast cancer?]

No

[What problems or worries do you think could happen — or did happen — if a screening mammogram missed cancer (i.e., said everything was normal when cancer was actually present)?]

I would be upset.

[What types of services did you receive during the breast cancer screening process and diagnostic process? This may include follow-up tests, biopsies, or treatments, including referrals to other providers.]

None

[Were your test results, diagnosis, and care explained in a way that was easy to understand? Please explain.]

Yes

[How long did you wait between your first screening mammogram and your first follow-up test (such as a diagnostic mammogram, ultrasound, MRI, or CT scan)?]

Two months

[Did anything make it hard for you to get a diagnosis or move forward with care? If so, how did these barriers impact how long it took to receive your diagnosis, and if needed, treatment?]

No

[Can you speak to your experience or perspective on redundant services, such as getting an imaging service elsewhere because a facility cannot access the previous one?]

Service delivery provided by the clinician.

[What parts of your care experience could have been improved?]

More information about follow-up and care.