
# 2025 Public Comment Summary Report for the Development of Cost and Value Measures

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# 1 OVERVIEW

## 1.1 Project Title

Physician Cost Measures and Patient Relationship Codes (PCMP): Call for Public Comment for Cost and Value Measure Development.

## 1.2 Dates

The Call for Public Comment ran from January 3, 2025 to January 24, 2025.

## 1.3 Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, to develop episode-based cost measures (EBCMs) and value measures for potential use in the Merit-based Incentive Payment System (MIPS) to meet the requirements for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This work is under the contract "Physician Cost Measures and Patient Relationship Codes" (Contract Number 75FCMC18D0015, Task Order 75FCMC24F0142).

CMS developed cost measures in cycles or "Waves" from 2017-2024 (Waves 1-6). Currently, the MIPS cost performance category has 35 measures for the 2025 performance period: 2 population-based or global cost measures and 33 EBCMs for a range of procedures, acute inpatient medical conditions, and chronic conditions. Additionally, 3 cost measures underwent Pre-Rulemaking Measure Review (PRMR) for potential future use in MIPS. The final PRMR recommendations for these measures can be found on the Partnership for Quality Measurement site.[1] CMS plans to continue development of measures, starting with Wave 7 development in Summer 2025. For more information about prior Waves of development, as well as the measure development process, please refer to the 2025 Summary of Cost Measures.[2]

As part of its measure development process, Acumen gathers input from interested parties and experts to identify clinical topics for prioritization and define the scope of candidate measure concepts. Acumen held a technical expert panel (TEP) on December 18, 2024, to discuss the development of new EBCMs and value measures. A summary of this discussion will be available on the CMS Quality Payment Program Cost Measures page.[3] This Call for Public Comment solicited further input by inviting interested parties to submit comments on which EBCMs and value measures to develop for future measure development.

[1] PRMR 2024 Final Recommendations, https://p4qm.org/media/3891
[2] 2025 Summary of Cost Measures, https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3129/2025-mips-summary-cost-measures.pdf
[3] About cost measures & development process, https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/about

## 1.4 Information about the Comments Received

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

- Posted a Call for Public Comment on the CMS Measures Management System (MMS) Current Public Comment Opportunities webpage.
- Sent multiple email notifications to Acumen contacts, such as previous participants in measure development and specialty society contacts.
- Sent multiple email notifications to the MMS listservs.

We received 3 letters and 10 completed surveys from 5 organizations and 5 individuals. The verbatim text of each submitted comment is presented in Appendix A: Public Comment Verbatim Report.

# 2 INTERESTED PARTY COMMENTS: FEEDBACK SUMMARY

This section summarizes feedback received throughout the public comment period. The following subsections describe feedback on potential concepts for future EBCMs (Section 2.1), potential concepts for future value measures (Section 2.2), and additional feedback on the MIPS cost performance category (Section 2.3).

## 2.1 Cost Measure Prioritization

This section summarizes feedback we received on EBCM concepts. The PCMP Measure Development Public Comment Survey solicited input on the following potential EBCM concepts as well as open-ended input for additional EBCM concepts:

- Breast cancer
- Chronic bowel diseases
- Chronic liver disease
- Dementia and/or Alzheimer's
- Dysphagia
- Foot deformities
- Inflammatory skin conditions
- Lung cancer
- Osteoarthritis
- Osteoporosis
- Other eye conditions
- Pain management
- Urinary tract infection
- Non-patient facing specialty care

### 2.1.1 Dermatology

Several commenters supported the development of a dermatology-related EBCM. Particular recommended concepts included chronic pressure and non-pressure skin injuries as well as inflammatory skin conditions. Additionally, one commenter recommended measuring the use of skin grafts and cellular tissue products in a dermatology-related EBCM.

In contrast, one commenter noted challenges in developing an inflammatory skin condition EBCM that would assess both neoplastic conditions (e.g., actinic keratosis and seborrheic keratosis) and inflammatory conditions (e.g., psoriasis and dermatitis), stating that these conditions significantly differ in clinical nature, treatment management, cost utilization, and patient populations. The commenter noted that treatment variability and lack of severity classifications may create risk adjustment challenges in developing an inflammatory skin condition EBCM. Furthermore, the commenter noted that inflammatory skin condition treatment involves long-term drug therapy and providers often cannot choose which therapies to prescribe

under Medicare Part D. The commenter also noted that there is limited cost variability in inflammatory skin condition treatments outside of drug therapies.

#### 2.1.2 Pain Management

A few commenters discussed the development of a pain management EBCM. While two commenters supported a pain management EBCM, one commenter expressed concern noting potential overlap with clinicians and clinician groups already attributed to the existing MIPS Low Back Pain EBCM. In response to this concern, the same commenter recommended excluding injections for low back pain from a pain management EBCM so as to not attribute any providers already attributed to the existing MIPS Low Back Pain EBCM.

#### 2.1.3 Non-Patient Facing Specialty Care

One commenter supported the development of a cost measure for non-patient facing specialty care, specifically for radiology. In contrast, one commenter did not support the development of a non-patient facing specialty care cost measure and cited significant challenges in attributing costs to clinicians of this specialty type. Furthermore, the same commenter noted that a pathology EBCM concept would be of low utility for attributed clinicians as it may be too broad and could devalue team-based patient care.

#### 2.1.4 Osteoarthritis

One commenter recommended developing a hip or knee osteoarthritis EBCM and noted the high prevalence of the condition in the Medicare population and applicability to several specialties. The commenter also discussed that hip or knee osteoarthritis could assist in future development of a CMS longitudinal bundled care model for osteoarthritis management.

#### 2.1.5 Cancer

One of commenter recommended that cost measure developers reference current cancer clinical guidelines, staging, and treatment modalities for the development of any cancer EBCM.

#### 2.1.6 Podiatry

One commenter supported the development of a foot deformity EBCM.

#### 2.1.7 Chronic Conditions

One commenter supported the development of chronic condition EBCMs generally.

#### 2.1.8 Other Cost Measure Prioritization Comments

Two commenters discussed that cost measure development should consider the ability of attributed clinicians to meaningfully impact assigned costs. One of the commenters also further specified that cost measure development should prioritize conditions where there is spending

variation that is within the control of the provider rather than addressing existing service or specialty coverage gaps in the MIPS program.

One commenter recommended that cost measure development focus on subspecialty care and specialties where the highest cost of care is provided. They also stated that they believe primary care is overrepresented in the existing cost measures.

## 2.2 Value Measure Prioritization

This section summarizes feedback we received on value measure concepts, including specific outcomes or quality actions to be assessed alongside additional EBCM concepts identified in Section 2.1 and existing EBCMs.

### 2.2.1 Paired Value Measures Concepts with Additional Cost Measures

A few commenters recommended value measure concepts to be paired with new cost measure concepts identified in Section 2.1. One commenter suggested developing a value measure that assesses the number of false positive imaging results to be paired with a radiology-focused cost measure. Another commenter recommended the development of a pain value measure.

Two commenters discussed concerns about value measures paired with a new cost measure concept. One commenter stated that they do not recommend the development of any lung cancer-related value measure given variation in staging and treatment modalities, and another commenter recommended against value measures that aim to reduce testing or laboratory services. Additionally, one commenter expressed concerns with developing a value measure for inflammatory skin conditions if both neoplastic and inflammatory conditions are included within the cost and value measure, stating that these conditions are significantly differ in clinical nature, treatment management, cost utilization, and patient populations. The same commenter noted that treatment variability and lack of severity classifications may create risk adjustment challenges in developing an inflammatory skin condition value measure. Furthermore, the commenter stated that inflammatory skin condition treatment involves long-term drug therapy and drug choices are often limited to the options available for a particular Medicare Part D plan rather, and also noted that there is very limited variability in treatments other than drug therapies.

### 2.2.2 Paired Value Measures Concepts with Existing EBCMs

Multiple commenters identified value measures concepts for development to be paired with an existing MIPS EBCM. In particular, several commenters recommended the development of a value measure to pair with the MIPS Diabetes, Heart Failure, and Sepsis EBCMs. One of the commenters suggested developing a paired value measure for the Diabetes and Heart Failure EBCMs to assess hospitalization avoidance. Additionally, one commenter recommended the

development of a value measure to pair with the MIPS Lumpectomy, Partial Mastectomy, Simple Mastectomy EBCM to assess post-surgical radiation oncology and medical oncology services for the same patient population already evaluated under the EBCM.

One commenter suggested the development of a value measures to pair with the Non-Pressure Ulcers EBCM to assess limb salvage amputation survival and quality-adjusted life year. Commenters also recommended developing value measures to pair with the following existing EBCMs:

- Chronic Kidney Disease
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Emergency Medicine
- End-Stage Renal Disease

### 2.2.1 Other Value Measure Prioritization Comments

A few commenters discussed that CMS should examine the inventory of existing MIPS quality measures that may already address outcomes being prioritized for value measure development. These commenters recommended that value measures be aligned with both existing MIPS cost and quality measures. One commenter recommended analyzing existing EBCMs to identify services in which lower costs could result in the undertreatment of patients and develop value measures that evaluate if these services are delivered appropriately.

Two commenters discussed that cost and quality measures should be analyzed as a bundle to ensure that the attributed providers, measurement periods, and data elements are aligned. Furthermore, one commenter supported the use of registry, Electronic Clinical Quality Measures (eCQMs), and Digital Quality Measures (DQMs) instead of claims-based value measures to improve quality of care, citing that the former data sources offer more insight into disease severity and health-related social needs.

## 2.3 Additional Feedback on MIPS

The remaining feedback collected from the survey is summarized below, which includes general feedback on the MIPS cost performance category.

### 2.3.1 Total Per Capita Cost (TPCC) Measure

One commenter recommended that CMS develop more EBCMs to replace the TPCC cost measure. The commenter stated that the measure is too broad and no existing quality measures can mitigate inappropriate low spending that may result from the measure.

### 2.3.2 MIPS Value Pathways (MVPs)

One commenter discussed that CMS refine the current MVP framework to ensure each MVP is focused on a specific patient condition and utilize cost and quality measures specific to the

given condition. Furthermore, the commenter recommended that CMS should identify quality and cost measure misalignment within MVPs.

### 2.3.3 Measure Development Process

One commenter recommended that CMS increase stakeholder engagement and transparency throughout the measure development process, particularly among Workgroup members. The commenter noted that they would like to better understand how feedback has been considered and implemented during the measure development process.

# 3 NEXT STEPS

CMS will consider all the feedback received during the public comment period, feedback from the December 2024 TEP meeting, and empirical analyses to select cost and value measures for future development. All cost measures and value measures selected by CMS for development must go through rulemaking prior to use in MIPS.

Any questions or feedback related to the MIPS program or MIPS measures currently in use should be submitted to the QPP Service Center (QPP@cms.hhs.gov). We also encourage interested parties to email pcmp-info@acumenllc.com with additional input on potential EBCMs and value measures so that we can consider this in any future MIPS measure development activities.

# APPENDIX A: PUBLIC COMMENT VERBATIM REPORT

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

Please note that the verbatim text has been edited to improve the readability of this report. We omitted letter template details (e.g., company logo), email signatures, and sensitive personally identifiable information (e.g., phone numbers and email addresses). Respondents' complete survey responses were concatenated together without the questions intact.

### 3.1.1 Comment Number 1

- **Date:** 01/04/2025
- **Submitter Name, Credentials, and Organization:** Marc DeHart, MD
- **Comment Text:** Clearly all of these common chronic health issues are important for cost measure development. The challenge is how to curtail providers, treatments and promotion of care that is of higher value and disincentivize care that has minimal benefit in degree or in duration. This highly depends on the health condition, the specialists, the available treatments, and the role patient preference and company marketing plays a role in care selection. I've spent a long career in orthopaedic surgery, so I can speak best to topics in those areas. The priority should be placed in the areas where the most overall money is being spent.

  While this concept are can fall in osteoarthritis or pain management above, the chronic low back pain arena is clearly a high priority. It is also an area ripe for the use of low value care either because of patient ignorance of what has any long term effect, how providers/companies profit from use and the endless hope of patients for something that works "better".

### 3.1.2 Comment Number 2

- **Date:** 01/05/2025
- **Submitter Name, Credentials, and Organization:** Anna Weber, DPM
- **Comment Text:** The list looks appropriate

### 3.1.3 Comment Number 3

- **Date:** 01/07/2025
- **Submitter Name, Credentials, and Organization:** Edward Bowron Jr., DPT
- **Comment Text:** All areas of medical practice should be scrutinized and measured to ensure fraudulent practices do not profit in this world

skin grafts and CTP overuse

#### 3.1.4 Comment Number 4

- **Date:** 01/09/2025
- **Submitter Name, Credentials, and Organization:** Cathlin Bowman-Young
- **Comment Text:** Pain Management

  Other

  pain

  anesthesia

#### 3.1.5 Comment Number 5

- **Date:** 01/17/2025
- **Submitter Name, Credentials, and Organization:** Amanda Holt, MPH, American Academy of Family Physicians (AAFP)
- **Comment Text:** Of the above concepts, we think the following should be prioritized: inflammatory skin conditions (dermatology), non-patient facing specialty care (radiology), foot deformities (podiatry).

  Additional concepts should focus on subspecialty care. Primary care has been over-represented in the existing cost measures, and more attention should be given to specialty care where most high-cost care is provided.

  heart failure (avoidance of hospitalization), chronic kidney disease (avoidance of dialysis), diabetes (avoidance of hospitalization)

  non-patient facing specialties (specifically radiology) - measure level of false positives (e.g. mammography)

#### 3.1.6 Comment Number 6

- **Date:** 01/21/2025
- **Submitter Name, Credentials, and Organization: Ramesh Poluru,**
- **Comment Text:** Yes, the concepts well identified

  Include Probiotics supplementation's cost-effectiveness

  Diabetes, Sepsis

#### 3.1.7 Comment Number 7

- **Date:** 01/22/2025
- **Submitter Name, Credentials, and Organization:** Cindy Tomilson, American Society for Radiation Oncology (ASTRO)
- **Comment Text:** While the concepts shared are reasonable, ASTRO recommends that CMS and Accumen refer to the National Comprehensive Cancer Network (NCCN) guidelines before pursuing additional cost measures involving cancer care. The NCCN

guidelines are continuously updated and serve as a key resource in determining appropriate guideline concordant care. Additionally, use of the guidelines provides the Agency with a clear understanding of the variety of cancer stages and modalities of treatment that exist by disease site which underscores the complexity of developing cost measures for cancer care.

ASTRO also recommends the use of stakeholder engagement and transparency in the development of cost measures. We recognize that work groups have been established for the development of cost measures associated with previous Waves. However, we are concerned that stakeholder input was disregarded which is disappointing given the expertise and time commitment involved. We recommend that there be greater transparency regarding how stakeholder input is processed and considered as part of cost measure development.;

As a result of the Wave 1 cost measures development work, CMS and Acumen established the Lumpectomy, Partial Mastectomy, Simple Mastectomy Measure. This measure evaluates the risk-adjusted cost to Medicare for beneficiaries who undergo partial or total mastectomy for breast cancer during the performance period. The cost measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or triggers, the episode through 90 days after the trigger. Patients who are treated for breast cancer with a lumpectomy, partial mastectomy, or simple mastectomy are frequently referred to a radiation oncologist and/or a medical oncologist for further treatment with radiation therapy and/or chemotherapy. Because CMS and Acumen have already established the surgical cost measure, it would be reasonable to consider a post-surgical cost measure specific to the radiation oncology and medical oncology services that are delivered as part of the overall cancer care continuum. Additionally, since patients are already identified under the surgical cost measure, this may alleviate the complexity of capturing the intended patient population. We would welcome a dialogue with CMS, Acumen and our colleagues at the American Society for Clinical Oncology to further discuss how such a measure would be developed and implemented.

As previously stated, it would be reasonable for CMS to build on the existing Lumpectomy, Partial Mastectomy, Simple Mastectomy Measure. However, ASTRO urges caution with regard to the development of a measure associated with lung cancer due to the variation in staging and modality of treatment which can greatly impact the cost of care delivered. Again, we recommend that CMS refer to NCCN guidelines to fully understand the complexity associated with lung cancer treatment.

### 3.1.8 Comment Number 8

- **Date:** 01/23/2025
- **Submitter Name, Credentials, and Organization:** Carolyn Millett, American Academy of Physical Medicine & Rehabilitation (AAPM&R)
- **Comment Text:** On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to Acumen regarding the Physician Cost Measures and Patient

Relationship Codes (PCMP). Our comments relate specifically to the proposed consideration of clinical topics for future cost measure development.

AAPM&R has reviewed the clinical areas outlined in the call for public comment. We have particular concern with the proposed consideration of pain management (e.g., epidural injections and local injections for pain management). The subset of clinicians impacted by this measure would likely have significant overlap with the clinician group captured under the existing low back pain cost measure. In order for these two cost measures to function simultaneously, the pain management measure would need to exclude injections provided for back pain, which would significantly decrease the number of relevant clinicians. Low back pain is likely to be on of the more common conditions for which pain management is required, which suggests that it is likely not a high priority measure to pursue.

Thank you for the opportunity to pariticpate in the ongoing cost measure development process. Th AAPM&R looks forward to continuing to work with Acumen in future measure development waves.

### 3.1.9 Comment Number 9

- **Date:** 01/23/2025
- **Submitter Name, Credentials, and Organization:** Jennifer Hananoki, JD, American Medical Association (AMA)
- **Comment Text:** CMS and its contractor, Acumen, should develop cost measures based on conditions or episodes of care where there is a variation in spending that is within the control of the physician. It is not sufficient to look at gaps in cost measures based on service or specialty. This does not tell the public about whether those clinical conditions or episodes of care include unnecessary costs that could be reduced by changes in ordering, prescribing, care coordination, or other activity by the physician or qualified health care professional. Furthermore, we urge CMS and Acumen to carefully consider feedback from the national medical specialty societies regarding the specific measure topics outlined above as the AMA has heard concerns from physicians about these measure concepts.

  In addition, to prioritize measure development, CMS should identify mismatches within MVPs between cost and quality measures. The AMA has developed an alternative framework for MVPs, called the Condition-Stratified MVP Framework. The appendix at the end of this letter (https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfmips.zip%2F2024-4-24-Letter-to-Brooks-LaSure-re-MVP-Framework-v4.pdf) identifies gaps in cost measures in the heart disease and eye care MVPs.

  The only way to fairly measure the performance of physicians on cost is to ensure (1) that the cost measures assess the aspects of cost that physicians can control, and (2) that there are also quality measures that can identify whether reductions in cost are being achieved by delivering fewer of the services that patients need to achieve good outcomes. Although it sounds attractive to use outcome measures to assess the quality of care, a physician cannot control all the factors that affect a patient's outcome. No risk adjustment methods can adequately adjust for all the uncontrollable factors, and risk adjustment

methods based solely on information on claims data will perform particularly poorly. Just as cost measures must be focused on the aspects of cost that physicians can control, quality measures also have to focus on the aspects of care that physicians can control, rather than outcomes that they cannot control. Cost and quality measures should be developed as a bundle, not merely identifying a quality and a cost measure for the same condition and pairing them together. It would be inappropriate and provide little actionable information, to pair cost and quality measures based on different groups of patients and physicians, different time frames, and differences in services or other data elements. Because it is then impossible to say for sure whether lower costs are being achieved at the expense of quality for some patients, or whether higher quality is being achieved through spending that is not included in the cost measure. The TPCC measure is already much too broad, and there are no quality measures, or aggregate measure, that could appropriately protect against inappropriately low spending in such a broad measure, particularly given the current approach of monthly benchmarking, which is contrary to how the quality measures are reported. This is why the AMA has urged CMS to refine their MVP approach and implement MVPs that are focused on specific patient conditions and that use cost and quality measures specific to those conditions. Developing value measures using claims data alone is concerning. There are significant attribution and risk adjustment problems with the existing episode-based cost measures that we think would be exacerbated by developing value measures using claims data. Furthermore, claims data gives no insights into patient-specific or clinical data, so there is little to no ability to adjust for disease severity or health-related social needs. Measure developers moved to registry and electronic/digital quality measures because they are much richer and more granular sources of data. Claims data alone, do not provide the level of granularity needed to move the needle on quality. The AMA previously comments on the concept of a sepsis value measure, as well as other topics discussed at the last TEP meeting, in a letter to CMS (https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfmips.zip%2F2024-4-19-Letter-to-Brooks-LaSure-re-MIPS-Cost-Performance-Category-v2.pdf). CMS has quality measures with electronic specification, (eg, eCQMs) and provides resources and tools for development of these measures (https://ecqi.healthit.gov/ecqi-tools-key-resources?qt-teste=ecqi-tools-resources-library). Acumen and CMS should incorporate these measures in discussions of value measures and aligning cost and quality measures.

MVPs were intended to be a mechanism for aligning cost and quality measures. Acumen should assist CMS to identify and develop more and better episode-based cost measures to replace TPCC. It should also identify the types of services included in each episode-based cost measure where undertreatment of patients could result in lower costs and identify or develop measures of whether those services are being delivered appropriately. Specifically, CMS and Acumen should analyze and publicly report information about cost and quality measures for the same conditions and episodes and whether they cover the same timeframe, same physicians or eligible clinicians, same panel of patients, and same sets of services. This is the only way to know that the value of both the cost and quality measures are improving or maintaining quality while reducing costs and not reducing quality for the sake of reducing cost.

### 3.1.10 Comment Number 10

- **Date:** 01/24/2025
- **Submitter Name, Credentials, and Organization:** Colleen Skau, College of American Pathologists (CAP)
- **Comment Text:** Previous efforts to develop measures for non-patient-facing specialties including attempts to develop a shadow bundle have not yielded viable concepts due in part to significant challenges with attributing costs to non-patient-facing clinicians. Additionally, analyses show limited variability in individually-attributable costs for non-patient-facing specialties. Finally, capturing an entire specialty as diverse as pathology in a single cost measure has low utility for the attributed clinicians. Costs for analysis of a radical prostatectomy are not related to costs for assessing lactate in a blood sample. While these are all part of pathology and laboratory medicine, they lack clinical coherence and would not be attributable to a single clinician. What's more, isolating the costs of pathology from the broader effort to treat a patient devalues team-based care and could encourage a reduction in testing that would otherwise make care safer and more effective. Therefore, the CAP suggests that non-patient-facing specialty care should not be the highest priority until these ongoing challenges can be more adequately addressed. We remain committed to efficient, effective care and look forward to partnering on novel ways to manage these issues.

  The CAP recommends that CMS prioritize not only the highest impact areas (per clinician and patient coverage) but also areas with greatest disparity in attributable costs. We continue to emphasize that the ability attribute costs clearly and directly to the providers who are scored on these measures will be critical. Since MIPS participants do not submit data for cost measures and are only provided scores after the fact, it is essential that attribution of any new cost measure be clear and direct. Furthermore, the ability of attributed clinicians to meaningfully impact the associated costs should be clearly demonstrated as part of cost measure development.

  While we understand the desire to pair quality and cost together within the MIPS program, we suggest that de novo measure development may not be necessary to achieve this aim. Many of the concepts mentioned above, such as returns to the operating room and readmissions, are already captured in existing quality measures. Instead of developing new measures which could partially overlap existing quality measures, CMS should consider supporting the measure stewards and relevant specialty societies who are experts in these areas to modify measures if needed to align them with the definition of value measures. We also note that while appropriate use is an important goal and there are low-value services whose use should be reduced, we emphasize that development of value measures should not be geared towards across-the-board reduction of testing or use of clinical laboratory services. A wide variety of resources exists, including the expertise of pathologists themselves, to help clinicians select appropriate tests and services and avoid low-value services. If value measures are needed to target specific areas, these should be well-justified by gaps in existing measures. However, the existence of MIPS Value Pathways, cohesive sets of quality and cost measures, suggests that gaps are limited in many of these areas.

### 3.1.11 Comment Number 11

- **Date:** 01/24/2025
- **Submitter Name, Credentials, and Organization:** Traci A Kimball, MD, MBA, CWSP, The WISH Clinic (Arvada,CO)
- **Comment Text:** Yes any chronic care of communicable and non communicable disease in humans should have cost variables and measures of quality and outcome.

  Provisions of care for acute and chronic skin disease and disorders inclusive of acute and chronic pressure and non-pressure skin injuries.

  Sepsis, Revasc, Emergency Medicine, Heart Failure, Respiratory Failure, ESRD and Diabetes should all be prioritized.

  Total episodic cost of care by DRG or HCC and acute care utilization costs by HCC or DRG - also limb salvage amputation free survival for patients with non-pressure chronic ulceration with MCC by episode of care; you already track utilization of offloading and compression for DFU and VLU - why not track QALY and censoring rates in certain sites of service where risk is managed.

  N/A

### 3.1.12 Comment Number 12

- **Date:** 01/24/2025
- **Submitter Name, Credentials, and Organization:** Seemal R. Desai, MD, FAAD, American Academy of Dermatology Association (AADA)
- **Comment Text:** Dear Administrator, The American Academy of Dermatology Association (AADA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) and Acumen on its Wave 7 Measure Development that includes cost and value measure concepts for consideration.

  The AADA represents more than 17,500 dermatologists nationwide who are committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease.

  **The AADA is concerned that CMS is considering inflammatory skin conditions as a cost or value measure concept, as currently outlined, which inappropriately groups neoplastic conditions, such as actinic keratosis and seborrheic keratosis, with inflammatory conditions like psoriasis and dermatitis. These conditions are clinically distinct, differing in treatment management, cost utilization, and patient populations. The AADA opposes this grouping, as it lacks clinical relevance and would result in a flawed cost or value measure. Additionally, we strongly urge CMS to address the challenges of defining a clear episode of care and accounting for the role of drug costs in the treatment of inflammatory skin conditions before moving forward.**

  **Neoplastic vs. Inflammatory Skin Conditions**

**The AADA strongly urges CMS to recognize the clinical distinctions between neoplastic and inflammatory skin conditions when considering creating a new cost or value measure.** These conditions are clinically distinct, differing in etiology, treatment, management, cost utilization, and patient populations. The AADA opposes this grouping, as it lacks clinical relevance and would result in a flawed cost or value measure. Neoplastic conditions, such as actinic keratosis and seborrheic keratosis, typically involve episodic, procedure-driven care. In contrast, inflammatory diseases, such as psoriasis and dermatitis, usually require long-term, ongoing management via drug therapies. Grouping these conditions together would result in measures that are not clinically relevant or meaningful and would fail to provide actionable feedback. **We recommend that CMS avoid merging neoplastic and inflammatory skin conditions into one measure and focus on creating measures that align with the unique aspects of each disease category.**

**Challenges with Comprehensive Inflammatory Skin Conditions Measure**

**The AADA strongly cautions CMS against developing a single cost or value measure for inflammatory skin conditions without addressing challenges related to variability in episodes of care and treatment costs.** Inflammatory skin conditions represent a broad range of chronic diseases that do not fit well into CMS's typical episode-based cost measurement framework due to the variability in the treatment of care. Treatment often involves long-term use of biologics or other drug therapies and frequent adjustments to treatment plans. Unfortunately, in the current medical system, the cost of biologics and other drug therapies is not transparent to the prescribing physician. Instead, therapeutic options for patients are limited by the deals their insurer has made with the pharmacy benefit manager for that particular Medicare Part D plan. Consequently, while therapeutic plans should be based on disease severity and patient response, in reality, they are based on the formulary list and the deals that have been made to tier the list. This variability makes it difficult to standardize resources and costs for a single measure.

Furthermore, there is no consistent lab value or widely used disease severity index for inflammatory skin conditions in clinical practice. Terms like "mild," "moderate," and "severe" are inconsistently documented in the narrative note, and not captured claims data. This makes it impossible to create standardized measures that enable meaningful comparisons and no ability for risk adjustment.

Additionally, CMS must recognize that drug costs, particularly for biologics, are the primary driver of care costs for inflammatory skin conditions. Excluding drug costs, which has been done in some other cost measures, would make any cost measure for inflammatory skin conditions ineffective since there is little variability in other cost components. At the same time, including these costs, but not adjusting them appropriately, could hinder patients' access to biologic therapies or penalize providers for prescribing these necessary treatments. These therapies are essential in improving patients' quality of life and managing the long-term burden of their disease. **Therefore, the AADA urges CMS to carefully consider the challenges of defining a clear episode of care for inflammatory skin conditions and the role of drug costs before moving forward with a cost or value measure for inflammatory skin conditions.**

**Conclusion**

The AADA appreciates the opportunity to comment as CMS works to develop new cost and value measures and we look forward to ongoing engagement and providing stakeholder input.

### 3.1.13 Comment Number 13

- **Date:** 01/24/2025
- **Submitter Name, Credentials, and Organization:** James I. Huddleston, MD, American Association of Hip and Knee Surgeons (AAHKS)
- **Comment Text:** To Whom It May Concern:

  It has been an aspirational goal of CMS to create a longitudinal bundled care model for the management of osteoarthritis of the hip and/or knee. Both have a high prevalence in the Medicare age group population with focused care from several specialties, especially orthopaedic surgery. Such care represents large volumes of beneficiaries and providers as well as substantial costs.

  To this end, the American Association of Hip and Knee Surgeons (AAHKS) is recommending consideration of the creation of an episode of care cost measure for these conditions. It would represent a new challenge requiring a longer time period and a more open-ended definition of what is an episode of care, including both non-operative as well as surgical treatments. The process of creating such a measure, however, could serve as template for cost of care measures of other chronic diseases and would provide a needed option for CMS if such a care model is to be implemented.