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Partnership or Quality Measurement (PQM)
Pre-Rulemaking Measure Review (PRMR)
Measures Under Consideration (MUC)

Submitted electronically via [PRMR MUC List Commenting Form](#)

RE: MUC2023-209: Rheumatoid Arthritis Episode-Based Cost Measure

The Coalition of State Rheumatology Organizations (CSRO) is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist.

Today, we write to share feedback on the Rheumatoid Arthritis (RA) episode-based cost measure that the Centers for Medicare and Medicaid Services (CMS) is considering proposing for adoption in the Merit-Based Incentive Payment System (MIPS) in the upcoming CY 2025 Medicare Physician Fee Schedule.

Request to Postpone Adoption of the RA Cost Measure

CSRO appreciates the challenges associated with developing episode-based cost measures, particularly for complex diseases like RA. As we've noted in comments to CMS and its measure development contractor Acumen, there are no appropriate resource use measures for rheumatologists under MIPS. CMS' recently implemented MIPS Value Pathway (MVP) for Advancing Rheumatology Patient Care would benefit from a more applicable measure of cost related to this condition, as rheumatology practices have struggled to meaningfully respond to feedback on the Total Per Capita Costs (TPCC) measure—a measure whose methodology has been critiqued for not producing fair and accurate assessments of variations in costs within the control of MIPS-eligible clinicians as intended. Nevertheless, **we remain deeply concerned that the RA cost measure under consideration is deeply flawed and may have unintended negative consequences for beneficiary care.**

Rheumatologists are keenly aware of the impact medication costs have on RA episodes. However, due to CMS' coverage and payment policies associated with Part B ("physician-administered") and Part D ("self-administered") medications, including those governing Part D Prescription Drug Plans, rheumatologists may not be able to prescribe what they believe is the most clinically and cost-effective therapy. Rather, they must select within the coverage restrictions imposed on the beneficiary by the plan – and these restrictions can be severe. For example, a beneficiary may be subject to step therapy requirements in their Part D plan, thus limiting the prescribing options to a narrower set of "fail-first" medications on the plan's formulary. By design, such requirements will inevitably result in a subset of patients who do in fact fail the first-line treatment. That subset will be left without appropriate treatment for a longer time period and, thus, worse outcomes and potentially higher ancillary costs – all of which is outside the control of the prescribing physician.

Worse yet, a beneficiary who is an appropriate candidate for the physician-administered formulation of a drug on the Self-Administered Drug (SAD) Exclusion List would not be able to access that particular formulation – *even if they have a disability* – since these medications are excluded from coverage. ***Until rheumatologists have unfettered access to all available treatment options for RA without interference from third party cost control policies, it is inappropriate to hold rheumatologists accountable for the costs of the medications that beneficiaries require.***

CSRO, and a coalition of other providers, have been working to address some of these issues with the Agency, and hope to review proposals in future rulemaking.

Rheumatology Practice Comments from RA Cost Measure Reports During Field Testing

Rheumatologists that reviewed field test reports for the RA cost measure raised a number of concerns, which were shared with Acumen during development and remain relevant as the measure is considered for MIPS.

First, rheumatologists believe the measure does not generate actionable results, which means most will not be able to take meaningful action or change their behavior. One rheumatologist said,

“Once we get the results of this measure, what are we supposed to do? Do we look at the results and say, ‘Hmm... I guess I’m ordering too many orthotics on this patient?’ How are we supposed to change our treatment plan based on the results we get from this?”

Second, rheumatologists commented that the costliest aspect of RA treatment is the medication – medications that are the standard of care – and raised similar concerns about how the measure results could be used to change how they treat RA patients using these medications. One rheumatologist said,

“We don’t need the measure to tell us that our drugs are expensive. But if we get a ‘high cost’ attributed to the individual physician and the results don’t tell us what changes impact treatment, the only obvious thing to do would be to withhold medication from patients when we do not control the cost of the drug. Withholding care is not good for the patient or society.”

Third, rheumatologists felt the reports did not separate patients who have a treatment that is directly related to rheumatoid arthritis versus a treatment for another diagnosis. They noted that the assigned services for the episode group may or may not be directly related to the rheumatoid arthritis, and therefore, may be inappropriately attributed services that the rheumatologist could not control. If the goal of measures is to meaningfully drive clinical practice, then attribution of services that a physician does not provide or prescribe would make little difference in achieving the goal. It would be impossible for rheumatologists to change their behavior with regard to services they did not provide nor prescribe.

CSRO Recommendation

Administrative measures that focus exclusively on cost-of-care with no regard to quality have created confusion for rheumatologists, particularly since most of the attributed costs are outside their control and fail to balance meaningful clinical factors. In addition, the challenges we’ve raised above have not been resolved by CMS or its contractor. For these reasons, **CSRO requests that the RA cost measure is NOT recommended for use in the MIPS program at this time.**

Thank you for considering our comments on the development of RA-focused episode-based cost measure. Please do not hesitate to contact us at info@csro.info should you require additional information.

Sincerely,

A handwritten signature in blue ink that reads "Gary Feldman". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Gary R. Feldman, MD, FACR
President

A handwritten signature in black ink that reads "M. Feldman". The signature is cursive and somewhat compact.

Madelaine A. Feldman, MD, FACR
Vice President, Advocacy & Government Affairs