American Society for
Gastrointestinal Endoscopy

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The Honorable Greg Murphy, MD
Co-chair, GOP Doctors Caucus
U.S. House of Representatives
Washington, D.C. 20515

The Honorable John Joyce, MD
Co-chair, GOP Doctors Caucus
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kim Schrier, MD
Chair, Democratic Doctors Caucus
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Murphy, Congressman Joyce and Congresswoman Schrier,

The American Society for Gastrointestinal Endoscopy (ASGE) appreciates the invitation to provide comment on the future of physician health care quality reporting and value-based payment and delivery models. The ASGE, with more than 16,000 members, is grateful for your leadership and for your continued interest in upholding programs that can lead to meaningful improvements in patient outcomes and minimize physician practice administrative burden.

ASGE offers the following responses to your questions pertaining to the Centers for Medicare and Medicaid Innovation (CMMI) and the Merit-based Incentive Payment System (MIPS).

***If MIPs were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes*?**

- CMS physician quality programs need to be meaningful and fair. Fair means getting rid of the "tournament style" competitive, zero-sum framework of MIPS for determining physician payment adjustments. Instead, quality improvement programs should support all manner of practice, including independent and rural practices.

- While quality standards should be national, improving quality is best done at the local level.

- As ASGE has repeatedly attested, the MIPS Value Pathways (MVPs) is measurably *no different or worse* than the traditional MIPS program, imposing tremendous administrative burden on physician practices without clear demonstration that patient outcomes are improving. After nearly two decades of public quality reporting, the current iteration of MIPS should be repealed.

- If MIPS is maintained, reform of the program should center on significant reduction of administrative burden, the use of meaningful measures as determined by specialty societies, and upholding qualified clinical data registries (QCDRs).

Now is the time to have Congress consider, in collaboration with physician organizations, how quality improvement initiatives can be re-imagined with recognition that physicians, allied health care professionals, and their teams inherently want to provide the best care they can. Quality metrics are essential components in building and maintaining high-performing delivery of care, and physicians are willing to commit resources to measurement that they know can lead to true improvements in patient outcomes. For example, adenoma detection rate (ADR) is the key outcome measure in preventing death from colorectal cancer, and, therefore, an excellent quality metric. Gastroenterologists have done a great job of continually increasing their ADRs, knowing for each 1 percent increase in ADR, there is a 3 percent decrease in risk of interval cancer and 5 percent decrease in risk of fatal interval cancer.[1] Yet, physicians don't receive higher reimbursement based on their ADR despite devoting more time to identify and remove these lesions. We know ADR is improving over time for a host of reasons, but not because of participation in MIPS or alternative payment models (APMs).

We suggest a shift to looking at built-in incentive structures, leveraging quality measure concepts recognized as high priority by specialty societies. For example, we know it is important to perform a colonoscopy within six months of a positive stool-based test (SBT), and CMS has access to claims data that could detect a CPT code for colonoscopy together with an ICD-10 code indicating a positive SBT within six months of the lab test claim with ICD-10 for colon cancer screening. This would allow for a way to pay more for a colonoscopy completed within this six-month window. After six months, standard RVUs would apply. This incentivizes high-quality performance without penalty for delays that are beyond the control of a medical practice. **The point is, there are quality metrics well-researched and described by the specialty that already have some type of RVU-based incentive that eliminates a separate program which requires the reporting of quality measures. Further, such an approach can be easily duplicated across states, payors, and health care systems and incorporated into clinical benchmarking registries.**

CMMI could serve a purpose as a centralized repository of such specialty-society nominated quality measures, and through existing mechanisms set the expected criteria for coding. Unlike the past nearly routine rejection of APMs for specialty care, nomination by specialty societies should be accepted as a default, and such measures could be reviewed every 5 years or so to assure they are still timely and appropriate.

If Congress is going to stick with tying Medicare fee for service with reporting quality measures, there needs to be a comprehensive inventory of measures, and the role of clinician-led clinical data registries must be preserved and strengthened. The burden of MIPS participation is *not* reduced by shrinking the inventory of measures as the opposite is true in practice. Reporting measures that have little value to a clinician's practice or to patient outcomes is just burdensome, no matter how few or many measures are required for reporting. Successful participation in a quality program should not be a matter of who has the bandwidth and resources to report the measures. Small and rural practices will always lose because they can't afford the staff or consultants. The cottage industry that is MIPS consultancies has fueled the topping out of measures and their removal from the program by picking the measures that will get their clients the best possible scores with little regard for meaningfulness of the measures.

More recently, CMS has begun a programmatic shift from MIPS to MIPS MVPs. Unfortunately, CMS' MVP pathway mirrors essentially all the flaws of MIPS, including scoring methodologies, low statistical reliability of quality measures, lack of confidence in measure benchmarks, lack of timely and actionable feedback, program burden, and the marginalization of clinical data registries. If MIPS is maintained, reform of the program should center on significant reduction of administrative burden, the use of meaningful measures as determined by specialty societies, and upholding QCDRs.

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[1] Corley, D.A. et al.; Adenoma detection rate and risk of colorectal cancer and death; N Engl J Med. 2014; 370:1298-1306

At the onset of the Quality Payment Program (QPP), CMS saw a role for clinical data registries in advancing the quality component of its accountability program and specialty societies agreed, establishing QCDRs. The GI Quality Improvement Consortium (GIQuIC), a collaboration of ASGE and the American College of Gastroenterology (ACG), supports the only gastroenterology (GI) specialty-specific clinical benchmarking registry and QCDR. GIQuIC amplifies the importance of and facilitates monitoring performance on priority quality measures, such as ADR, relative to established performance expectations as defined by leaders in the specialty and provides data to inform new metrics (i.e., sessile serrated adenoma detection). As MIPS has evolved, CMS has continually marginalized QCDRs in ways well-articulated in letters submitted by the Physician Clinical Registry Coalition and as evidenced by limited inclusion of QCDRs measures in MIPS MVPs.

ASGE, jointly with the ACG, American Gastroenterological Association, and GIQuIC, has provided extensive feedback to CMS, which has largely been ignored, on the GI Care MVP. For example, we opposed the inclusion of the Colorectal Cancer Screening (QID 113) and Closing the Referral Loop (QID 374) measures in the GI Care MVP. These measures are generally geared toward primary care providers and not gastroenterologists. Yet, CMS inexplicably forced the inclusion of these measures in the GI Care MVP.

ASGE's physician members and staff have devoted significant time and expertise to support the development of episode-based cost measures and quality measures. Yet, with MVPs, CMS continues to drive specialists toward mandated reporting of measures that are not relevant to their specialty.

Contributing to the problem, the process of submitting quality measures into the QPP for acceptance as a MIPS clinical quality measure is highly complex, involving multiple stages of rigorous evaluation, revision, and testing to ensure that the measure is evidence-based, clinically meaningful, reliable, valid, and ultimately capable of improving patient outcomes. An example of this complexity is the development of the Sustained Virological Response (SVR) measure for patients with hepatitis C.

In 2022, the American Gastroenterological Association (AGA) was approached by CMS and Mathematica following a request from the White House Office of Science and Technology Policy (OSTP) to help advance the national priority of testing, treating, and eradicating hepatitis C from the U.S. population. The AGA, with support from various levels of government, contractors, content experts, and financial assistance, worked diligently to develop, test, and submit the SVR measure for the Pre-Rulemaking Measure Review (PRMR) process. Despite receiving broad support, access to top-tier data science teams, and significant financial resources, the development process still took nearly four years to complete and the measure is finally included for CY 2026. The first benchmarking data for this measure is expected in CY 2028, marking approximately six years from initial development to real-world implementation and the first available data to evaluate whether this measure has been impactful for patients with hepatitis C. Meanwhile, during all this elapsed time, the management of hepatitis C has now shifted from gastroenterologists to infectious disease providers, primarily because of the availability of novel, highly effective oral therapies. In essence, the slow, cumbersome process of measure inclusion has made a measure obsolete for our specialty.

The pathway for submitting a quality measure as a QCDR measure - while maintaining equal rigor to ensure that the measure is evidence-based, clinically meaningful, reliable, valid, and ultimately capable of improving patient outcomes - can be just as challenging. The GIQuIC QCDR measure set has changed *nearly every year* since CY 2014, with currently only three GIQuIC QCDR measures available for reporting for CY 2026. While registry participants appreciate that quality measures foundational to their quality improvement programs and available in their clinical registry can also serve the purpose of accountability in public reporting, the unpredictability of the QCDR measure set has been a point of frustration and adds additional burden if a clinician or group needs to report supplemental cross-cutting measures through an alternate mechanism to ensure program requirements are met.

These examples highlight the glaring gaps in meaningful quality measures available for reporting. Without a clear priority from CMS to fill these gaps in a timely manner, it remains unclear to our society what the goals are with MVPs versus Traditional MIPS.

What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?

- Federal policies should support the development of new, voluntary physician-led APMs that meet the needs of practices of varying types, sizes, and specialties.
- Models should begin with voluntary participation and should allow ample time for practices to prepare for participation. Models must be tested and proven in the marketplace before mandatory participation.
- Models should be developed with the input of all relevant stakeholders.
- The work of the private sector to develop APMs should be upheld through the Physician-Focused Payment Model Technical Advisory Committee (PTAC) as originally intended.

Most Medicare providers, and physician specialists in particular, are disadvantaged by the lack of choice within the QPP by not having Advanced APMs available to them. Nearly a decade ago, ASGE wrote to CMS expressing frustration with the process being used by the PTAC to review and comment on proposed physician-focused payment models (PFPMs). When the *Medicare Access and CHIP Reauthorization Act (MACRA)* was enacted, the physician stakeholder community believed the PTAC offered promise for creating greater APM opportunities for specialty physicians, but this has not been the case. The PTAC ultimately recommended more than a dozen PFPMs, but not a single model has been implemented or even tested by the CMMI.

Development of PFPMs requires access to data. Among the priority criteria that PTAC used in its evaluations is whether a proposal will improve health care quality without increasing spending, reduce spending while maintaining quality, or reduce spending and improve quality. As the PTAC pointed out to CMS, evaluating a proposal against this criterion usually requires analysis of Medicare claims data that has been disaggregated into the types of conditions and procedures being addressed by the PFPM. Without this analysis, PTAC cannot adequately review many of the proposals it has received.

Information should be gathered from the physicians and organizations that developed APM proposals that were recommended by PTAC to learn:

- why they believed their proposal would better support higher-value care than the existing APMs;
- the challenges they faced developing their proposal and their feedback on their experience with the PTAC process;
- whether CMMI contacted them to learn more about their proposed APM or to try and resolve any concerns about it;
- whether the physicians received any explanation as to why their proposal would not be implemented; and,
- whether they still believe the proposal they developed should still be implemented by CMMI.

If there is to be a more robust pipeline of APMs available to all types of physicians in all geographic locations, the shortcomings and the failings of the PTAC and CMMI must be understood and corrected, as well as to understand the challenges of participation in existing CMMI models.

ASGE also wishes to use this opportunity to voice vigorous support for legislative efforts to halt implementation of the *Wasteful and Inappropriate Services Reduction (WISeR)* model. WISeR borrows some of the worst elements of prior authorization and incorporates them into Original Medicare, specifically, the use of artificial intelligence (AI) to review authorization requests, and it gives vendor participants a financial incentive to deny patient care — an approach we strongly oppose.

CMMI's launch of WISeR was done without bringing physician organizations to the table during the model's development despite patient care and physician practice being directly impacted by its requirements. First, **we urge Congress to use legislative levers to ensure that CMMI solicit through formal mechanisms feedback and input from affected stakeholders of any future CMMI models.** Second, the WISeR model should be stopped until engagement with the physician community can occur to ensure that any adoption of WISeR is thoughtful, equitable, and minimally disruptive to clinical practice. Most important, this model *must* require vendors to disclose the evidence-based criteria, algorithms, and AI/machine learning tools used to make determinations, ensure that clinical judgment is not overridden by automation, and protect patients through independent validation and public reporting.

Given the ASGE's long history in measure development and data collection, we are eager to engage with the GOP and Democratic Doctors Caucuses in an effort to move beyond the current quality reporting paradigm which, quite frankly, is not improving patient outcomes. We hope that you are compelled by our novel suggestion to utilize incentive structures that are built into the current Medicare payment system to reward physicians for high-quality care that can improve patient outcomes. In that regard, ASGE physician leaders are at your disposal to further contemplate this idea as an alternative to MIPS and APMs.

For questions or requests for additional information, please contact Camille Bonta, ASGE policy advisor, at cbonta@summithealthconsulting.com or (202) 320-3658.

Regards,

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ASGE President