



November 20, 2017

Submitted electronically via <https://www.surveymonkey.com/r/macra-cost-measures-field-testing>

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Field Testing for Episode-Based Cost Measure Development for the Quality Payment Program

Dear Administrator Verma:

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE) appreciate the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Access and CHIP Reauthorization Act (MACRA) Episode-Based Cost Measures Field Testing. Together, our societies represent virtually all gastroenterologists in the United States.

Our societies appreciate CMS' demonstrated commitment to ensuring the engagement of physicians in the development of the eight episode-based cost measures currently in development. Specifically, the process of physician engagement has been significantly improved through Acumen's convening of the Clinical Committee and Subcommittees. The Gastrointestinal (GI) Disease Management Clinical Subcommittee has 35 members (including 11 gastroenterologists) representing 22 medical specialty societies. To date, the process has been inclusive, engaging, and transparent. The input from diverse clinicians and subspecialties has been vital to the development of the Screening/Surveillance Colonoscopy cost measure.

We are writing to provide feedback on the draft materials for the Screening/Surveillance Colonoscopy cost measure and to express our members' concerns and frustration with aspects of the field testing process. We urge CMS to consider the lack of data received from all providers before submitting these measures for endorsement this year. For the reasons outlined below, we also urge CMS to keep the field testing process open so that these measures are vetted and properly reviewed by the Clinical Subcommittee. Otherwise, these episodes of care will require ongoing revisions, causing confusion among our members precisely at a time when the cost performance category increases to 30 percent of the total Merit-based Incentive Payment System (MIPS) score. We believe it is more important to ensure the accuracy of these episodes of care rather than to incorporate the measures into MIPS as soon as possible.

Approval and Refinement of Cost Measures

It is our understanding that CMS plans to send these eight episode-based cost measures through the National Quality Forum's (NQF) Measure Application Process (MAP) in early December. This

aggressive timeline provides insufficient time for the Clinical Subcommittees to evaluate feedback on the field testing and to make recommended changes on the measure structure. Given that no changes can be made to the measure structure after it has gone through the NQF MAP process, it is important that CMS and Acumen ensure that the Clinical Subcommittees are given appropriate time and ample feedback to be confident that the measure structure is correct before it goes to the NQF and before its inclusion in 2019 proposed rulemaking for the Quality Payment Program. To give short shrift to this phase of development undermines the process.

Lack of Access to the Portal = Limited Data

Based on feedback received from members thus far, our societies believe that difficulty accessing field test reports will limit the feedback provided to CMS on the draft Screening/Surveillance Colonoscopy cost measure. Our societies are committed to building awareness and educating our membership on the role that episode-based cost measures will play in the new payment system. We strongly encouraged our members through various communications to participate in the field testing period (October 16-November 20, 2017) of the colonoscopy cost measure under consideration, to access their test reports, and provide feedback. Before field testing started, our societies' representatives expressed concerns through the Clinical Subcommittee that test report accessibility, and thus feedback, may be low given these reports must be accessed through the CMS Enterprise Portal. Due to the lack of education on how to use the portal and accessibility issues, our members have had tremendous difficulty in the past accessing their Quality and Resource Use Reports (QRUR) through the CMS Enterprise Portal.

Our members, including some of those who serve on the Clinical Subcommittee for GI Disease Management, expressed difficulty and frustration in navigating the CMS Enterprise Portal. In some cases, members spent hours just trying to log on to the portal. Because the portal did not identify some practices at any level of identification (e.g., National Provider Identifier (NPI), Taxpayer Identification Numbers (TINs), NPI/TIN, group name, address, zip code, etc.), many sites and clinicians were unable to access their test reports to provide feedback. Below are examples of issues that our members experienced while attempting to access their test reports through the portal.

- Repeated delays in creating a password. We were informed that before passwords are confirmed, users must complete all the security questions before they are notified that the password submitted was rejected, even when the password met the stated criteria. After each password rejection, the security questions must be answered again.
- The fields in the portal did not capture input properly. For example, one of our members was asked to confirm input of her email address repeatedly, even though the email address she submitted was correct.
- Wait times for assistance through the telephone help desk were at least one hour.
- The directions on how to capture the necessary information to input the 3rd level of security was incomplete (e.g., identification of the correct cell phone number).
- Once the portal was accessed, there was confusion regarding which section of the site was the appropriate section to review and which pull down menu should be utilized to access the test reports. For example, the reports were in the quality payment pull down; however, some users thought it was more logical to find the report in the quality pull down.
- The field test reports were presented in duplicate with a separate - 508 format. It was unclear to the user that the files were enumerated by the NPI.

Issues like those mentioned above must be corrected if CMS wants clinicians and sites to successfully access their test reports. CMS is losing potential participation due to system errors and the complexity of the current navigation within the portal. These issues have been prevalent in regard to QRUR accessibility and have been the subject of comments to CMS for years. If CMS wants clinicians to complete the first step of accessing their reports, it is critical that the portal operates properly, access is made straightforward, and that clinicians are provided the appropriate resources needed to navigate the system.

Summary Results for Colonoscopy Cost Measure

The goal should be to design the Episode-Based Cost Measure Report in such a way that clinicians in practices of all sizes can easily interpret the reports so that actionable steps can be identified to improve patient care and cost efficiencies. We believe that the structure of the field test report is a vast improvement over the QRURs. The *Screening/Surveillance Colonoscopy Cost Measure: Summary Results (Summary Results)* are easy to read and the charts and graphs are also helpful. The selected benchmark provides a good basis for comparison.

The section on Clinical Themes is also beneficial, however, we urge CMS to clarify the data presented. For the Screening/Surveillance Colonoscopy cost measure, the included clinical themes are: All; Cardiopulmonary complications; Lower GI hemorrhage; Pathology; Perforation or Peritonitis; Repeat Colonoscopy or Flexible Sigmoidoscopy. One may interpret “All” to be all costs and the other themes to be complications, yet neither pathology nor repeat exam are complications. If the intent of this section is to provide information on services and costs common in the post-trigger period, then this should be made clear. If the intent is to present utilization and cost information for complications, we request that pathology be removed as it is not a complication. We would further note that if a physician has a higher adenoma detection rate, a positive measure of quality as it closely correlates with reduced future risk of colon cancer, or missed interval cancers, the result is likely higher pathology costs. As such, including pathology utilization and cost data in a list of complications suggests that physicians should strive to reduce pathology costs, which may have the perverse consequence of reducing quality by reducing adenoma detection. Again, we urge CMS/Acumen to remove data for pathology utilization and costs from this section of the *Summary Results*. Data on pathology costs is also captured in *Appendix A* under the “Utilization and Cost for Physicians/Supplier Part B Claims” section, so this information remains available to physicians, even if it is removed from the *Summary Results*.

Appendix A: Screening/Surveillance Colonoscopy Episode

In review of *Appendix A* for the Screening/Surveillance Colonoscopy cost measure, our members continued to find challenges. Absent the ability to access test reports, to drill down and determine the causes for elevated costs in certain episodes, our members’ ability to positively impact change in the cost of care is hindered. Further, clear information on attribution methodology and parameters of the episode is key to providers identifying where their performance can be influenced. We recommend using one standard deviation from the mean for the Screening/Surveillance Colonoscopy cost measure to provide an understanding of the measure spread.

Appendix A Layout

Our members expressed confusion on the definition of some of the section titles. For example, the section titled “Share of Episodes with Certain Services” does not indicate what “Certain Services” entail. In order to ensure that everyone is looking at the test reports from the same perspective, we request that CMS

provide hyperlinks for each section title, definitions, and additional information regarding the section. Further, in some sections of *Appendix A* where hyperlinks were embedded for additional information, the hyperlinks did not work or information had been moved.

As it relates to the broad services (e.g., ancillary, hospital inpatient, emergency room, post-acute, hospice, all other) captured under the “Medicare Setting and Service Category,” our societies request that this section include only services that apply to the specific cost measure, as specified by the relevant Clinical Subcommittee. Removing services that never apply to the Screening/Surveillance Colonoscopy cost measure (e.g., home health), will eliminate the artificial “0” for services in this section. For ease-of-use, we recommend that only the services applicable to the cost measure be included.

Patient Cohort - Trigger Codes

Based on our initial review, the Healthcare Common Procedure Coding System/ Current Procedural Terminology (HCPCS/CPT) codes identified as trigger codes for the Screening/Surveillance Colonoscopy cost measure appear accurate. However, it is important to note that the identified HCPCS/CPT codes must be accompanied by a primary diagnosis code of screening. These ICD-10 codes include:

- Z12.11 (Encounter for screening for malignant neoplasm of colon)
- Z86.010 (Personal history of colonic polyps)
- Z83.71 (Family history of colonic polyps)

Additionally, CPT G0105 and G0121 are also appropriate HCPCS codes to report screening colonoscopy.

Claims that have the identified HCPCS/CPT codes, but do not include a screening diagnosis code (Z12.11, Z86.010 or Z83.71) as the primary diagnosis are not screening or surveillance colonoscopies. The other diagnosis codes identified as potential primary diagnosis codes should be removed. Inclusion of these is an error in the overall construct of the episode, and results in much higher costs, for example from inpatient settings and from addition of numerous other codes that are utilized in diagnosis.

A further recommendation is to use the PT modifier, which is appended to CPT codes to identify screening/surveillance colonoscopies where the purpose of the service was screening, but the presence of polyps converted the procedure to a diagnostic service. CMS developed the PT modifier to indicate that a colonoscopy that was scheduled as a screening was converted to a diagnostic or therapeutic procedure. The PT modifier (Colorectal cancer (CRC) screening test, converted to diagnostic test or other procedure) is appended to the CPT code. Finally, it was suggested that the ability to peel back the data to see how and what was coded on the same date of service would be helpful.

Facility, Anesthesia, and Pathology Costs

The site of service, Ambulatory Surgery Center (ASC) versus Hospital Outpatient Department (HOPD), is a primary determinant of cost for Screening/Surveillance Colonoscopy episodes. Data should be presented that summarizes by NPI, what percent of procedures were performed in each site of service, as well as applicable allowed charges. Data for both sites should be compared to the data of other peers and national norms. Further, screening/surveillance colonoscopies are rarely performed in an inpatient site of service and should be excluded from the episode. When the examination is rarely performed in this setting, it is typically for beneficiaries who have socioeconomic risk factors or physical status/function limitations that make it unfeasible to perform successfully the exam in an outpatient setting.

In addition, we do not believe that anesthesia costs, another major determinant of cost, are included in a majority of the identified episodes. These costs should be included. Lastly, it appears that CMS is relying on CPT codes 88305 and 88307 to capture pathology costs. Costs associated with CPT Code 88307 should not be included in this cost measure as it should only be reported for a colon segment that is resected for a reason other than a tumor. Moreover, this pathology service is reported with these services less than one percent of the time. We recommend that CPT code 88307 be removed from the cost measure. As noted above, the inclusion of pathology creates the paradox where better quality (more adenomas found, removed, and analyzed by pathology) drives up immediate costs but is the key outcomes indicator correlating with the goal of reducing incidence rates and deaths from colon cancer.

Patient Cohort - Exclusions

Adding to the complexity, members noted that the current episode has also captured colonoscopy procedures that were performed with a diagnostic or therapeutic upper endoscopy. These procedures may be performed in the same setting. For example, a patient undergoing screening colonoscopy may also undergo upper endoscopy with dilation for symptoms of dysphagia. Given it will be difficult to attribute the costs of the site of service (e.g., balloon dilation is not available due to costs in most ASCs or offices), the different costs of anesthesia for these procedures, and complication attribution, we recommend that double procedures be excluded from the episodes.

Look Back Period

The current look back period for the Screening/Surveillance Colonoscopy cost measure is six months. We are concerned that a six-month look back period for this episode is problematic. Experienced providers, who are currently engaged in analogous episodes at the local/state level, noted that even twelve months is insufficient due to the time required for claims to move through the adjudication process. We have concerns that risk-adjustment will be inaccurate for this reason and would suggest CMS reconsider this timeframe.

Attribution Methodology vs. Patient Relationship Categories

CMS has previously stated that it intends to provide information on the resource use of each member of a clinical team. This information would enable one clinician's directly-performed services to be considered, as well as another clinician's indirect services, when performed in the same clinical context. We would like to better understand how the implementation of the patient relationship categories, which will be voluntarily reported for CY 2018, will impact the overall attribution of cost of care, as these categories were not included in the current field testing. We would also like to better understand how this will impact assigning clinician responsibility to a patient's care when multiple clinicians are involved. As CMS considers how it will apportion the cost of care among physicians when they are attributed to the same episode of care, we see several potential pitfalls, which could inadvertently penalize physicians. These two related but separate issues cannot be reviewed in isolation of one another. The data collected and reviewed for the current model may look entirely different post patient relationship category implementation.

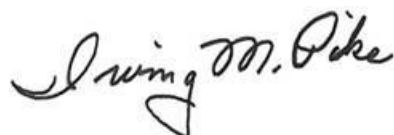
Conclusion

We appreciate the opportunity to participate in the process and to provide feedback on the draft materials for the Screening/Surveillance Colonoscopy cost measure, the field testing process and the test report. If we may provide any additional information, please contact Brad Conway, Vice President of Public

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Policy, ACG, at (301) 263-9000 or bconway@gi.org; Jessica Roth, Director of Regulatory Affairs, AGA, at (240) 482-3230 or jroth@gastro.org; or Lakitia Mayo, Senior Director of Health Policy, Quality and Practice Operations, ASGE, at (630) 570-5641 or Imayo@asge.org.

Sincerely,



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