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January 2, 2018

Ms. Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted online at: https://www.regulations.gov/document?D=CMS-2017-0082-1300

Re: Medicare Programs: CY 2018 Updates to the Quality Payment Program [CMS-5522-FC]

Dear Administrator Verma:

The American Society for Gastrointestinal Endoscopy (ASGE) appreciates the opportunity to comment on finalized changes to the Quality Payment Program (QPP) for the 2018 performance year as published in the *Federal Register* on November 16, 2017.

The ASGE was founded in 1941 and since that time has been dedicated to advancing patient care and digestive health by promoting excellence in gastrointestinal endoscopy. ASGE, with more than 14,000 members worldwide, promotes the highest standards for endoscopic training and practice, fosters endoscopic research, recognizes distinguished contributions to endoscopy, and is the foremost resource for endoscopic education.

In response to the 2018 QPP proposed rule, ASGE commended the Centers for Medicare and Medicaid Services (CMS) for taking a measured approach to implementing the QPP, but cautioned that the QPP is only as meaningful and reliable as the measures upon which physicians are assessed. We also highlighted the outsized investment required of physicians to participate in the Merit-Based Incentive Payment System (MIPS). We are grateful CMS has made accommodations for small practices through modified reporting requirements, bonus payments and additional participation exemptions. However, with more than 900,000 clinicians estimated to be exempt from the MIPS requirement in 2018, the redistributive effect of MIPS, due to budget neutrality, will likely be limited. As the burden of MIPS participation grows, for example physicians being assessed on measures and tasks that are poor predictors of outcomes or for which attribution is questionable, with minimal upside financial benefit, the value proposition from physician's perspective is lost and MIPS is simply a regulatory burden.

Increasing Opportunities for Advanced Alternative Payment Model Participation

The vast majority of gastroenterologists in single specialty practice will not have available to them an Advanced Alternative Payment Model (APM) for the 2018 performance year. Consequently, the MIPS pathway may yield minimal financial return for a significant investment in quality measure reporting and use of electronic health records.

Increasingly, ASGE is hearing from gastroenterologists who are entering into alternative payment arrangements with commercial payers. ASGE therefore strongly supports expanding opportunities for participation in Advanced APMs. CMS states in the CY 2018 QPP final rule that commercial and other private payers, that are not states, Medicare Health Plans, or payers with arrangements that are aligned with a CMS Multi-Payer Model, can request a determination of whether their APM arrangements qualify as Other Payer Advanced APMs for the 2020 Performance Period and each year thereafter. We are disappointed that CMS chose to limit other payer arrangements, other than those specified in the final rule, until the 2020 performance period rather than the 2019 performance period. We encourage CMS to re-evaluate this timeline. Nonetheless, CMS should move expeditiously to allow commercial and other private payers to request a determination of whether their arrangements qualify as Other Payer Advanced APMs. As part of the process of identifying Other Payer Advanced APMs, CMS should recognize retrospective shared payment models with no downside financial risk as MIPS APMs. And, if they can achieve savings consistent with other qualified Advanced APMs, these payment models should be reclassified accordingly.

Measuring Cost

ASGE is disappointed with CMS' decision to assign a weight of 10 percent to the cost category for the 2018 performance period while development of episode groups is still underway. Despite the lack of confidence that medical societies have in the Medicare spending per beneficiary (MSPB) and total per capita cost measures, as well as their reliability, CMS continues to consider these measures appropriate for assessing resource use. It also seems premature to proceed with measuring improvement within the Cost category for the 2020 payment year while CMS continues to use the broad total per capita costs and MSPB measures to evaluate the resource use of individual physicians.

ASGE, and its member volunteers, are committed to the development of measures that more accurately reflect physician resource use. Eleven gastroenterologists, including six ASGE representatives, have devoted considerable effort to the development of a Screening and Surveillance Colonoscopy episode group through the Acumen-led process. Ultimately, this and other well-developed episode groups should supplant the total per capita costs and MSPB measures.

ASGE has commented previously that the process for incorporating episode groups for cost measurement should include evaluation and refinement of the trial set of episode groups by relevant Acumen-convened clinical subcommittees and a period of notice and public comment. As ASGE, alongside the American College of Gastroenterology and the American Gastroenterological Association, commented to CMS on November 20, 2017, in response to the

episode group field testing, the episode group clinical subcommittees had insufficient time to evaluate feedback on the episode group field testing before the measure was submitted to the National Quality Forum's Measure Applications Partnership (NQF MAP) for review. The evaluation of feedback on the field test was further complicated by the inability of physicians to access their test reports. The short feedback period also made it difficult for physicians to drill down into their reports and determine the causes for elevated costs in certain episodes. ASGE and its members embrace the use of episode groups for measuring cost but their accuracy must be confirmed before they are used as a metric to assess value.

Definition of Ambulatory Surgery Center (ASC)-Based Eligible Clinicians

CMS has finalized the definition of an ASC-based MIPS eligible clinician as one who furnishes 75 percent or more of his/her covered professional services in sites identified by POS 24. We are aware that CMS is basing its definition of an ASC-based MIPS eligible clinician on the standing definition of hospital-based eligible professional.

ASC-based eligible clinicians will be exempt from the Advancing Care Information (ACI) requirements for the 2018 performance year. Unfortunately, the vast number of eligible clinicians who practice in the ASC still will not be helped by CMS' finalized threshold definition. Furthermore, the final rule states that for group reporting, 100 percent of the MIPS eligible clinicians in the group must qualify for an exemption for the ACI category to be reweighted. We ask that CMS reconsider this requirement and instead consider reweighting the ACI category in the case that at least 50 percent of MIPS eligible clinicians in a group meet the definition of an ASC-based MIPS eligible clinician.

Quality Measure Benchmarks

In its comments in response to the proposed rule, ASGE also asked CMS to reconsider its proposals to score improvement within the Quality category and to increase the performance threshold from three to 15. We are disappointed that CMS finalized both proposals while questions about benchmark accuracy persist.

ASGE strongly recommends that CMS continue to stratify benchmarks by reporting mechanism but further delineate benchmarks by the Qualified Registry (QR) and Qualified Clinical Data Registry (QCDR) mechanisms. Stratifying QR and QCDR data will help improve the validity of the benchmarks. QCDR participants submitting a large volume of their cases should not be benchmarked against QR reporters who may only report a select subset of their cases to meet data completeness requirements and which may be biased for high performance. CMS may also wish to stratify benchmarks by QCDR since there is variability among QCDRs in data collection integrity and refinement.

QRs and QCDRs are two very different types of reporting mechanisms; combining their data will lead to inaccurate benchmarks. Setting separate benchmarks for registries is really not different than establishing separate benchmarks for measures that can be reported via claims and registry. Here we find it necessary to restate our recommendation that when establishing quality measure benchmarks CMS undertake a thorough review of a measure's clinical recommendation

statement in relation to that measure's decile ranges and consult with the measure steward. For example, CMS' 2017 benchmark for measure #343 (Screening Colonoscopy Adenoma Detection Rate) is greatly inconsistent with evidence, and, therefore, physician expectations. As ASGE has previously commented, it is critical that clinicians view the MIPS requirements as achievable. A quality measure benchmark that does not match published evidence diminishes physician confidence in the program. MIPS scoring policies should be reviewed in light of cases such as measure #343 and its benchmarks.

QCDR Measures Review Process

CMS is seeking comment on whether the standards used for selecting and approving QCDR measures should align more closely with the standards used for the Call for Quality Measures process for consideration in future rule making. CMS also notes in the final rule that it is interested in "elevating" the standards for which QCDR measures are selected and approved for use. ASGE agrees that QCDR measures should aim to be of the highest caliber, but disagree with aligning these standards — a position held by the Physician Clinical Registry Coalition of which ASGE is a member. Congress established, as part of the American Taxpayer Relief Act of 2012, that physicians could fulfill the requirements of the Physician Quality Reporting System (PQRS) by submitting data via a QCDR. The physician community called upon Congress to establish this quality measure reporting pathway for two fundamental reasons: 1) physicians who were participating in clinical data registries were burdened by duplicate PQRS quality measure reporting; and 2) the process for getting measures approved in PQRS lacked agility and, consequently, PQRS lacked specialty-specific measures.

Rather than exploring an alignment of standards for measure approval, CMS first needs to create an organized, transparent, and consistent QCDR measures review process. The QCDR self-nomination process has been fraught with confusion. For example, for the 2018 QCDR self-nomination process, the GI Quality Improvement Consortium, Ltd. (GIQuIC), the non-profit collaboration of the American College of Gastroenterology (ACG) and ASGE, was directed to combine four measures into a single measure with multiple strata or provide a rationale for why that would be inappropriate. For a number of reasons, GIQuIC, in summary, determined this action to be inappropriate for 2018 performance year, including the lack of testing and analysis of this single measure with multiple strata before deployment. Ultimately, the four measures were approved individually, but we have been told the measures must be combined for 2019. It is unclear that measure integrity is preserved with this kind of capricious combination; therefore, an appropriate analysis is required. Consequently, registries are forced to dedicate scarce resources to defend validated established measures, rather than dedicating those resources to new measure development. We request the development of a more consistent and standardized process to contest and demonstrate whether the merging and consolidation of measures is appropriate.

ASGE is concerned that aligning the QCDR measure review process more closely with the Call for Quality Measures process may negatively impact the agility of the QCDR measure approval process, as was originally intended. For most medical societies, the appeal of maintaining a QCDR and developing QCDR measures lies in the ability to create specialty-specific measures in a timely manner to support clinicians engaging in meaningful measurement at the local level

for quality improvement purposes in addition to using many of the same measures for accountability purposes.

Any changes CMS makes to its QCDR measure review process must serve to incentivize registries to develop new QCDR measures and to self-nominate as QCDRs. Ultimately, the time and resources QCDR owners must invest in developing systems to meet CMS' requirements, which are not always clear, detours those resources away from new endeavors. GIQuIC was a successful registry prior to the introduction of QCDR status as evidenced by the consistent, steep growth in its participant curve and participant usage of the registry. (There are more than five million colonoscopy cases in the registry presently, a number that is growing rapidly.) The registry and its member societies welcomed the opportunity for GIQuIC to serve as a QCDR, successfully self-nominating for the 2014 reporting year and each subsequent reporting year. This has not come without compromise. GIQuIC has desired to move beyond colonoscopy and esophagogastroduodenoscopy (EGD) quality measurement for years and into other important areas for gastroenterologists but such efforts have been stifled by the overwhelming task of supporting Medicare reporting with its constantly changing and confusing requirements.

Lastly, CMS states in the final rule that it believes an annual self-nomination period (rather than multi-year approval) is appropriate. In the final rule, CMS highlighted what it views as challenges to multi-year approval. ASGE looks forward to working with CMS to overcome what it perceives as barriers to multi-year QCDR approval.

Measure Stewards for GI Measures

The final rule incorrectly lists the American Gastroenterological Association (AGA) as the measure steward for measure #343. ASGE is the measure steward for #343. ASGE has served as the steward for measure #343 since it was introduced into the Medicare program beginning with the 2014 performance year. ACG and AGA are co-owners of the measure. The final rule also lists AGA/ACG/ASGE as measure stewards for measure #401. AGA serves as the sole measure steward for #401. We ask that this be corrected in future CMS publications.

Improvement Activities Inventory

ASGE and its members are pleased that for the 2018 performance year, the following programs were officially approved as MIPS improvement activities and will be available to gastroenterologists for quality reporting that is meaningful to their practices:

- *Endoscopy Unit Recognition Program (EURP)* encompassed under IA_PSPA_18 "Measurement and Improvement at the Practice and Panel Level."

- *ASGE Skills Training Assessment Reinforcement (STAR) Certificate Program* encompassed under IA_PSPA_28 "Completion of an Accredited Safety or Quality Improvement Program."

ASGE recommends the development of a clear pathway to confirm applicability of new society programming as meeting an activity included on CMS' list of improvement activities. Programs may be conceived, developed, and deployed between Calls for Measures and Activities as was

the case with ASGE programming and the 2017 reporting year. Our experience in gaining confirmation of program applicability varied widely when working through the QPP Help Desk and representatives from a third-party vendor.

ASGE will submit in the upcoming Call for Measures and Activities its new GI Operations Benchmarking platform so that it may be considered for inclusion on CMS' list of improvement activities for the 2019 reporting year. ASGE's GI Operations Benchmarking provides practices with an agile, user-friendly platform with analytic capabilities to support operating in a more cost-effective and efficient manner.

Ultimately, ASGE can support gastroenterologists for the 2017 reporting year in fulfilling the MIPS Improvement Activities performance category with five programs, in which thousands of gastroenterologists currently participate. Notably, some of this programming actively engages all members of the health care team caring for patients with digestive diseases and disorders, which would include the following MIPS-eligible clinicians: anesthesiologists, pathologists, physician assistants, certified registered nurse anesthetists, clinical nurse specialists, and nurse practitioners.

Conclusion

ASGE appreciates the opportunity to provide comment on this final rule. Should you have questions or require additional information, please contact Lakitia Mayo, Senior Director of Health Policy, Quality and Practice Operations at lmayo@asge.org or (630) 570-5641.

Sincerely,

Karen L. Woods, MD, FASGE
President