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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8013

Re: Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Proposal to Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule

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 comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule (CMS-1734-P), published on August 17, 2020 in the *Federal Register*, regarding the proposed policy revisions to the CY 2021 Medicare Physician Fee Schedule (PFS). Together, our three societies represent virtually all practicing gastroenterologists who provide preventive, consultative and therapeutic care for the U.S. population.

Our societies submitted comments on Revisions to Payment Policies under the "Physician Fee Schedule and Other Changes to Part B Payment Policies" proposals of the CY 2021 Medicare PFS proposed rule on September 9, 2020. This letter includes comments specific to "Updates to the Quality Payment Program" proposals.

There are several provisions pertaining to the Quality Payment Program (QPP) in the proposed rule that adversely impact Medicare beneficiaries and the practicing gastroenterologists who treat them.

In this letter, we offer comments on the following provisions:

- Merit-based Incentive Payment System (MIPS)
  - Performance Category Weighting
  - Performance Threshold
  - Quality Performance Category
  - Cost Performance Category
  - Promoting Interoperability
  - Improvement Activities
- MIPS Value Pathways (MVPs)
- Alternative Payment Model (APM) Performance Pathway (APP)

A summary of our recommendations can be found on page 11.

Merit-based Incentive Payment System

Our societies welcome the opportunity to comment on specific changes to the Merit-based Incentive Payment System (MIPS) for the 2021 performance year.

Performance Category Weighting

CMS proposes to weight the cost performance category at 20 percent of the MIPS final score for the 2023 payment year, and as required by statute, to weight the cost category at 30 percent for the 2024 payment year. The weight of the cost performance category has remained at 15 percent for MIPS payment years 2021 and 2022, and CMS considered maintaining a weight of 15 percent for the 2023 payment year in light of the public health emergency. However, CMS was concerned this would not help clinicians' transition to the level mandated in year six of the program.

Our societies recommend CMS use the authority granted to it under the Bipartisan Budget Act of 2018 to maintain the cost performance category weight at 15 percent for the 2023 MIPS payment year and then increase it to 30 percent beginning with the 2024 MIPS payment year. Because the percentage points attributed to the quality and cost performance categories are in tandem, we recognize an increase in the weighting of the cost category from 15 percent to 30 percent from the 2023 to 2024 payment year constitutes a significant increase from one year to the next; however, it is important at this time to not increase the cost category weight at the expense of the quality category for which clinicians have greater control.

According to examinations of health care utilization early in the pandemic, more than a third of Americans reported putting off health care, including preventive services. And while patient volume for most physician practices began to rebound after stay-at-home orders were lifted, most practices are still struggling to return to pre-COVID capacity, creating a backlog of patient care and services that could linger into 2021. In fact, Massachusetts General Hospital (MGH) has reported a backlog of 10,000 colonoscopies as a result of the pandemic, with other practices reporting similar conditions. The ultimate effect on Medicare beneficiaries delaying or foregoing care is unknown at this time, but the result could be exacerbation of medical conditions that are ultimately more costly to treat. Therefore, the weighting of the cost category should not increase for the 2023 payment year.

Performance Threshold

Our societies support CMS' proposal to set the performance threshold at 50 points for the 2023 MIPS payment year, instead of 60 points as previously finalized. We believe it is paramount that CMS take steps amidst the COVID-19 pandemic to protect small physician practices from receiving a 2023 negative payment adjustment, and under CMS' assumptions a threshold of 50 points would result in fewer small practices receiving negative payment adjustment in 2023.

In general, **we recommend keeping many aspects of the program stable as our nation's clinicians and patients continue to struggle to navigate this unprecedented public health emergency and its long-term impact on our healthcare system.**

Quality Performance Category

Groups and Virtual Groups Reporting via the CMS Web Interface

Although our societies believe MIPS participants have the greatest chance of success when they have access to multiple reporting options to meet MIPS requirements, the majority of gastroenterologists utilize qualified registries and Qualified Clinical Data Registries to submit their data to CMS. Therefore, **we support CMS' decision to remove the web interface reporting option.**

Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

Our societies support the integration of one telehealth item into the performance year 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey as proposed. With the expectations that telemedicine will continue to be an important health care delivery tool to protect the most vulnerable throughout the COVID-19 pandemic and that payment policies will support the expansion of telemedicine beyond the pandemic, especially for vulnerable populations and those in medically underserved areas, delivery of health care through telemedicine will become an increasingly important measure of patient satisfaction. Inclusion of questions related to telemedicine in the CAHPS for MIPS Survey for 2021 is a practical step and should be considered for inclusion for future performance years. Further, we believe the inclusion of a telemedicine item in the CAHPS for MIPS Survey is important for those clinicians and groups that are selecting the CAHPS for MIPS Survey as an optional improvement activity. **We also agree with the Agency's proposed revisions to the CAHPS for MIPS Survey cover page to include a reference to care received in telehealth settings to ensure patients who respond to the CAHPS for MIPS survey are reflecting on experiences of the care they received via telehealth in their responses.**

Other health systems have incorporated telemedicine questions into their patient satisfaction surveys or have separate surveys for those that are done in-person, or "live," and those conducted via telehealth. We suggest, based on those surveys, that possible questions could include:

> How satisfied were you with your video/telephone visit?
> How well did the video/telephone visit address/manage your medical needs?
> How easy was the technology to use?
> How would you rate the technology (picture and sound quality) of the program?

Hospital-Wide, 30-day, All- Cause Unplanned Readmission Rate (HWR) for MIPS Eligible Clinician Groups

Our societies do not agree with CMS' proposal to add the HWR into the quality performance category. While the AGA, ACG, and ASGE are encouraged to see that CMS proposes to continue to only apply this measure to groups of 16 or more clinicians and only those with a case minimum of 200 patients or greater, we continue to have serious concerns and issues with the measure that warrant attention and consideration. The HWR for MIPS Eligible Clinician Groups measure lacks transparent evaluation on whether it is appropriate to apply the readmission of one patient to multiple physicians since no evidence or testing was provided to support the attribution of this measure to the three distinct groups (discharge physician, primary inpatient care provider, and outpatient primary care provider) during the National Quality Forum (NQF) endorsement review. In addition, while we agree there is evidence to demonstrate that improved care coordination and programs focused on discharge planning can lead to reductions in hospital readmissions, most of the evidence used to support attribution to physicians involves multiple partners and clinicians such as the health system, hospital, nurse, and/or pharmacist. Insufficient evidence was provided to support that physicians or practices using the proposed attribution approach in the absence of some coordinated program or targeted intervention led by the health system or hospital can implement structures or processes leading to improved outcomes for these patients.

In addition, the impact that social risk factors in the risk adjustment model could have on the absolute change of performance rate has not been fully explored. These shifts could potentially influence the points physicians score in the quality category in MIPS and, as a result, either positively or negatively impact the overall penalty or incentive they receive and the resources available for those individuals and groups who serve larger numbers of disadvantaged patients. This information plus understanding how the measure performs using the MIPS benchmark methodology and Physician Compare Star Ratings, since CMS utilizes two different methodologies for ranking and profiling physicians, must be provided.

Therefore, **until appropriate evaluation and potential refinements to the measure can be made, physicians should not be held accountable for the HWR measure and the measure should be removed from the program.**

Our societies also question the ability of the HWR to meaningfully distinguish better or worse performers based on the available benchmarks from the 2017 performance period. Performance ranged from 13.82% to 15.75% across the clinician groups to whom the measure was applied. Using the current benchmarking approach, this less than 2% difference in performance was distributed across the seven deciles with less than half a percentage point difference captured within each decile. This lack of significant variation leads us to question the utility of the HWR within MIPS.

Data Completeness Requirement

For MIPS performance year 2017, CMS finalized a data completeness requirement of 50 percent for quality measure reporting. CMS increased this requirement to 60 percent for performance years 2018 and 2019 and to 70 percent for performance year 2020. As such, MIPS eligible clinicians and groups submitting data on QCDR measures, MIPS CQMs, and eCQMS must now submit data for at least 70 percent of the MIPS eligible clinicians or group's patients that meet the measure's denominator criteria, regardless of payer, while those submitting Part B claims measures must submit data on 70 percent of applicable Part B patients.

Although CMS is not proposing to modify the data completeness requirement for 2021, we continue to oppose the 70 percent requirement and urge CMS to consider a requirement of no more than 60 percent. Over time, we encourage CMS to adopt requirements that are based on a set number of eligible patients per measure, rather than an arbitrary percentage, which will make it easier for physicians and practices to track. Percentage requirements of 60 or 70 percent or higher do not account for physicians who provide care beyond a single site and wrongly assumes that data is fluid between sites. Some specialties, including gastroenterology, provide services across multiple sites using the same NPI/TIN; however, not all sites (including across sites of service) may: (1) participate in MIPS; or (2) use the same registry or EHR that the physician uses for MIPS reporting. **Until physicians and other eligible clinicians can work within an environment where data and care are integrated seamlessly across settings and providers, it is premature to continue to increase the MIPS data completeness requirement.**

Scoring

Quality measures, eligible for benchmarking, can receive between 3 and 10 achievement points. For measures with history in the program for which benchmarks could be established based on prior year's reporting, these benchmarks are published prior to reporting; however, for those quality measures without a benchmark, achievement points are capped at 3 points with the caveat a benchmark may be established with performance period data.

This policy creates a disincentive for clinicians to report new measures, leading them to instead choose measures they are confident will lead to the greatest number of achievement points, and, consequently, the highest possible MIPS score. The point disincentive to report new measures can consequently make it more difficult for a measure to meet the requirements for establishing benchmarks.

Our societies support CMS' proposal to set benchmarks for the CY 2021 performance period based on the actual data submitted during the CY 2021 performance period.

We appreciate the rationale for setting the benchmark on performance period data is to accommodate for physicians who did not submit data for the 2019 performance year as a result of the COVID-19 outbreak, which could compromise a representative sample of 2019 performance data and potentially skew the benchmarks. While CMS could use historic benchmarks (data from the CY2018 performance period), setting the CY 2021 benchmark based on corresponding performance period data presents an opportunity to eliminate the point interference that dissuades clinicians from reporting new measures and will help to level the MIPS measure field.

Fewer clinicians submitting MIPS data for the CY 2019 and CY 2020 performance periods could also skew whether quality measures are truly topped out and should be subject to a scoring cap of 7 measure achievement points. **Therefore, we also support CMS' proposal to make an exception to its topped-out measure methodology for the 2021 performance period.** Specifically, we support the 7-point achievement cap will apply only to measures that meet the following two criteria collectively: First, a measure has been topped out for two or more periods based on the published 2020 MIPS performance period historic benchmarks; and second, a measure remains topped out after the 2021 MIPS performance period benchmarks have been calculated.

Establishing Separate Performance Periods for Administrative Claims Measures

Our societies do not agree with different performance periods for the administrative claims measures in the quality performance category. It is not clear why CMS believes that different performance periods should be considered only for measures derived from administrative claims. The inherent assumption that measures are reliable and valid based on 12 months of data can only be assessed measure-by-measure and it should not be assumed that unreliable data using 12 months can occur only using administrative claims. All measures should be evaluated on the degree to which the data yield reliable results, and if an acceptable minimum threshold of 0.7 cannot be achieved, then the measure specifications, including longer performance periods, should be considered. This recommendation should not be limited to just administrative claims.

The need to expand performance periods into lookback periods longer than 12 months should also be balanced with the degree to which the meaningfulness and actionability of the measure is lessened. If CMS desires to have a program with quality and cost measures that are meaningful and the data can be used to drive improvements in patient care, then measures that are based on retrospective data over multiple years should not be prioritized.

Quality Measures

Our societies thank CMS for considering and approving the recommended changes to measure QPP439 – Age Appropriate Screening Colonoscopy. The end goal of this inverse measure is to eliminate inappropriate screening. As such, the intent of the measure is to look at all patients undergoing screening colonoscopy as the target population with the quality action in that population being to capture unnecessary screening of older individuals. By defining the target population as such we aim to assess all eligible clinicians routinely performing screening colonoscopy, including those doing lower volumes. A further benefit of this approach is to strengthen analysis and benchmarking of the measure. We also thank CMS for agreeing with the recommendation to retire measure QPP390 – Shared Decision Making for Hepatitis C (HCV) patients. Given the advancements in treatment options, a shared decision-making model for HCV patients is less relevant. Since 2017 there are treatments that target all genotypes. Genotype testing, though still performed, is less important than in the past and it no longer significantly influences treatment choices.

Cost Performance Category

Concerns with TPCC and MSPB – Clinician

Our societies encourage CMS to carefully reconsider the continued inclusion of the measures Total Per Capita Cost (TPCC) and Medicare Spending per Beneficiary (MSPB) – Clinician in MIPS in light of recent National Quality Forum (NQF) endorsement review. While a final decision on these measures has not yet occurred, the preliminary recommendations released for public comment highlight many concerns voiced by specialties on the scientific acceptability of these measures. Specifically, the NQF Cost and Efficiency Standing Committee did not recommend MSPB – Clinician for endorsement and the group did not achieve consensus on the validity of the TPCC.

We remain concerned with the potential low reliability threshold results that may be produced for either measure given the fact that the minimum threshold is set at 0.4. We continue to encourage CMS to **consider setting the minimum threshold to a higher level, such as greater than 0.7,** as it is important that these measures provide the most reliable and consistent information on cost.

We were also disappointed to see that no correlations to quality measures were provided in the NQF testing form. **Our societies believe that cost must be assessed within the context of the quality of care and the questions of what interactions there are must be answered prior to implementation of any MIPS Value Pathway (MVP) (more on this below).** The risk models for both of these measures produced generally low R-squared results and did not adequately address the question of whether social risk factors should be included. The question of how costs attributed to physicians and practices enable us to distinguish low versus high performers also remains unknown.

The absence of this information paired with the ongoing concerns over the attribution methodology serve as significant threats to validity. We support the concerns voiced by the NQF Cost and Efficiency Standing Committee.

In addition, the continued overlap or "double counting" that results from the attribution of many of the same beneficiaries in the episode-based cost measures and the TPCC or MSPB – Clinician and resulting unknown impact that the attribution of one beneficiary for the same episode to multiple measures will have on the overall cost category leads us to **urge CMS to evaluate whether these two broad population-based measures should be included in future MIPS program years.**

Promoting Interoperability

Measure Attestation

Our societies support CMS' goal of reducing provider burden and promoting interoperability. We continue to believe a "less is more" approach to reporting will be the most effective. We are also encouraged to see CMS considering the need to transition away from prescriptive physician measurement, because, current numerator and denominator reporting creates confusion and adds unnecessary complexity to the program. Too often the rich clinical information generated from the physician-patient narrative is clouded by unnecessary additional "note bloat" in order to score promoting interoperability (PI) points. **All PI measures should therefore transition to "yes/no" attestation. This must be done to put patients over paperwork.**

Health Information Exchange Objective

CMS is proposing to add a new Health Information Exchange (HIE) Bi-Directional Exchange measure to the HIE objective as an optional alternative to two existing measures: the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. CMS is proposing the HIE Bi-Directional Exchange measure would be reported by attestation and would require a "yes/no" response.

Our societies welcome CMS' proposal to add a new optional alternative measure to the PI performance category's HIE objective. Many physicians find it challenging to meet the current HIE objective measures. The new optional measure provides physicians a flexible and useful opportunity to receive 40 points within PI. This also allows physicians to meet an important objective using technology that interacts with certified EHR technology (CEHRT).

Our societies request more clarity regarding the proposed multi-part physician attestation. CMS is proposing that physicians attest they "participate in an HIE in order to

enable secure, bi-directional exchange to occur for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period," and the HIE they participate in "is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and does not engage in exclusionary behavior when determining exchange partners." We believe this would be met when physicians attest that they have the *functional capability* to conduct bi-directional exchange for all patients during the PI reporting period, not that physicians *must conduct* bi-directional exchange for all patients during the PI reporting period.

Improvement Activities

Group Reporting

In the CY 2017 QPP final rule, CMS clarified that if at least one clinician within a group is performing an improvement activity for a continuous 90 days, the group may attest to and get credit for completing that activity when reporting to the improvement activities (IA) performance category. In the CY 2020 PFS final rule, CMS increased the minimum number of clinicians in a group or virtual group who are required to perform an improvement activity to 50 percent, beginning with the 2020 performance year and future years.

Although CMS is not proposing any changes for 2021, **our societies continue to oppose the 50 percent requirement since it discourages the use of specialty-oriented improvement activities within multi-specialty practices.** As we expressed last year, if only 20 percent of a group's NPIs are gastroenterologists then the group practice could not get credit for any gastroenterology-focused improvement activity. As a result, multi-specialty practices are obligated to select more generic improvement activities that apply to the entire practice but may not be as meaningful to its clinicians. **We continue to encourage CMS to adopt a lower requirement that incentivizes more meaningful engagement in improvement activities by multi-specialty groups.**

MIPS Value Pathways

Our societies appreciate the opportunity to provide feedback on the principles and proposed process for the MIPS Value Pathways (MVP). **We agree that MVPs should be further delayed to CY 2022, at the earliest, affording CMS and stakeholders the opportunity to develop a collaborative process. We also recommend that CMS look toward the process CMS/Acumen LLC employed when developing specialty-specific episode-based cost measures as a way to further develop MVPs**. We believe CMS currently does not provide a sufficient level of guidance on how the candidate MVPs would be evaluated or prioritized. There is great risk this process would create a catalog of information with little to no direction on how it would be applied. **Our societies also do not support mandatory MVP adoption. We believe that this would be counter to CMS' goal in developing MVPs.**

Measure and Activity Selection

Our societies appreciate CMS' recognition that physician input is critical, and **we support a collaborative and transparent process that allows MVPs to be developed and proposed with strong engagement of medical specialty societies**. We believe

significant refinement and clarification of the intent of the proposed criteria are necessary prior to their use.

Patient Report Outcome, Experience or Satisfaction Measures

We strongly caution CMS with moving forward with a single question or brief survey to measure the quality of patient experience and satisfaction due to the diversity among physician practice settings and specialties. Patient experience encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities. Patient satisfaction is related to whether a patient's expectations about one health encounter were met.[1]

Consistent Denominators

Our societies urge CMS to make efforts to reduce reporting burden and program inflexibility when developing MVPs. For example, maintaining the denominator criteria across quality measures or all categories could limit the applicability of MVPs to specialists and sub-specialists. The criteria would also require physicians to report on all four categories for the full calendar year and eliminate the option for physicians to only have to report on PI and IA for 90-days. Having to report on IA and PI for more than 90-days could greatly increase administrative burden.

Capturing the Patient Voice

Our societies support having patients at the table during the development of MVPs. Patients and patient advocacy organizations bring a unique voice to the quality improvement and development process. Including patients into the MVP development process may also help with selecting appropriate MVP metrics that do not unintentionally restrict care or inaccurately attribute costs to certain providers. MVPs should well-defined and applied consistently with a transparent process. Incorporating the patient voice may help achieve these goals.

Accept and Pilot Test New Cost Measures for MVP

Our societies urge CMS to partner with specialty societies to develop, validate, and implement new cost measures for MVPs. CMS should allow physicians to pilot test innovative and flexible approaches to measuring costs involved in an episode or condition, through MVPs. CMS should also allow for the development and testing of new risk adjustment and attribution methods.

TPCC and MSPB Measures

Our societies are also concerned about the following proposed MVP question: "If there are not relevant cost measures for specific types of care being provided (for example, conditions or procedures), does the MVP include broadly applicable cost measures (that are applicable to the type of clinician)?" It implies that if an episode-based cost measure is not available, the MVP must include a broadly applicable cost measure, including the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures. We continue to believe the inclusion of the TPCC and MSPB measures in MIPS hold physicians accountable for costs outside of their control, do not align with quality measures, and face reliability and validity problems.

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[1] [1] What is Patient Experience? Patient Experience Defined. About CAHPS. Agency for Healthcare Research and Quality. https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html. Accessed 09-05-2020.

Attribution is also a challenge for many specialties. MVP developers should not have to rely on these problematic measures to advance their MVPs. Instead, CMS should work with the specialty societies to share the costs and burdens of developing new cost measures applicable to MVPs, such as a measure that evaluates the cost-effectiveness of routine colonoscopy screening in preventing colorectal cancer. **We recommend CMS revise this proposed question to indicate CMS is willing to partner with specialty societies to develop and pilot test new measures that are not currently on the list of MIPS episode-based cost measures.**

Reporting Burden

We also note that the criteria do not assess the degree to which the construction of the MVP would reduce reporting burden. **Given that burden reduction was one rationale for moving to MVPs, we believe that it should be included as a specific item within the criteria**. **Assessment of potential unintended consequences through the implementation of an MVP should also be incorporated, particularly for cost measures where low cost implies higher quality or whether the inclusion of the clinically relevant, yet topped out measures, could provide context to costs.**

Actionability and Informed Decision Making for Physicians and Patients

The criteria should also assess the degree to which an MVP provides the context and information related to the care provided by a specialty or sub-specialty in a way that is understandable and useful to physicians and patients.

Process to Solicit MVP Candidates

While a rolling review process would expedite MVP selection, CMS must ensure that the evaluation is as objective as possible and completed in coordination with the relevant specialties and sub-specialties. Medical specialty societies often report that submission of measures to the Measures Under Consideration process lacks transparency, feedback on why measures were not selected is often perfunctory, and the CMS/contractor responses clearly indicate that the relevant clinical expertise was not consulted during the review. A repeat of this process must not occur as MVPs are selected. Medical specialty societies must be at the table as any applicable MVP is evaluated and have the ability to provide substantive input on the proposals. The input cannot be achieved with one advisory committee, technical expert panel or interdisciplinary committee. CMS must not limit these reviews to one group. Instead, we recommend a more collaborative process.

Alternative Payment Model (APM) Performance Pathway (APP)

Our societies agree with the Agency's decision to postpone the implementation of MVPs and revisit potential MVP implementation through future rulemaking, possibly beginning with the 2022 performance period. Similarly, **we recommend CMS postpone implementation of the APM APP for the 2021 performance year.**

The proposed rule does not provide much insight into CMS' thinking around this approach and gives rise to questions as to how CMS selected the APP measure set and arrived at the decision to assign a broad set of measures across different MIPS APMs.

As an alternative to the APP measure set, CMS proposes an individual physician could opt-out of reporting the APP and report under the standard MIPS requirements and scoring. While the MIPS quality measures may be more appropriate than the pre-defined APP measure set, it is

subjecting APP participating physicians to the MIPS program, as well as the APM scoring standard.

More time is needed for CMS to fully engage with physician stakeholder organizations before attempting to move forward with this new approach to MIPS APM quality reporting.

Conclusion

We urge CMS to:

- Use the authority granted to CMS under the Bipartisan Budget Act of 2018 to maintain the cost performance category weight at 15 percent for the 2023 MIPS payment year and then increase it to 30 percent beginning with the 2024 MIPS payment year.
- Set the performance threshold at 50 points for the 2023 MIPS payment year, instead of 60 points as previously finalized.
- Integrate one telehealth item into the performance year 2021 CAHPS for MIPS Survey as proposed and implement the proposed revisions to the CAHPS for MIPS Survey cover page to include a reference to care received in telehealth settings to ensure patients who respond to the CAHPS for MIPS survey are reflecting on experiences of the care they received via telehealth in their responses.
- Remove the HWR measure from the program until appropriate evaluation and potential refinements to the measure can be made.
- Implement a data completeness requirement for 2021 of no more than 60 percent and, over time, adopt requirements that are based on a set number of eligible patients per measure, rather than an arbitrary percentage, which will make it easier for physicians and practices to track.
- Not establish different performance periods for administrative claims measures in the quality performance category.
- Reconsider the continued inclusion of the Total Per Capita Cost (TPCC) and Medicare Spending per Beneficiary (MSPB) – Clinician in MIPS and whether these two, broad population-based measures should be included in future MIPS program years.
- Transition all PI measures to "yes/no" attestation.
- Provide more clarity regarding the proposed HIE multi-part physician attestation.
- Reduce the 50 percent requirement for clinicians in a group or virtual group required to perform an improvement activity as we believe it discourages the use of specialty-oriented improvement activities within multi-specialty practices. Instead, we recommend CMS adopt a lower requirement that incentivizes more meaningful engagement in improvement activities by multi-specialty groups.
- Use the process CMS/Acumen LLC employed when developing specialty specific cost-episodes as a model to further develop MVPs.
- Reject mandatory MVP adoption and create a collaborative and transparent process that allows MVPs to be developed and proposed with strong engagement of medical specialty societies.
- Reject implementing a single question or brief survey to measure the quality of patient experience and satisfaction for MVPs.
- Include in the development criteria for MVPs an item relative to reducing reporting burden and program inflexibility.
- Partner with specialty societies to develop, validate, and implement new cost measures for MVPs.

- Revise the proposed MVP question on cost measures to indicate CMS is willing to partner with specialty societies to develop and pilot test new measures that are not currently on the list of MIPS episode-based cost measures.
- Incorporate burden reduction and assessment of potential unintended consequences through the implementation of an MVP, particularly for cost measures where low cost implies higher quality or whether the inclusion of the clinically relevant, yet topped out measures, could provide context to costs.
- Implement a more collaborative process to solicit MVP candidates.
- Not finalize the APM APP for the 2021 performance year.

The ACG, AGA and ASGE appreciate the opportunity to provide comments on the Quality Payment Program of the CY 2021 Medicare PFS proposed rule. If we may provide any additional information, please contact Brad Conway, ACG, at 301-263-9000 or bconway@gi.org; Kathleen Teixeira, AGA, at 240-482-3222 or kteixeira@gastro.org; or Lakitia Mayo, ASGE, at 630-570-5641 or lmayo@asge.org.

Sincerely,

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