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

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

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