The American Society of Clinical Oncology (ASCO) appreciates the opportunity to submit comments on the Measures Under Consideration (MUC) List to the National Quality Forum (NQF) Measure Applications Partnership (MAP). The MAP will consider input provided by external stakeholders in developing its final recommendations due to CMS by February 1, 2019. By necessity our comments are brief, owing to the six-day timeframe allotted by NQF for public comment. We anticipate that we will provide further, more detailed comment during the notice-and-comment rulemaking phase of measure development. Following are our general comments on the Medicare Spending per Beneficiary (MSPB) and Total per Capita Cost (TPCC) measures and episode-based cost measures.

ASCO is the national organization representing nearly 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. ASCO members are also dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans, including Medicare beneficiaries.

Medicare Spending Per Beneficiary & Total per Capita Cost Measures

Given the growing number of episode-based cost measures, and continued work on their development, ASCO would encourage the MAP to consider whether the TPCC and MSPB measures still serve a purpose, as many of the beneficiaries captured in the episode-based measures will also be included in either or both the MSPB and TPCC measures. With the measures as proposed, a beneficiary could potentially be attributed to multiple providers within and across multiple measures. First, this could magnify the impact on cost measures of any individual beneficiary and second, could complicate any true differences in cost and value.

CMS has proposed a revised attribution methodology and conducted field testing for both of these measures. While a version of the proposed revised measure specifications for both measures is available on the CMS public website (for example see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html), currently we are not aware of publicly available information on the validity and reliability of the measure. It is also currently unknown what the impact of these measures would be compared to earlier versions.

Specifically, for the TPCC measure, ASCO is supportive of attempts to remove certain specialty physicians such as oncologists from the measure, as its intent is to capture overall costs of care and encourage coordination of care by primary care providers. While the methodology does exclude chemotherapy and radiation therapy, there is the potential for providers such as physician assistants, nurse practitioners, and other advanced practice professionals who work with oncologists or radiation oncologists to have beneficiaries attributed to them, which would seem to defeat the purpose of the revised measure. In addition, if the exclusion relies on the provider billing for chemotherapy administration or radiation therapy under the Medicare Physician Fee Schedule, it would fail to consider clinicians who order therapy to be delivered in the hospital outpatient department under the Hospital Outpatient Prospective Payment System. ASCO would therefore recommend that the MAP also consider the following exclusion criteria: oncologists delivering primary care services to a patient with a principle diagnosis of cancer.

More generally, the proposed attribution method for the TPCC measure will likely cause confusion, as it relies on a complex combination of "events" and services linked to the care of all individual physicians in a TIN, rather than just one. Further confusion will be caused by the timing of episodes: the episode itself consists of a month, yet the attribution period continues for a full year; it is therefore possible for a clinician to have more than one "episode" existing concurrently for the same beneficiary.

CMS has also proposed removal of the specialty adjustment without explicitly stating that the new attribution methodology compensates for that removal. The specialty adjustment was used as an attempt to overcome an inherent flaw in the TPCC, i.e. the combination of prospective risk adjustment with retrospective attribution. That methodology can lead to scenarios where a patient in good health in the prior year (e.g. 10% risk quartile for Hierarchical Condition Categories) presents with acute leukemia in the current year, leading to huge differences in observed versus expected costs. In contrast, the MSPB measure considers diagnoses up to and during the trigger event. In sum, the existing specialty adjustment worked to mitigate this inherent flaw in the TPCC by adjusting those specialties most likely to suffer adverse selection under the measure, but ultimately failed to address the root of the problem.

Episode-based Cost Measures

ASCO supports the episode-based measure development process, as episode-based measures can provide a more appropriate and meaningful assessment of care costs than extremely broad cost measures that also lack clarity in attribution. We appreciate the opportunity to participate in the development of those measures and look forward to working on measures related to oncology care, in addition to oncology surgical procedures. However, as we have stated before in numerous comment letters to CMS, the reliance on administrative claims with the failure to consider other important sources of data leads to a crude measure of true cost, and limits both risk adjustment and exclusion criteria. Section 105(b) of the MACRA statute specifically allows for the sharing of data by CMS with qualified clinical data registries; to date, CMS has not provided a process to make this data accessible to clinical registries, instead implementing a "quasi-qualified entity" pathway that is onerous, time-consuming, and may provide access to the data for a limited period. We continue to urge CMS to make this data available, as clearly intended by the MACRA statute, and to work with stakeholders including professional societies to assess how the potential linkage of administrative claims data and clinical registry data could improve existing and new cost measures.

We thank NQF for this opportunity to submit comments and look forward to engaging further in the measure development process timeline.