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December 19, 2016

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## RE: Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

The American Society for Gastrointestinal Endoscopy (ASGE) appreciates the opportunity to respond to the final rule with comment period published in the Federal Register on November 4, 2016 regarding implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) incentive under the Medicare Physician Fee Schedule.

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.

We appreciate that the Centers for Medicare and Medicaid Services (CMS) accepted a number of recommendations from the physician community that are likely to improve success rates among eligible clinicians during the first year of MIPS. As we have previously commented, it is important for eligible clinicians to view the MIPS requirements as achievable. Toward that end, we commend CMS for finalizing a program structure that allows eligible clinicians to “pick their pace” during the initial year of MIPS. We believe the truncated time period between this final rule and the start of the 2017 performance period necessitates participation flexibility. Giving eligible clinicians more time to become familiar with the various MIPS requirements, is not, however, the only reason to have a transition year. A method for adequate risk adjustment remains an outstanding issue, as well as reliability that a measure accurately captures real variation in quality of care, for example, the hospital all-cause readmissions measure under the Quality component of MIPS.

We believe MIPS requirements should increase at a measured, realistic pace.

Therefore, we ask CMS to continue to maintain some level of flexibility for eligible clinicians for the 2018 performance period and to use a scoring system that mitigates the number of eligible clinicians subjected to a negative payment update. At a minimum, we urge CMS to continue a 90-day reporting period option across all performance categories for 2018. In particular, we believe that ongoing assistance and participation flexibility is needed for small practices, which includes finalizing the concept of virtual groups.

When developing virtual groups, we agree with recommendations offered by the American Medical Association (AMA) that CMS should offer significant flexibility by avoiding initial, annual, or other limits placed on the maximum number of groups approved each year or the required geographic proximity. Furthermore, there should be no requirement that all clinicians within a virtual group be within the same specialty. Scoring and reporting accommodations should also be given to practices and eligible clinicians who join a virtual group in the initial year virtual groups are available.

## **MIPS PERFORMANCE CATEGORIES**

ASGE appreciates that CMS has taken some initial steps to streamline reporting requirements across the MIPS performance categories. We encourage these efforts to continue so the least amount of administrative burden is placed upon eligible clinicians and practices. We acknowledge that CMS responded to the concerns expressed by ASGE and others throughout the physician community by reducing the overall reporting burden across the MIPS performance categories. For the 2018 performance year, greater reporting and data collection burdens should not be imposed on clinicians.

ASGE offers the following suggestions regarding the MIPS performance category requirements for the 2018 performance year.

### ***QUALITY***

Because the Quality component of MIPS will constitute 50 percent of the total performance score for 2020 payment, we believe it is important to maintain achievable requirements.

**Number of Required Measures** — We ask that CMS not add additional measure requirements for the 2018 performance period. Increasing the required number of measures does not necessarily contribute to the goal of better patient outcomes. This Quality category should not center on the number of measures reported, but rather on whether clinicians are reporting on measures that will have a meaningful effect on outcomes. Toward this end, we ask CMS to consider the development of an endoscopy measure subset of the larger gastroenterology measure set. This would ensure that gastroenterologists who focus on endoscopy are held accountable to measures that are relevant to their scope of practice. ASGE welcomes the opportunity to work with CMS on the development of such a measure subset.

**Gastroenterology Quality Measures** — In previous comments, ASGE encouraged CMS to maintain measure #425 — Photodocumentation of Cecal Intubation as a reportable measure for the 2017 performance year so the Agency would have at least two years of data on

which to evaluate the measure's performance. We thank CMS for maintaining the measure's reporting eligibility.

ASGE would like to note a correction to the listing of measure #343 Screening Colonoscopy Adenoma Detection Rate in the MIPS Specialty Measure Set for Gastroenterology. It lists the American College of Gastroenterology as the sole measure steward. This measure is co-owned by ASGE, the American Gastroenterological Association, and the American College of Gastroenterology with ASGE serving as the primary measure steward.

**Cross-Cutting Measure Requirement** — We are pleased that CMS modified its proposal to not require patient-facing eligible clinicians to report a cross-cutting measure for the 2017 performance period. CMS acknowledged in the final rule that while it supports the concept of a common set of measures available to clinicians, not all cross-cutting measures are the most meaningful to clinicians and their scope of practice. We agree.

It is our position that a cross-cutting measure should not be required in future years of the MIPS program. As ASGE has expressed in previous comments, a cross-cutting measure requirement poses significant operational and financial challenges for Qualified Clinical Data Registries (QCDRs). A specialized registry collects data addressing specific aspects of care; it is not a complete electronic health record (EHR) system. This is important because there will be patients eligible for the denominator of cross-cutting measures, but the data would not necessarily be captured in the registry if it is outside the scope of the condition or procedure. Furthermore, the proposed MIPS measure numerators and denominators are based on encounter codes, but many QCDRs are not able to collect these codes. Instead, QCDRs utilize measures from particular clinical data fields.

In addition to QCDR data capture issues, the larger challenge exists for practices planning on upgrading their health information technology, which, for endoscopy includes roughly 20 vendors. Many of these vendors have told us it would take a minimum of 12-18 months to implement system changes, which would include incorporating data elements to support a cross-cutting measure.

Due to the time and resources that would need to be diverted to create the capacity of a QCDR to collect data for a cross-cutting measure, we are deeply concerned that registries would go through the expense only to have the cross-cutting measure classified as topped-out and either removed from the program or assigned less than the optimal points for quality measures. We ask that CMS consider these concerns before it imposes a requirement of a cross-cutting measure for future performance years.

**Global and Population Health Measures** — As expressed in previous comments, ASGE has concerns with future inclusion of global and population-based administrative claims measures in the calculation of an eligible clinician's quality performance score. Instead, we recommend these measures (Acute Composite and Chronic Composite) should be an option under the Improvement Activities component of MIPS.

CMS states in the final rule that the acute and chronic composite measures (based upon their use in the value-modifier program) have been determined reliable with a case minimum of 20 with average reliabilities of 0.64 to 0.79 for individual clinicians and groups. Good reliability is generally defined as a coefficient of 0.80 to 0.89. We also wish to point out that for the purpose of including a measure on Physician Compare, reliability is calculated using two methods: (1) the beta-binomial model and (2) a split-half reliability test. Reliability scores calculated using a beta binomial model range from 0 to 1, where scores closer to one indicate better reliability. If the 25th percentile of the reliability scores for a given measure falls below 0.90, the measure is considered unreliable. The split-half reliability test randomly divides the population into halves and compares performance between the two halves. If the resultant interclass correlation coefficient is under 0.75, the measure is designated as unreliable. Based on these methods, we question whether the Acute and Chronic Composites reliability rates are sufficient.

We appreciate that CMS agreed with comments that additional enhancements are needed to these measures, including risk adjustment. We concur with comments previously offered by the AMA that CMS must test the AHRQ risk-model at the physician-level and allow an opportunity for review and comment before these measures are included in the Quality Payment Program.

ASGE appreciates that CMS modified its proposal to only apply the all-case hospital readmissions measure to groups with 16 or more eligible clinicians with at least 200 attributed cases. However, we remain concerned about the measure's reliability rates.

**Data Completeness Criteria** — ASGE thanks CMS for setting a data submission threshold of 50 percent for all reporting mechanisms for the 2017 performance period and asks that this threshold be maintained and not increased to 60 percent for the 2018 performance period. We believe that as more clinicians gravitate to QCDRs and EHRs to fulfill their quality measure reporting requirements, they will meet or even exceed a data submission threshold of 50 percent, which helps to ensure a more accurate assessment of a clinician's quality performance and avoids selection bias. However, a lower required threshold ensures a margin for error and reduces the burden on clinicians who may practice at one or more practice sites that lack EHRs that are compatible with a QCDR. ASGE recommends that CMS consider developing a bonus structure for eligible clinicians and groups who exceed the 50 percent threshold.

**End-to-End Electronic Reporting** — ASGE supports the awarding of bonus points to eligible clinicians who use end-to-end electronic reporting for their quality data submissions. ASGE in collaboration with the American College of Gastroenterology established the GIQuIC registry, which has been in operation since 2010 and has been an approved QCDR for the 2014-2016 reporting years. GIQuIC, as it is currently configured, would not allow its registry participants to qualify for the end-to-end reporting bonus for the 2017 performance period. At this time, the process of uploading data into GIQuIC is not fully automated. ASGE is currently investigating the option of adding automated uploader functionality to the GIQuIC system. We ask that CMS continue to offer bonus payments for end-to-end electronic reporting of quality data so that GIQuIC participants may avail themselves of the end-to-end electronic reporting bonus points in the future.

**QCDR Self-Nomination** — More than 1,100 eligible clinicians reported through the GIQuIC QCDR for the 2015 reporting year and that number will be exceeded for the 2016 reporting year. While we appreciate the improvements made to the self-nomination process last year that are carrying forth for the 2017 QCDR self-nomination process, as the Physician Quality Reporting System (PQRS) transitions to MIPS, we do wish to express concerns relative to the process of proposing elimination or harmonization of non-PQRS measures.

ASGE understands CMS' goal of streamlining the measure set available for public reporting; however, the process undertaken was untimely with notifications received by QCDRs in October 2016 with an effective date of January 1, 2017. CMS did not consult with registry stewards before sending emails directing that QCDRs make changes to their measures. Over the course of two weeks, GIQuIC staff received a series of five emails covering a different topic or request concerning the registry's non-PQRS measures, creating more administrative burdens for GIQuIC during this self-nomination process. Subsequent conversations with CMS and its contractors have been helpful, although they have lacked formal documentation such that GIQuIC continues to prepare its self-nomination and, therefore, cannot, at this point, educate its 4,000 plus participants on its plans to continue as a QCDR for the 2017 reporting year, leaving our membership with uncertainty on how reporting will occur.

ASGE urges CMS to allow quality measures that have been approved in prior years to receive automatic approval for the Quality performance category for no less than a period of three years. As QCDRs require roughly a year to code and develop software updates for new measures, and additional time to train registry participants to utilize these measures, an annual approval period makes it difficult for QCDRs to justify the development of new measures and thus stifles the reporting of such measures. With a three-year approval period, QCDRs are much more likely to invest in the creation of new measures, which will advance the collection of quality measures and the evolution of MIPS. The three-year approval also provides eligible clinicians with the stability needed to support both quality improvement activities and public reporting requirements concurrently. Furthermore, stability over time is more essential when CMS considers that numerous EHR vendors must adapt their software to capture the data points from clinical notes and be able to report the data to the QCDR.

We appreciate the option for QCDRs to serve as a mechanism for reporting to the Advancing Care Information (ACI) and Improvement Activities performance categories. Given that QCDRs are currently in the self-nomination process, we are anxiously awaiting sub-regulatory guidance to further explain how MIPS eligible clinicians will report on activities within the Improvement Activities category. We suspect that EHR vendors are also awaiting this guidance, as they will also need time to adapt data capture and reporting to QCDRs.

**Topped-Out Measures** — ASGE supports CMS' decision not to remove topped out measures at this time and to not modify scoring for topped out measures until the second year the measure has been identified as topped out. In previous comments, ASGE suggested that CMS institute a phased process for topped-out measures. We strongly recommend that the same topped out policy that applies to MIPS measures should apply to non-MIPS QCDR measures that are identified by CMS as "low-bar."

ASGE recommends that scoring for a measure should not be modified until three years, rather than two years, after the measure has been identified as topped out. We believe that three years provides a more reasonable timeline for QCDRs to supplement their measure set when measures are identified as topped out, or low-bar measures. The three-year window is particularly important for QCDR participants. It would be unfair to provide inadequate time for QCDRs to add new measures, which could leave QCDR participants without the ability to report on measures that will allow them to earn the highest possible points under the Quality category. Consequently, clinicians may be forced to choose a different, less desirable reporting mechanism.

Before the scoring for a “topped out” measure is modified or the measure is removed from the program, we ask that CMS consult with the measure stewards and consider public comment. We also believe it is important to take into consideration, during the process of identifying topped-out measures, the number of physicians, by specialty, who are reporting on the measure, the potential for increased reporting rates and whether new reporters of a measure have the potential to downgrade its topped out status.

Once a measure has been identified as topped out, ASGE supports a mid-cluster scoring approach under which CMS would identify clusters within topped out measures and assign all MIPS eligible clinicians within the cluster the same value, which will be the number of points available at the midpoint of the cluster.

**Measure Benchmarks** — To encourage reporting on new measures, we are pleased that CMS has finalized a three-point floor specifically for new measures and measures without a benchmark based on baseline period data. In the final rule, CMS states it expects new measures to have the three-point floor for the first two years until it has a comparable historical benchmark. ASGE is seeking clarification from CMS on what would be necessary to establish a valid benchmark thereby allowing the measure to be eligible for the maximum number of points.

ASGE would also like to restate past comments that a benchmark floor should be applicable to the first year a measure is available in MIPS, as well as the first time a physician reports on the measure.

Lastly, we encourage CMS to evaluate whether a three-point floor for new measures provides adequate incentive for eligible clinicians to report those measures.

#### ***ADVANCING CARE INFORMATION***

**21st Century Cures Act** — Sec. 16003 of the recently passed 21st Century Cures Act stipulates that no payment adjustment to eligible professionals may be made for 2017 and 2018 under the EHR Incentive Payment Program in the case of an eligible professional who furnishes substantially all of his/her covered professional services in an ambulatory surgery center (ASC). The provision further states that this exception will cease three years after EHR technology applicable to the ASC is certified. At a minimum, this exception will apply for the 2019 MIPS payment year. ASGE looks forward to future rulemaking on implementation of this section. ASGE supports Sec. 16003 but asks that it be implemented in a manner such that an eligible

clinician could choose to include covered professional services provided in an ASC for the purposes of calculating their ACI performance score.

**Data Submission and Collection** — ASGE agrees with giving eligible clinicians flexibility of whether to use for the 2017 performance year EHR technology certified to the 2014 or 2015 edition. In the final rule, CMS states that eligible clinicians will be expected to use EHR technology certified to the 2015 edition starting in 2018. ASGE believes this timeline is unnecessarily aggressive, even if CMS maintains a 90-day ACI performance period in 2018. Feedback from ASGE members raises serious concern with the ability of smaller health information technology vendors to meet this timeline. It is unreasonable to expect, from a financial perspective, that an eligible clinician or group practice would switch EHR vendors. Furthermore, ASGE has heard from its members that forcing these timelines and requirements sidelines other important health information technology investments. For example, integrating health information technology and Prescription Drug Monitoring Programs is a critical aspect of combatting this country's opioid misuse epidemic, particularly in parts of the country where the preventable overdose and misuse are most pervasive. We strongly encourage CMS to permit use of EHR technology certified to the 2014 or 2015 editions for the 2018 performance period.

**Base Measures** — ASGE supports CMS' decision to reduce the number of measures that comprise the base score to five (or four measures if using EHR technology certified to the 2014 edition) from the proposed 11. ASGE opposes an increase in the number of measures that comprise the base score for the 2018 performance year. If the number of base measures is increased for 2018, accommodations should be made with the scoring methodology, as noted below.

**Group Advancing Care Information Reporting** — We understand that in future years, CMS may require that groups can only submit their ACI performance category data as a group if 50 percent or more of their eligible patient encounters are captured in certified EHR technology. As such, CMS is seeking comment on what would be an appropriate threshold for group reporting in future years. Without changes in the objectives and measures as previously suggested by the physician community, we do not believe it is acceptable to impose a reporting threshold for group reporting of the ACI category, including for the 2018 performance period.

**Base Score** — In previous comments, ASGE voiced strong opposition to an all-or-nothing approach to scoring the ACI category. We appreciate that CMS reduced the number of measures that comprise the base score, which mitigates the potential an eligible clinician would be unable to earn the full base score of 50 points. Our primary concern with the base score calculation was with the Protect Patient Health Information objective and measure and that failure to meet the measure would result in a zero score for the ACI category.

We acknowledge that CMS has finalized the requirement that a MIPS eligible clinician must meet the Protect Patient Health Information objective and measure to earn any score within the ACI category. We thank CMS for highlighting in the rule that the Department of Health and Human Services has produced a security risk assessment tool designed for use by small- and medium-sized providers and that the ACI requirements incorporate many HIPAA privacy and security requirements for electronic protected health information. We suggest that greater

education of eligible clinicians of the security risk assessment tool is needed, including what exactly is required for clinicians to meet the Protect Patient Health Information objective and measure.

For future performance periods, any increase in the reporting thresholds for the base score measures should be accompanied by elimination of the pass/fail approach that CMS has adopted for the base score component of the ACI category.

**Bonus Points** — ASGE supports a bonus score of 5 percent to eligible clinicians or groups that report to one or more public health or clinical data registries beyond the Immunization Registry Reporting measures. Furthermore, we support that eligible clinicians are not required to report the Immunization Registry Reporting measure to earn bonus points.

In an effort to better streamline the MIPS performance categories, ASGE appreciates that CMS has identified a set of activities from the Improvement Activities category that can be tied to the objectives, measures, and certified EHR technology functions of the ACI category and would thus qualify for a bonus in the ACI category.

We encourage bonus points for these activities to continue for the 2018 performance period and beyond.

#### ***IMPROVEMENT ACTIVITIES***

**Activity Weighting** — ASGE supports CMS' decision to reduce the number of total achievable points under the Improvement Activities category from 60 to 40 for the 2017 performance year. However, because there are so few improvement activities assigned a high weighting, many eligible clinicians, specialty physicians in particular, will be required to participate in four medium weighted activities to achieve the highest possible score for the category. As such, even medium-weighted activities are likely to incur significant costs to practices in order to make meaningful changes to patient care. We do appreciate, however, that the burden associated with this category is somewhat mitigated by allowing all MIPS eligible clinicians, reporting as a group, to receive the same score for the Improvement Activity category if at least one clinician within the group is performing the activity for a continuous 90 days in the performance period. Even though CMS has provided accommodations to certain categories of eligible clinicians and groups, including small practices, we believe the number of required Improvement Activities should be further reduced during the initial years of the MIPS program unless CMS increases the number of high-weighted improvement activities.

**Data Submission** — For the transition year of MIPS, ASGE supports that all MIPS eligible clinicians or groups, or third party intermediaries that submit on behalf of a MIPS eligible clinician or group, must designate a yes response for activities on the improvement activities inventory. ASGE strongly supports the continuation in future performance years of a simple attestation method for data submission under this category.

**Sub-regulatory Guidance** — We ask that CMS act in an expeditious manner and issue sub-regulatory guidance to further explain how MIPS eligible clinicians will report on activities



within the Improvement Activities performance category, as well as on how MIPS eligible clinicians will be able to identify a specific activity through some type of numbering or other similar convention. If CMS is unable to issue this sub-regulatory guidance before the start of the 2017 performance period, we ask that CMS reduce the number of improvement activities that would be required for an eligible clinician to achieve the highest possible score under this category. Furthermore, we ask that CMS provide information to the physician community on the process that will be used to consider the inclusion of additional improvement activities for future performance years.

**Patient-Centered Medical Home Designation** — For the purpose of this category, ASGE appreciates that CMS has finalized that practices may receive a patient-centered medical home designation at a practice level, which means that individual TINs may be composed of both undesignated practices and practices that have received a designation as a patient-centered medical home. We ask CMS to continue this policy in future performance years.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey** — ASGE supports the inclusion of the CAHPS for MIPS survey as a qualified improvement activity. Because the CAHPS survey is onerous for both practices and patients, and expensive to implement in terms of manpower, support, and contracting, we are pleased that CMS has decided to give the survey a high-weighted designation. ASGE seeks clarification of whether participation in the CAHPS survey across at least one site of service, when a TIN includes multiple locations, will satisfy participation requirements.

**Alternative Payment Models** — While CMS has finalized that eligible clinicians participating in an APM that is not a MIPS APM would be awarded half credit under the Improvement Activities category 2017, we believe this unfairly disadvantages specialty physicians at this time given so few qualified MIPS APMs. Therefore, we request that CMS modify the requirements to allow eligible clinicians participating in an APM to get full credit under the Improvement Activities category until such time that there are more qualified MIPS APMs available for specialty physicians.

### *COST*

ASGE is grateful that CMS has decided to weight the cost category at zero for the initial year of MIPS. CMS states its decision to weight the category to zero was not due to concerns with attribution, risk adjustment, or measure specification and that it intends to use for the 2018 performance year the same measures (total per capita cost measures and Medicare Spending Per Beneficiary (MSPB)) currently used in the physician value modifier program, along with the same risk adjustment and attribution methodologies. ASGE continues to hold the position that these measures are imperfect for assessing physician resource use.

Over the past several months, three ASGE members have dedicated tremendous volunteer time as members of the Clinical Committee tasked with providing input on identifying episode groups for development and determining the codes used to trigger those episode groups. ASGE strongly encouraged CMS to consult with specialty societies in the development of episode groups, and we would like to share our observations regarding the process:

- The process was rushed. Acumen acknowledged repeatedly that it was working under a tight deadline. Acumen's approach was more collaborative, organized, and bottom up, than the approaches ASGE members have experienced at the state level. Acumen also did a good job making questions and answers (Q/A) available using an "office hours" approach, and by immediately publishing cumulative Q/A which helped everyone participating in the process. Unfortunately, as the episodes were developed, details were required that were simply too much guesswork. For example, assigning an arbitrary number of encounters to trigger an episode is based on an opinion and best guess. For proposed episodes, professional societies should have had time to look at the required elements, propose solutions based on evidence, acknowledge where evidence is lacking and recommendations were based on expert opinion, etc. This is true for nearly all of the data elements that ASGE members were required to submit. We appreciate Acumen's efforts, as ultimately, it was trying to provide an organized framework in a tough timeline.
- There has been an unreasonable push to include procedures for the sake of the procedure episode itself, when the heterogeneity of the underlying diagnoses may not make sense. There are procedures where costs are well understood, can be controlled to a certain extent, are highly utilized, and have known and measurable outcomes. There are likewise diagnoses that can be described with similar attributes favorable for an episode of care approach. Including every possible procedure and diagnosis into the mix leads to confusion and an impossible burden for a practice that wishes to understand the system, scrutinize areas where costs could be improved, and to study patient factors that could be impacted to lead to improved outcomes.

ASGE wants to underscore that the development of episode groups must be a highly transparent process, which allows for full vetting by affected stakeholder organizations. Toward that end, we believe that the process for identifying episode groups for inclusion in MIPS should include: 1) public comment on revised episode groups, resulting from the Acumen work; 2) collection of data on a trial set of episode groups resulting from the Acumen process and reflective of public comment; 3) evaluation and refinement of the trial set of episode groups by the Clinical Committee; 4) public comment on a final set of episode groups for use in the 2019 performance period.

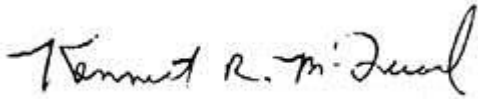
## ***CONCLUSION***

We reiterate our concerns that the ability of specialty clinicians to participate in advanced APMs will be largely limited to physicians who are part of multispecialty groups or faculty groups which are part of hospital-based ACOs. In these circumstances the quality measures are typically not those most important to the specialist's patient populations but predominantly by the primary care aspects of the ACO and generic hospital quality measures. The independently practicing specialists have very ill-defined pathways to advanced APMs and a timeline exists that may not allow for significant chance at the 5 percent bonus payment, even if the underlying APM fares well in its financial risk models. The best options for these specialists lie in the sphere of episodes of care and payment bundles, further emphasizing the points made above about the process for episode group development.

In conclusion, while ASGE appreciates that the MIPS program is intended as a “stepping stone” toward APMs for medical care that rewards quality and outcome over quantity of services provided, we are deeply concerned that the path forward to creating such APMs, especially for medical specialists such as gastroenterologists remains unclear. We have already outlined our concerns above that portions of the MIPS program contain unrealistic timelines and overly frequent changes in reporting requirements that frustrates investment in change by the medical community and also frustrates the meeting of program reporting requirements. We are equally concerned that APMs will be proposed without proper time for consideration of their clinical relationship to outcomes and without proper engagement with medical societies such as ASGE that would welcome the opportunity to play a constructive role in their development. The current clerical and bureaucratic burden placed on the medical community by the Affordable Care Act and now by MIPS is significant and cumulative and threatens to undermine the realization of our collective goals of easily accessible quality health care for all Americans. To that end, ASGE urges that in both future MIPS and APM rulemaking processes thought be given to mitigating the cumulative effect of added regulation and to the engagement of the full House of Medicine in designing a truly cost-effective and quality American health care system for the 21st century.

Thank you for consideration of our comments. Should you have any questions or require additional information, please contact Lakitia Mayo, Sr. Director, Health Policy, Quality, and Practice Operations at [lmayo@asge.org](mailto:lmayo@asge.org) or (630) 570-5641.

Sincerely,

A handwritten signature in black ink that reads "Kenneth R. McQuaid". The signature is written in a cursive, slightly slanted style.

Kenneth R. McQuaid, MD, FASGE  
President  
American Society for Gastrointestinal Endoscopy