December 31, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Ms. Verma:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 9,000 ophthalmologists in the United States and abroad who share an interest in cataract and refractive surgical care. We appreciate the opportunity to provide comments on this final rule.

The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical association of more than 1,100 ophthalmologists, nurses, and administrators who specialize in providing high-quality ophthalmic surgical procedures performed in cost-effective outpatient environments, including ambulatory surgery centers (ASCs).

Quality Payment Program

We appreciate that CMS continues to listen to physicians and take a measured and flexible approach to implementing the Quality Payment Program (QPP) that seeks to limit burdens on clinical and administrative staff. We appreciate that CMS has extended the MIPS transition period and will keep the Cost category at a low weight, as authorized by the Bipartisan Budget Act of 2018. Further, we appreciate the efforts to reduce burden and eliminate measures based on patient action in the Promoting Interoperability category of MIPS. As CMS formulates proposals for the 2020 performance year and beyond, we recommend it does so with an eye toward simplifying the reporting requirements and scoring methodology throughout the MIPS program.

In addition, we thank CMS for its continued efforts to incorporate physician and stakeholder input since the program’s inception to ensure that MIPS is successful and available to physicians long-term. Ophthalmologists have made serious efforts to understand and implement MIPS in their practices. Consequently, ophthalmology had the highest performance of any specialty in MIPS for the first performance year. This is a result of the groundwork laid in past years through measure development and adoption of the IRIS Registry. Following that, ASCRS worked with its members to educate them on MIPS by developing resources, such as in-depth guides, in-person training, and web-based tools. ASCRS and its members are committed to making MIPS a successful program long-term. Given that ophthalmologists do not typically coordinate care with other specialties, and...
solely practice in outpatient facilities in Part B, there are very few opportunities at this point to participate in APMs, which are generally primary care-based and do not measure ophthalmic care. MIPS is the best option for ophthalmologists to demonstrate the quality and value of care they provide to Medicare beneficiaries. We continue to urge CMS to maintain MIPS as a viable option and continue to incorporate physician feedback to ensure its long-term success.

E/M Proposal

In addition, we appreciate that CMS has listened to us and our colleagues in the medical community and agreed to implement reforms to evaluation and management (E/M) services with a more measured approach that will allow for physician input to the process through the AMA’s CPT/RUC workgroup. We support the policy changes for E/M that CMS is implementing in 2019, which will reduce physician administrative burden, but believe the documentation and payment changes delayed until 2021 should not be implemented because they are arbitrary, not resource-based, and pose potential instability to the physician fee schedule. We encourage CMS to take the recommendations being developed by the CPT/RUC group seriously, as they are being done so in a resource-based manner with input from the entire physician community.

ASCRS and OOSS will provide detailed comments on the following provisions of the final rule:

E/M Services

- ASCRS and OOSS support final policies for 2019 that reduce the burden of documenting E/M services. We support allowing physicians to focus documentation on changes or new information since the previous visit for established patients and allowing physicians to review information in the medical record entered by ancillary staff.

- ASCRS and OOSS support the efforts of the AMA’s CPT and RUC workgroup to review E/M services, which allows for input from the physician community. We appreciate that CMS has recognized the importance of this group’s work and will not implement the most significant changes to E/M payment and documentation in 2019 to allow time to respond to the workgroup’s proposal. We believe this process will allow for full consideration of possible changes to documentation requirements to ease burdens while maintaining a resource-based method for valuing the codes.

- For 2021, ASCRS and OOSS oppose the collapse of E/M code levels two through four. While we realize CMS modified its proposal and will not include level five in the collapsed codes, the final policy will still have a negative impact on the relativity of the physician fee schedule. We are concerned that this policy continues to ignore the current resource-based method of valuing physician services. We continue to support the resource-based relative value scale (RBRVS) system and the RUC system of valuing physician services.

- ASCRS and OOSS support CMS’ decision not to move forward with the proposal to reduce by 50% the lower-value code when a procedure is furnished in conjunction with an E/M service. The RUC has recently spent considerable time identifying and revaluing procedure codes, including ophthalmology codes, that are frequently performed in conjunction with an E/M service. This proposal would have been an additional cut to the reimbursement for these services.
ASCRS and OOSS continue to oppose the arbitrary add-on codes with additional reimbursement for primary care and for some non-procedure-based specialty care, as the codes are not resource-based and would further impact the relativity of the physician fee schedule.

Quality Payment Program

- **We continue to recommend that CMS focus on simplifying and streamlining MIPS reporting and scoring.** While ophthalmologists have been successful in the program, MIPS remains a complex program with differing requirements and scoring across all the categories. We recommend CMS identify strategies to simplify the program so clinicians can easily understand what is required and predict how they will be scored.

- **Support for maintaining a low MIPS threshold, and not using the previous year’s mean or median to set the threshold.** ASCRS supported the MACRA technical corrections in the Bipartisan Budget Act of 2018, and we believe this continued transition will allow physicians and practices additional time to implement the MIPS program.

- **Support for keeping the Cost category weight at a level below 30%.** The category weight should remain as low as possible since the category retains flawed population health measures, such as total per capita costs (TPCC) and Medicare spending per beneficiary. For 2019, these measures retain flawed attribution methodologies that continue to hold physicians responsible for the cost of care they did not provide. While ASCRS currently serves on the cost measure TEP and appreciates that recent efforts to refine the TPCC measure for future years will exclude ophthalmologists, optometrists, and other specialists, we believe the attribution of costs is overly complex and the measure still holds physicians responsible for costs out of their control. We continue to believe that episode-based measures are a better indicator of resource use and recommend that if a physician has an attributed episode-based measure, he or she should be excluded from the population health measures.

- **We recommend CMS shorten the Quality category performance period to a minimum of 90 days and lower the data completeness threshold for high-priority patient reported outcome measures that are difficult to report based on the current threshold.**

- **We appreciate the recognition that some physicians, including ophthalmologists practicing in areas with high penetration of Medicare Advantage plans, do not have a high volume of Part B patients and should have the option to participate in or be excluded from MIPS.**

- **We appreciate CMS’ efforts to simplify and streamline the PI category requirements and scoring by removing the confusing base and performance score methodology and eliminating measures that rely on patient actions. However, we remain concerned with the “all-or-nothing” requirement of the category and recommend additional exceptions for the opioid-related measures and the health information exchange measures.**

- **We recommend the small practice bonus be moved back to the MIPS final score in performance year 2020 rather than the Quality component.** Adding the bonus on the final score assures that it will be applied equally to all physicians in small practices.
• We recommend reinstating the claims reporting option for all physicians, regardless of practice size. Some practices have decided that claims reporting is the best option for the physicians in their group. This option should not be eliminated without additional lead time to allow these groups to explore other options for quality reporting.

• We continue to oppose CMS’ methodology for identifying and scoring “topped-out” measures and continue to support giving full credit to physicians who maintain high quality. Ophthalmologists have a high level of participation in quality reporting programs, and successful procedures, such as cataract surgery, have very little opportunity for improvement. Ophthalmologists should not be disadvantaged in the program or be forced to report on measures not relevant to their specialty because the measures are deemed to be “topped out.”

• We recommend CMS move forward with its original proposal to make all QCDR measures available to any QCDR that wants to offer the measure to its participants. We believe that individual QCDRs should not retain proprietary control over the measures, so that more physicians have access to measures that will help them fully participate in MIPS.

Our full comments are included below.

E/M DOCUMENTATION

As mentioned above, ASCRS and OOSS appreciate that CMS is taking a more measured approach to implementing changes to the documentation and reimbursement for E/M services. We support the documentation changes finalized for 2019 and thank CMS for delaying or not finalizing other more significant changes, which will allow time for physician input through the AMA’s CPT and RUC processes. ASCRS has been participating in the effort to update E/M services through the AMA’s workgroup, and we believe that process has been conducted in a resource-based manner that will preserve the relativity of the entire fee schedule. Given that we continue to have significant concerns about the policies finalized for 2019 because they continue to be arbitrary and not resource based, we recommend CMS modify its policies in future rulemaking and follow the completion of the CPT and RUC process.

• ASCRS and OOSS support the documentation changes CMS finalized for 2019. Specifically, we support the policy changes that will allow physicians to review, and not have to re-enter, pertinent information contained within the medical record for established patients. This will allow physicians to document relevant changes, or lack of change, since a previous visit and more effectively focus on the condition or conditions being addressed during the visit. In addition, we support allowing physicians to review and not have to re-enter information previously entered by ancillary staff. We believe these changes will significantly reduce administrative burden, alleviate the burden of sifting through irrelevant information in the medical record, and allow physicians additional time to focus on patient care.

• While we appreciate CMS’ efforts to reduce administrative burden through reducing documentation requirements in 2019, we continue to oppose the payment policies finalized for 2021, which could pose a significant risk to Medicare physician reimbursement and the relativity of the physician fee schedule. Therefore, we recommend that CMS abandon them. ASCRS and OOSS continue to support the resource-based valuation methodology for physician services. When a physician sees a patient with
a more complex disease, or diseases, requiring greater time and intensity, then he or she should be reimbursed at a higher level than for a patient with less complex medical needs. Collapsing levels two through four E/M visits ignores that foundational principle of the physician fee schedule. In addition, arbitrarily changing the RVUs associated with a particular code without significant analysis of the overall impact on the relativity of the fee schedule risks far-reaching unintended consequences for the value of other physician services. **We continue to support RBRVS and recommend CMS make new proposals for the value of E/M codes after the CPT and RUC have completed their review of the codes.**

- **We have supported the efforts of CPT/RUC workgroup to date because it has been conducted in a resource-based manner and allowed for physician input.** Prior to the release of the proposed rule earlier this year, there was agreement in the medical community that the current guidelines may be requiring more information to be documented than was clinically necessary, and that there were ambiguities in the current documentation guidelines that needed to be addressed. While there was disagreement as to how those concerns should be addressed, no formal process had been established to develop a consensus. Following the release of the proposed rule, AMA convened a workgroup made up of experts from the CPT and RUC committees to begin the process. At its inception, the group established as a guiding principle that their efforts would be resource-based and not intended to redistribute value between different specialties. The process has allowed for extensive physician input, including from ASCRS, and should be encouraged to continue with the assurance that CMS will consider its product seriously. **We thank CMS for delaying some provisions of the E/M proposal, which will allow time for any changes to E/M codes proposed by the medical community to go through the formal CPT and RUC process.**

- **We support CMS’ decision not to finalize its proposals related to indirect practice expense (PE) and the multiple procedure reduction.** Among the more troubling aspects of CMS’ original proposal was to create a new separate Indirect Practice Cost Index (IPCI) for E/M to account for the blended payment rate. To create the IPCI, CMS would have had to create a new Designated Medical Specialty for E/M visits and remove the indirect practice costs associated with those visits when calculating IPCIs for all other specialties. This proposal would have had far-reaching negative impacts on the indirect PE for many specialties, including ophthalmology. In addition, we opposed CMS’ proposal to implement a multiple procedure reduction on the lesser of two codes when a procedure was performed on the same day as an E/M visit because it was duplicative of recent RUC efforts to revalue codes that are frequently performed in conjunction with E/M services. **We thank CMS for not finalizing these proposals and do not recommend CMS consider them in future rulemaking.**

- **We continue to oppose the add-on codes for primary care and non-procedure-based specialty care finalized for 2021 because they are not resource-based and are arbitrary.** When proposing these codes, it is apparent that CMS realized that the proposal to collapse the E/M code levels would have a greater negative impact on reimbursement for some specialties and, therefore, determined the add-on codes were necessary. While we recognize that CMS was attempting to ensure that certain specialties were not significantly impacted by the code collapse, the proposed remedy of the add-on codes was an arbitrary solution that continued to ignore resource-based code valuation methodology and demonstrated that the proposal was flawed. **Given that the current efforts by the AMA’s CPT and RUC workgroup have been resource-based, which will ensure that no specialty is unequally impacted by the changes, we encourage CMS to abandon these add-on codes and not implement them in 2021.**
Again, ASCRS and OOSS appreciate that CMS has taken our concerns—along with those of the entire medical community—seriously and has taken an iterative approach to updating E/M documentation and payment. While we continue to oppose the policies that CMS has finalized for 2021, we are encouraged that it has delayed these changes in an effort to allow for the CPT and RUC processes to evaluate updates to these codes. We believe that this process is being done in a resource-based manner with a careful eye toward preserving the relativity of the physician fee schedule. We urge CMS to take that process’ product under strong consideration rather than proceed with the policies it has finalized for 2021.

THE QUALITY PAYMENT PROGRAM

Extended MIPS Transition Period

- ASCRS and OOSS thank CMS for extending the MIPS transition period into the 2019 performance period, as required by the MACRA technical corrections included in the Bipartisan Budget Act of 2018, and support the performance threshold of 30 points. In addition, we encourage CMS to continue using its statutory authority to extend the transition period through the 2020 and 2021 performance periods. As we have noted in previous comments on the first two years of the program, MIPS is a complex program that requires each practice to evaluate how to implement it. After years of the disparate legacy reporting programs that required all-or-nothing participation, physicians and practice administrators are still becoming familiar with the scoring and budget-neutral structure of MIPS payment adjustments. ASCRS has been working to provide our members with guidance, training, and other resources to help them understand and be successful in the program. Despite those efforts, it is only since the beginning of July that physicians received feedback on their performance in the first year of MIPS, so the 2019 performance period will be critical to determining how or if they need to make changes to their clinical or administrative processes to improve their performance and beyond. Furthermore, for certain specialists, such as ophthalmologists, 2019 is the first year of several episode-based cost measures, and physicians will need additional time to become familiar with them and how they are being measured. Continuing the transition flexibility for the full three additional years allowed by statute alleviates the burden on practices still trying to implement the program.

- We also appreciate that CMS kept the Cost category weight at a level below the previous statutorily required level of 30% in 2019 and request that CMS keep the weight as low as possible in future years because the category retains the problematic population-based cost measures, TPCC, and Medicare spending per beneficiary (MSPB) that continue to hold physicians responsible for the cost of care they did not provide. As we will focus on in our comments on the Cost category later in this letter, ASCRS and OOOS still have significant concerns about the TPCC and MSPB measures due to their flawed attribution methodology. In addition, despite exclusions for ophthalmologists and optometrists that CMS and Acumen made as a result of ASCRS’ recommendations as part of its participation on the cost measure TEP, we believe that the proposed refinements to the TPCC measure for future years will continue to hold physicians responsible for costs that are out of their control, and that the proposed attribution methodology is confusing. We have consistently opposed these measures from their inception in the Value-Based Payment Modifier program and continue to recommend that they not be used to measure physician resource use. We urge CMS to keep this category weight low to give additional time to develop more meaningful episode-based cost measures.
MIPS Program Simplification

- While we appreciate that CMS has modified the PI category in an effort to make it easier for clinicians to understand, we urge CMS to focus on developing ways to streamline and simplify the scoring of the MIPS program as a whole in future rulemaking. MIPS continues to retain complex requirements in each category, each with its individual scoring methodology. It is understandably difficult for clinicians, who must devote the bulk of their time and attention to patient care, to remember all the particular requirements, exceptions, and scoring for all four categories. We recommend CMS explore how it can simplify the scoring in other categories. As we suggested in our comments on the proposed rule, a key strategy to accomplish that would be to follow the proposal submitted by the medical community earlier this year that would align the available points in each category with its weight in the final score. For example, the Quality category is worth 45% of the final score, and in the category, physicians and groups could work toward earning a possible total of 45 points. In addition, we recommend identifying measures or activities that will count for scoring in all, or multiple, categories, such as a practice focusing on patient-reported outcomes through a qualified clinical data registry, which would accrue points in the Quality, PI, and Improvement Activities categories. We urge CMS to continue to work to refine and streamline the program to reduce the burden on physicians.

Performance Period

- ASCRS and OOSS recommend CMS shorten the Quality category performance period to 90 days in 2020 and beyond; and consider alternative performance periods or lower data completeness thresholds for high-priority patient-reported outcome measures. As CMS seeks to identify strategies to reduce physician administrative burden, we recommend CMS concentrate on reducing the amount of data reported for the Quality category. Physicians should be able to choose flexible performance periods to report data, without having to reduce time spent on patient care. The high benchmarks set for Quality measures, especially those reported through claims and registry, mean that physicians must report on all patients, not just the 60% minimum, to achieve more than nominal points for a measure. For measures related to high-volume services, such as cataract surgery, this becomes an onerous task for many practices. In addition, the high data completeness threshold prevents most practices from reporting high-value patient-reported outcome measures. For example, the American Academy of Ophthalmology’s IRIS Registry can no longer offer patient survey measures for cataract surgery because it cannot manage the number of surveys it would receive if they were to be conducted on at least 60% of all patients. Previously, these measures were part of the Cataract Measure group in PQRS and reported on 20 patients. While CMS may want to increase that patient threshold from 20 slightly, it should consider to what extent its own policies related to the performance period and data completeness are preventing physicians from reporting high-value measures. We encourage CMS to reduce the performance period and data completeness threshold in future years.

- ASCRS and OOSS support a 90-day performance period for the PI and Improvement Activities categories and recommend they be maintained in 2020 and future years.

Low-Volume Threshold
• ASCRS appreciates that CMS continues to recognize that some physicians may not see a high volume of Part B patients and should be excluded from MIPS. While most ophthalmologists see a high volume of Medicare patients and are MIPS-eligible, some may unexpectedly not meet the low-volume threshold. Low-volume ophthalmologists tend to be those who practice in areas with a high penetration of Medicare Advantage, or who have experienced disruptive events, such as changing practices or extended leave due to health issues, that happened during the determination period.

Small Practice Bonus

• We recommend reinstating the 5-point bonus on the MIPS final score for small practices rather than awarding the bonus to the Quality category. Maintaining the small practice bonus on the final score ensures that it impacts all physicians in small practices equally. If physicians or groups are not able to report quality measures, they will not be able to receive the bonus. Conversely, if a small group is performing well in the Quality category and scoring at or close to the total number of points, it will similarly not receive the small practice bonus. Finally, while we appreciate that CMS has increased the bonus to 6 points in the final rule, the issue remains that if a practice has had another category re-weighted to the Quality category, then the 6-point bonus takes on a greater weight than it would if the Quality category weight was 45% for that physician. **ASCRS and OOSS recommend CMS move the small practice bonus back to the final MIPS score in future years.**

Quality Category

Quality Category Scoring

• As noted above, we recommend CMS focus future rulemaking on modifying MIPS scoring to reduce complexity, including in the Quality category. The Quality category score continues to be based on a total of 60 or 70 points and then weighted at 45% of the clinician’s final MIPS score. It would be easier for clinicians to monitor and predict their performance in this category if the total points available were aligned to the weight of the category. For example, in year one of the MIPS program, the Quality category was worth 60% of the final MIPS score, and there were a potential 60 points in the category for small practices. This allowed clinicians to track their performance throughout the year and determine whether they were meeting their goals, such as meeting the exceptional performance threshold. The proposed weight and requirements for this category do not allow them to monitor in the same way without doing additional calculations. **The medical community has already offered CMS several proposals for reducing complexity, and we recommend CMS consider them seriously to reduce the burden on physicians participating in MIPS.**

Reinstatement of the Quality Measures Group Option

• ASCRS and OOSS continue to recommend CMS reinstate the measures group option previously available under PQRS to incentivize clinicians to report on outcome and high-priority measures and reduce burden. Many of our members used the Cataracts Measures Group or the Diabetic Retinopathy Measures Group, which required the reporting of 8 measures on 20 patients, 50% of whom had to be Medicare Part B patients, to successfully meet the PQRS reporting requirement. The reinstated
availability of the measures groups would continue the important work of evaluating the quality of care for particular conditions or related to specific procedures.

- We believe these measures groups meet the goals of the meaningful measures initiative to identify the measures most relevant to a clinician’s practice and incorporate outcome and high-priority measures. The Cataracts Measures Group featured six outcomes measures that focus on surgical complication rates, clinical outcomes, patient-reported outcomes, and patient satisfaction. We believe these highly relevant measures are more in line with CMS’ stated goals than other measures, many of them process, not grouped to address particular conditions or procedures.

- Reinstating the measure group option would allow ophthalmologists to report meaningful patient-reported outcome measures. CMS encourages MIPS participants to report patient reported outcome measures, but, as noted above, most ophthalmologists are not able to because they do not practice in large enough groups to use the CAHPS for MIPS survey, and the IRIS Registry no longer offers measures 303 and 304, which measured patient outcomes following cataract surgery. Since cataract surgeons may perform thousands of surgeries per year, the category’s data completeness threshold of 60% of all patients makes analyzing patient responses to the surveys unmanageable and, therefore, prevents any clinician from reporting the measure. **Reinstating the cataract measure group would allow clinicians to continue to report these valuable patient experience measures on a limited, but still significant, set of patients.**

**Scoring for Measures with High Success Rates and Topped-Out Measures**

- ASCRS and O OSS continue to oppose the methodology for scoring and removing topped-out measures. Cataract surgery is the number-one Medicare-reimbursed procedure and is performed on millions of beneficiaries, contributing not only to increased visual function but secondary benefits, such as increased independence, and reduced risk of other health conditions, including falls or depression. Given that importance, measures relating to cataract surgery that have high performance rates should be carefully considered before being considered topped out, and physicians should have the ability to receive full credit for maintaining high quality.

- We continue to oppose capped scoring for topped-out measures, and recommend CMS continue to award full credit to physicians maintaining high quality. Cataract surgery is overwhelmingly successful, and as a result, our members tend to score highly on measures pertaining to the procedure. Much of the success of the procedure is due to the attention cataract surgeons pay to ensuring high-quality care with positive outcomes. Cataract surgery measures serve as a useful monitor to maintain that high quality. In addition, many of the measures are outcomes measures and must be reported via registry or QCDR. Sustained reporting of these measures contributes to continued research and efforts to maintain high quality. **If these measures are only eligible for capped scores, or are not retained in MIPS, our members would be required to report on less relevant measures.**

- Despite our opposition to the topped-out measure methodology, CMS appears to be bypassing it with the “Meaningful Measures” initiative, which purports to be aimed at focusing on the most relevant measures to reduce administrative burden but instead has the effect of arbitrarily removing clinically appropriate measures, several of which are ophthalmology measures. Without these measures in 2019, many ophthalmologists will be required to report on less relevant primary care-based measures to participate fully in the Quality category. While we believe the current topped-out measure
methodology is flawed, at a minimum, it allows for a phased approach to evaluate the measures and allow physicians time to select alternative measures. We urge CMS to take a more incremental approach to topped-out measures rather than arbitrarily removing them in future years.

- Instead of arbitrarily removing measures through the “Meaningful Measures” initiative, we recommend CMS develop a more transparent methodology for assessing the continued relevance of individual quality measures that incorporates feedback from the medical community and measure stewards. Quality measures undergo regular maintenance by their owners with input from physicians who use the measures to ensure they reflect the most recent clinical practices and guidelines. This regular maintenance should not be overlooked by CMS, and therefore, measures should not be removed without a request that they be withdrawn by the measure owner or go through a transparent process allowing for comments from stakeholders.

- For measures related to high-volume services, such as cataract surgery, CMS should consider the overall effect of removing or devaluing the measure on the overall percentage of Medicare beneficiaries and expenditures covered by MIPS measures. Cataract surgery is the number-one Medicare-reimbursed procedure and, as such, should have a quality measure component. Current outcome measures for cataract surgery are nearing designation as topped-out measures. CMS must provide a level of oversight to ensure that the topped-out measure methodology does not arbitrarily remove clinically relevant measures related to high-volume procedures, such as cataract surgery.

**Claims Reporting**

- We continue to recommend CMS maintain claims reporting for all MIPS-eligible clinicians, regardless of practice size, and reinstate the ability of large practices to report via claims in future performance years. While most ophthalmology practices, of any size, choose to report quality measures through submission mechanisms other than claims, some of our members still report through claims. Generally, these practices have determined that implementing EHR is not appropriate for their group. Ophthalmic practices have access to the IRIS Registry, but without an EHR, the data completeness threshold of 60% of all patients makes it too labor-intensive to enter the data manually. Therefore, the only option these practices have is to report via claims. Without this option, many of these practices may conclude that the cost and disruption to the practice of implementing a new system is more than the potential negative payment adjustment and choose not to engage in any quality reporting, or the MIPS program, at all. We recommend CMS maintain the claims reporting option for practices of all sizes.

**Bonus Points**

- ASCRS and OOSS support maintaining the Quality category bonuses for additional outcome and high-priority measures and for electronic end-to-end reporting and recommend maintaining them in the program for future years. As noted above, the data collection and reporting can be onerous and labor-intensive for some outcome and high-priority measures. To incentivize clinicians to continue to report measures that CMS has deemed to be more meaningful, it should maintain bonus points for reporting additional outcome or high-priority measures beyond the required one measure. In addition, the electronic end-to-end bonus points help incentivize clinicians and groups to move beyond claims.
reporting and adopt EHRs or clinical registries. Maintaining the bonus points in the Quality category ensures that clinicians will strive for advanced participation in MIPS.

All-Cause Hospital Readmission Measure

- We continue to oppose the inclusion of the all-cause hospital readmission measure in the Quality category. We appreciate that CMS will continue scoring the measure for practices of 16 or more providers who have 200 attributed patients, but we continue to oppose the attribution methodology and urge CMS to remove it from the MIPS program completely. As we have stated before, and will again in our comments on Cost, the all-cause hospital readmission measure potentially holds providers, especially such specialists as ophthalmologists, responsible for care they did not provide, regardless of the practice size. Ophthalmologists do not provide treatment in inpatient settings and, therefore, have no control over readmission rates. They should not be scored on this measure because they have no ability to impact their performance on it.

- The attribution process is problematic since CMS will first assign beneficiaries who have had a plurality of primary care services rendered by primary care physicians, and second, for beneficiaries who remain unassigned, will assign beneficiaries who have received a plurality of primary care services (billed as E/M services) rendered by non-primary care physicians in the TIN. CMS changed this attribution model for ACOs and, at the time, noted the possible negative effects it could have on specialists. These same issues arose with the VBPM—and will likely with the all-cause hospital readmission measures—and may have the effect of holding specialists, such as ophthalmologists, accountable for the cost and quality of care they did not actually provide. CMS should remove the additional measure completely and evaluate the Quality category only on the six measures physicians choose to report.

Qualified Clinical Data Registries (QCDRs)

- ASCRS and OOSS recommend that CMS move forward with its proposal to require QCDRs to make their measures available to other QCDRs in 2020. While most ASCRS members use the IRIS Registry to report clinical outcomes and MIPS data, some may want to use other available QCDRs. However, since CMS did not finalize its proposal to require QCDRS to share their measures, physicians will only have access to MIPS measures or those developed by their particular QCDR. For some physicians, particularly sub-specialists such as retina specialists, there may not be enough relevant MIPS measures to participate fully. Physicians should have access to clinically relevant measures and be able to report them through the QCDR of their choosing. We recommend that CMS require QCDRs to share their measures with other QCDRs.

Cost Category

Cost Measures Continue to Attribute Cost of Care an Individual Physician Did Not Provide

- While we appreciate efforts CMS has taken through its contractor Acumen to update the two population-based measures, total per capita costs (TPCC) and Medicare spending per beneficiary, such as excluding eye care providers and other specialists from TPCC, we continue to oppose the inclusion of these measures in the MIPS program because they continue to hold physicians responsible for the
cost of care they did not provide and cannot control. ASCRS has been participating in the Cost measure TEP and appreciates that CMS and Acumen have listened to our feedback and excluded eye care providers from TPCC. However, ASCRS and OOSS continue to believe that episode-based cost measures are more appropriate than population-based all-cost measures in measuring resource use. Episode-based measures, such as for cataract surgery, only evaluate the cost of care that is related to a specific episode of care and within the attributed physician’s control. While we understand CMS is attempting to improve accountability and encourage care coordination, the population-based measures do not meet those goals. Physicians who have attributed episode-based measures should not be attributed the population health measures. The total cost of care for a single patient can never by controlled by an individual clinician and, therefore, CMS should remove these population-based measures and continue to focus on the development of episode-based measures.

**Episode-Based Measures**

- As we noted in our comments on the proposed rule, ASCRS and OOSS thank CMS for following the recommendations of the Ophthalmology Subcommittee of the Episode-Based Cost Measure TEP in developing the new cataract surgery measure, and we continue to urge CMS to employ this specialized and individual approach to developing new episode-based cost measures, including for chronic care. As part of both the overarching TEP and the clinical subcommittee, ASCRS participated in the development of the cataract surgery measure and worked with the members of the committee who grappled with all the relevant costs associated with cataract surgery. The measure is to account only for elements that are within the cataract surgeon’s ability to influence and excludes patients with significant ocular co-morbidities that often impact the cost and outcome of cataract surgery through no fault of the surgeon. In addition, the measure accounts for differences in payment based on CMS’ own policies, such as whether the surgery was performed in an ambulatory surgery center (ASC) or hospital outpatient department (HOPD) and whether one or both eyes were operated on within the episode window.

- While this was a painstaking process, it was an effective one that built consensus and focused the measure on the factors over which physicians have control and that drive differences in the cost of cataract surgery. Treatments vary for different procedures and diseases. Factors that influence the cost of cataract surgery may not be relevant for other procedural episodes, such as knee arthroplasty, and the costs of caring for different chronic diseases can vary widely. The specialized focus of the TEPs that bring together clinicians who perform the procedure or care for patients with a specific disease is the right approach to developing episode-based measures and should continue, especially as CMS begins to consider developing chronic-care episodes. **We urge CMS to continue to focus on developing episode-based measures, with input from the physician through the TEPs, as a better alternative to population-based measures.**

- While we support the inclusion and development of episode-based measures, we continue to have some concern about their scoring and feedback. Throughout the field test conducted on the draft cataract measure, we expressed frustration with CMS’ insistence on comparing the clinician’s cost to a standardized national average figure. While we realize that the clinician’s final average cost was adjusted to account for such factors as site of service, geographic payment differences, and other risk adjustments, the clinician is not given the information to see how that adjustment impacted the final average cost. Given the four-episode sub-groups for site of service and laterality, the final average
figure may not be close to any of the observed costs. Only by looking at the drill-down tables is the physician able to determine where he or she may be more or less costly. As CMS develops new episode-based measures, this problem will persist and should be corrected. We continue to recommend CMS use an alternative metric than national average as the final comparison for the cataract episode, or any episode-based cost measure. We believe physicians would better understand the report and be able to act in response if they were shown how their average observed cost compared to their average expected cost.

Exclude Part B Drugs

- ASCRS and OOSS continue to recommend CMS exclude the cost of Part B drugs from future cost calculations. The price of certain drugs administered in the office is rarely within the physician’s control, and other options may not be available. As noted previously, physicians do not control the cost of the drugs administered in their offices. Ophthalmologists, both in general practice and retina sub-specialties, frequently use intravitreal injections to treat age-related macular degeneration (AMD) and diabetic retinopathy. Injectable drugs for these chronic diseases may cost in the tens of thousands of dollars over the course of the treatment, and lower-cost repackaged versions may not be available. Including the cost of Part B drugs potentially significantly overstates a physician’s cost of caring for patients. To accurately assess the cost of care a physician provides, these drugs should be excluded from cost attribution.

Promoting Interoperability Category

- ASCRS and OOSS appreciate and thank CMS for listening to both our recommendations, and those of the medical community, and proposing to overhaul the PI category. The original scoring methodology was cumbersome and difficult for physicians to understand, and physician’s scores depended too heavily on the actions of other physicians or patients. We believe the category overhaul will reduce burden and allow physicians to focus on measures most relevant to their practices. Despite these major improvements, there are still some issues CMS should address, such as the continued “all-or-nothing” structure of the category, streamlining reweighting measures, and the need for additional exclusions for opioid measures and health information exchange.

- In addition, we continue to recommend that physicians who use QCDRs that integrate with their EHR be awarded full credit in the PI category.

Promoting Interoperability Scoring

- We continue to recommend CMS award full credit in the PI category to any physician or group who participates in end-to-end electronic reporting through a QCDR. Ophthalmologists have access to the IRIS Registry, a QCDR that integrates seamlessly with most EHR systems and provides them with full reporting capabilities for MIPS. The use of the QCDR is a clinically relevant tool to provide a full picture of the physician’s performance. PI measures are process related and generally primary care-based. They do not provide useful information to specialists, such as ophthalmologists.
• Physicians using a QCDR are participating at a higher, and more meaningful, level in MIPS and should be given full credit in the PI category, so they can concentrate on clinically relevant measures.

• As mentioned above, CMS’ overhaul of this category retains the troublesome “all-or-nothing” scoring methodology that began under Meaningful Use and continued through the first two years of MIPS. For any credit in the category, clinicians must report on each of the measures included in the category. Participants receive no partial credit for reporting on some, but not all, of the required measures. The other categories of MIPS provide some credit for reporting some data, and the PI category should be modified accordingly. If clinicians know they will not be able to complete all the required measures, they do not have any incentive to work toward meeting any of the others. For future years, we recommend CMS remove the “all-or-nothing” scoring methodology and award partial credit for physicians who attempt to report on some of the PI measures.

• To simplify the PI category scoring in future years, beginning with the 2020 performance period, CMS should consider requiring physicians and groups to attest a “yes” or “no” for each measure, which would indicate whether or not they had at least one patient in the numerator. The clinician would be awarded 10 points for each “yes,” rather than be scored on each measure’s performance. In addition, the clinician should only be scored at the objective level by being required to report one measure from the objective and receive bonus points for any additional measures reported. This methodology would allow the clinician to focus on the measures that are the most relevant to his or her practice. For example, most ophthalmologists report to the IRIS Registry and would therefore want to report the clinical data registry measure but cannot report any of the other registry measures because they do not administer immunizations and syndromic surveillance, and electronic case registries do not accept ophthalmic data. By attesting to the clinical data registry measure, which is the most relevant to ophthalmology, the clinician would satisfy the Public Health/Clinical Data exchange objective. CMS has already recognized that not every physician can report to all the public health registries—or report on several of the measures in other objectives—and, therefore, must offer exclusions. An approach that allows physicians to report on the most relevant measures would eliminate the need for any exclusions in the category. In addition, we suggest CMS explore options for EHR vendors to report the functionality of CEHRT products they offer, and the physicians’ use of those functions, rather than rely solely on physicians to report. We encourage CMS to consider alternatives that will reduce burden and increase flexibility and allow clinicians to report on the measures that are most relevant to their specialty and practice.

• We recommend reinstating the PI bonus for improvement activities accomplished using CEHRT, which would streamline requirements and provide credit across categories. The bonus for using CERHT in improvement activities provided ophthalmologists with an incentive to participate fully in both categories, such as providing 24-hour electronic access to patient records. Furthermore, for the 2019 performance year, ophthalmologists, who don’t typically prescribe opioids, will not have any options in the category to earn bonus points. The bonus for using CEHRT in improvement activities should continue to be an option for MIPS participants.

Promoting Interoperability Measures

• While we understand the measures are optional for 2019, we continue to request that exclusions be included for the opioid measures for physicians who do not frequently prescribe opioids. ASCRS and
OOSS appreciate the efforts CMS is making to combat the opioid abuse crisis and support including these measures in the program. However, ophthalmologists almost never prescribe controlled substances, if at all, and would likely not have any encounters to report for this measure. Currently, there is an exclusion for the e-prescribe measure if a clinician writes fewer than 100 prescriptions during the performance period. If a clinician took that exclusion, he or she would also be excluded from the opioid measures. Ophthalmologists regularly write prescriptions for medicated eyedrops and so would otherwise exceed the e-prescribe threshold and would not be able to take the exclusion. Therefore, CMS must provide a low-volume exclusion for the opioid measures individually, as well. We thank CMS for acknowledging in the final rule the issues ophthalmologists and other physicians who do not prescribe opioids would have in meeting these measures in the future. We support CMS’ plan to include exclusions for these measures in 2020, or whenever they are required measures.

- While ASCRS and OOSS continue to recommend CMS award full credit in the PI category to physicians who participate in end-to-end electronic reporting through QCDRs, at a minimum, CMS should keep a measure related to clinical data registries in the PI category in the future. As we noted above, most ophthalmologists participate in the IRIS Registry. IRIS allows ophthalmologists to track clinical outcomes and trends across various patient populations. While we appreciate the overall changes to the PI category that reduce the burden associated with some measures, the measures themselves are not tailored to ophthalmology and may not provide ophthalmic practices with relevant information, such as what they would receive by participating in a clinical data registry like IRIS. Feedback from registries is valuable information to ophthalmologists and other specialists seeking to maintain high-quality care and should be recognized as a higher-level of engagement with EHRs and health information technology, and therefore eligible for full credit in the PI category. However, if CMS does not award full credit for use of a QCDR, it should continue to recognize the clinical relevance of reporting to data registries and maintain the measure in the PI category.

\textit{Improvement Activities}

- In the proposed rule, CMS noted that it plans an overhaul of the Improvement Activities category in next year’s rulemaking. While we encourage CMS to refine and simplify scoring in the MIPS program overall, we believe that the requirements and scoring in this category are clear and do not require major changes. Recently, an ophthalmic practice administrator, who is a member of our sister organization, the American Society of Ophthalmic Administrators (ASOA), participated in a TEP on improvement activities. She and the other members of the TEP generally agreed that the included activities reflected what practices are doing to improve outcomes. In addition, improvement activities should be as broad as possible to reflect the heterogeneity of practices across the country and to give credit for the actions they are taking to care for their patient populations. We believe this category is meeting the needs of a broad scope of physician practices and urge CMS to concentrate its efforts to reduce burden by simplifying overall scoring in MIPS, and in the Quality category rather than in Improvement Activities.

- In addition, we continue to oppose scoring improvement in this category. CMS has no statutory authority to measure year-to-year improvement in this category and should not be contemplating policies related to improvement. We believe that integrating improvement scoring would be difficult, and that the category should continue to be based on attestation.
Alternative Payment Models

- ASCRS and OOSS continue to have concerns that despite CMS’ efforts to encourage physicians to move away from traditional fee-for-service, there are very few options for ophthalmologists to participate in alternative payment models (APMs) at either the advanced or MIPS APM levels. Most current models are primary care-focused, and none are ophthalmology specific. Ophthalmologists are solely focused on eyecare and do not coordinate care with physicians treating other parts of the body. Like many specialists, when ophthalmologists can participate in APMs, they are not generally involved in the management of the APM and often do not have any day-to-day involvement. In addition, the measures used in APMs, such as ACOs, do not focus on ophthalmology or other specialty care but are targeted at primary care. ACOs do not report on any measures related to common procedures performed by ophthalmologists, such as cataract surgery, or medical care for chronic ocular diseases, such as glaucoma and macular degeneration. Furthermore, ophthalmologists practicing in traditional fee-for-service have already taken steps to make care more cost-efficient, such as migrating all ophthalmic procedures to lower-cost hospital outpatient departments and ASCs. Currently, MIPS is the only program available that allows ophthalmologists to report on and demonstrate the quality performance and value of the ophthalmic care they provide. Therefore, CMS must maintain a viable fee-for-service option in Medicare so that ophthalmologists can continue to provide specialized and efficient care to beneficiaries.

CONCLUSION

ASCRS and OOSS appreciate that CMS has scaled back from its original proposals for E/M services in 2019. We believe CMS has set a good balance of implementing documentation changes for 2019 that will significantly reduce the burden of documentation, and is allowing time for the medical community, working through the CPT and RUC process, to update the codes before it implements major payment and documentation changes. We continue to oppose the E/M policies finalized for 2021 because they are arbitrary and not resource-based, but we are encouraged that CMS will take seriously the medical community’s proposed updates to E/M services and modify its policies in subsequent rulemaking.

We continue to support an extended MIPS transition period that will give physicians and practices additional time to implement the program. In addition, we recommend CMS work with the medical community to implement policies in future rulemaking that will streamline and simplify the requirements and scoring of the overall MIPS program.

Thank you for providing our organizations with the opportunity to present our comments on the final rule. Should you have any questions regarding our comments, please do not hesitate to contact Allison Madson, ASCRS manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220, or Michael Romansky, OOSS Washington counsel, at mromansky@ooss.org or 301-332-6474.

Sincerely,

Thomas W. Samuelson, MD
President, ASCRS

Maria C. Scott, MD
President, OOSS