



OUTPATIENT OPHTHALMIC  
SURGERY SOCIETY  
*Belong Today, Shape Tomorrow®*

September 13, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: [CMS–1751–P] RIN 0938–AU42; Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.**

Dear Administrator Chiquita Brooks-LaSure:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing 6,500 ophthalmologists in the United States and abroad who share an interest in cataract and refractive surgical care.

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 surgical centers (ASCs).

We appreciate this opportunity to provide comments on the 2022 Medicare Physician Fee Schedule (MPFS) proposed rule, which includes the Quality Payment Program (QPP) and the Merit-Based Incentive Payment System (MIPS).

**Below is an executive summary of key recommended actions:**

***Medicare Physician Fee Schedule***

**2022 Proposed Conversion Factor**

- **ASCRS and OOSS urge CMS to work with Congress to reduce the cuts that are scheduled to take effect on January 1, 2022, due to the 3.89% reduction to the conversion factor that will harm specialties, like ophthalmology, at a time when physician practices are continuing to struggle as a result of the COVID-19 pandemic. For calendar year (CY) 2022, CMS proposed a MPFS conversion factor of \$33.58, a decrease of \$1.31 from the CY 2021 conversion factor of \$34.89. The decrease primarily reflects the expiration of the 3.75% additional payment included in the *Consolidated Appropriations Act*, which modified the CY 2021 MPFS by providing a 3.75% increase to all services for CY 2021 to mitigate the impact of the budget neutrality cuts. The majority of these cuts were a result of CMS increasing the standalone evaluation and management (E/M) codes billed mostly by primary care. In addition, CMS did not apply those same increases to the corresponding E/M post-op codes that are billed by specialty physicians included in the 10- and 90-day global surgical codes.**

Regrettably, CMS did not propose any changes to this policy in the CY 2022 MPFS that would address this issue, and we urge the agency to do so.

- **Ophthalmology was one of the hardest-hit surgical specialties due to closures of ambulatory surgical facilities and a temporary halt on elective procedures, such as cataract surgery, during the public health emergency (PHE). Unfortunately, we are beginning to see some states postpone elective surgeries again due to the recent spikes in COVID-19 cases.**
- **ASCRS and OOSS are concerned about the growing financial instability of ophthalmic practices due to the reduction in revenue caused by the COVID-19 PHE, as well as the proposed cuts to the CY 2022 MPFS conversion factor and sequestration cuts that begin on January 1, 2022. Ophthalmology practices, the majority of which are small private practices that are trying to recover from the impacts of the COVID-19 PHE, will be negatively impacted by further reimbursement cuts, which could have an impact on patient access.**

#### **Policies Related to Evaluation and Management (E/M) Codes**

- **ASCRS and OOSS continue to oppose policies related to the Evaluation and Management (E/M) codes that fail to incorporate the revised E/M values in the 10- and 90-day global surgical codes and urge CMS to adjust the values to reflect the increases that were implemented on January 1, 2021.**

#### **10- and 90-Day Global Surgical Services**

- **We reiterate our strong opposition to CMS' policy that will not apply the 2021 increased values of standalone evaluation and management (E/M) services to the post-operative E/M visits in 10- and 90-day global surgical codes for CY 2022. CMS implemented RUC-recommended increases to standalone E/M services for CY 2021 and other select bundled services and codes but is not following the RUC's recommendation to extend those increases to global surgical post-operative services. In the CY 2022 proposed rule, CMS continues to ignore our comments that by applying this update to standalone codes, and other additional codes, the policy violates the Medicare statute by creating a specialty payment differential and impacts the relativity of the Medicare physician fee schedule.**
- **ASCRS and OOSS urge CMS to adjust the values of the E/M post-operative visits included in 10- and 90-day global surgical codes to reflect the updated office/outpatient E/M code payment increases that were implemented on January 1, 2021. We remind CMS that cataract surgery was recently revalued in 2019 with an effective date of January 1, 2020. CMS adopted the RUC recommended value, that confirmed ophthalmologists are providing three post-operative visits, rather than the previous 4 postoperative visits, in the 90-day global period (one level 2 visit and two level 3 visits). Furthermore, CMS' RAND implemented study confirmed that ophthalmologists are indeed providing 3 post-operative visits following cataract surgery in the 90-day global period. Since CMS accepted the revaluation, there is no reason that ophthalmologists should not be paid at the same level E/M visit payments as other physicians when they are providing the same level of service per patient.**

**Opposition to CMS' proposed values for CPT Codes 669X1 and 669X2:**

- **ASCRS and OOSS strongly disagree with CMS' proposed work values for CPT 669X1 (10.31) and 669X2 (7.41). The CMS recommendation is significantly below the RUC-recommended work RVU values of 12.13 for CPT 669X1 and 9.23 for CPT 669X2 and destroy the relativity between this family of procedures within the RBRVS. Furthermore, the CMS recommendation fails to recognize the necessary incremental work in addition to the corresponding standalone cataract intraocular lens procedures. We are concerned that CMS' work value proposal for the new combination cataract/MIGS codes may make it more difficult for patients to access these sight-saving procedures.**
  
- **CPT codes 669X1 and 669X2 are two new Category I combination codes. CPT code 669X1 represents complex cataract extraction in combination with the insertion of an anterior segment aqueous drainage device. CPT code 669X2 represents regular cataract extraction in combination with the insertion of an anterior segment aqueous drainage device.**
  - **669X1:**
    - **ASCRS and OOSS strongly oppose the CMS-proposed recommended work RVU of 10.31 for 669X1. CMS is basing its proposed work RVU on a ratio of the survey total time for CPT 669X1 to the total time for CPT 66982 (complex cataract surgery) and assumes that the procedures are identical. CMS' assumption is flawed and based on an inaccurate assessment of the RUC recommendation regarding the time and intensity of this procedure. CMS also fails to account for the fact that more experienced surgeons are performing the combined procedure and that the work involved with complex cataract surgery and the cataract/intraocular lens portion of 669X1 are more variable from patient to patient, resulting in variable ISTs for the complex cataract surgery component of 669X1.**
  
    - **CMS does not recognize the additional work and intensity associated with CPT code 669X1 compared to the standalone procedure for CPT code 66982. Our comments below detail the additional 19 steps associated with the combination procedure for CPT code 669X1 and the insertion of the aqueous drainage device. We urge CMS to accept the RUC-recommended value of 12.13 for CPT 669X1, which is a rather modest value based on the 25th percentile magnitude estimation of physician work supported by a comprehensive survey of 113 physicians who perform the procedure and are familiar with the work involved. If CMS is unwilling to accept the RUC-recommended value of 12.13 for CPT 669X1, then we suggest carrier pricing until the new technology review by the RUC.**
  
  - **669X2:**
    - **ASCRS and OOSS strongly oppose the CMS-proposed recommended work RVU of 7.41 for 669X2. CMS' proposed value for CPT code 669X2 is flawed because it is based on the inaccurate proposed value for 669X1, which CMS assumes is appropriate. We urge CMS to accept the RUC-recommended value of 9.23 for CPT 669X2, based on the increment in work between the RUC-recommended value for CPT 669X1 (12.13 WRVU) and the corresponding standalone cataract procedure CPT 66982 added to**

the work value of CPT 66984, to obtain a work value for CPT 669X2 of 9.23. If CMS is unwilling to accept RUC-recommended value of 9.23 for CPT 669X2, then we suggest carrier pricing until the new technology review by the RUC.

### Telehealth

- ASCRS and OOSS support the proposal for extended coverage of certain telehealth flexibilities through the end of 2023, and we urge that this policy is finalized. Specifically, we ask that the additional services added to the telehealth list during the PHE, including the CPT codes for audio E/M services (99441-99443), be included in the category of services which are proposed to remain on the telehealth list through 2023. Additionally, we encourage CMS to consider extending coverage for telehealth services beyond the PHE to ensure our members can continue to maximize the benefits of telehealth and enhance patient access to care.
- ASCRS and OOSS urge CMS to allow for the continuous delivery of audio-only E/M services following the PHE to increase Medicare beneficiary access to specialty care.
- ASCRS and OOSS urge CMS to recognize the significant education and financial investments that practices have made to expand access to telehealth services by providing additional guidance that clearly defines supervision requirements, as well as state scope of practice and licensing, and any applicable state or local laws, to help better ensure the quality of care for telehealth services.

### *Quality Payment Program*

#### COVID-19 Pandemic MIPS Exceptions

- **Automatic Application of Extreme and Uncontrollable Circumstances Hardship Exception**  
ASCRS and OOSS appreciate CMS continuing to provide burden relief/hardship exceptions for extreme and uncontrollable circumstances policy exceptions for 2021 due to the COVID-19 pandemic. However, due to the ongoing pandemic and the continued PHE, which will be in effect through the calendar year and probably longer, and its significant impact on physicians and their practices, **we urge CMS to apply the Extreme and Uncontrollable Circumstances Hardship Exception automatically for the 2021 MIPS Performance Period. All eligible physicians should be held harmless from the 9% MIPS penalty.** We urge CMS to continue to make these hardship exceptions available during the 2022 performance year.
- **Maintain Current Performance Threshold and Cost Performance Category Weight**  
While we recognize that under statutory language, beginning in the 2022 performance year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period specified by CMS, and the Cost category weight must be 30%, we urge CMS to consider any options it can use to take advantage of the authority it has under the Extreme and Uncontrollable Circumstances Hardship Exception policy or PHE to lower the performance threshold from the proposed 75 points and maintain the current 60 points and reweight the Cost performance category weight to 15%, but at a minimum, the current 20%.

#### MIPS Performance Threshold and Category Weights

- As indicated above, ASCRS and OOSS strongly urge CMS to limit the number of changes to MIPS at a time when physicians are continuing to struggle to keep up with the demands and expense of daily practice due to the ongoing pandemic. As we have stressed throughout these comments, there continues to be major disruptions in ophthalmic practices, including the cancellation of elective procedures (such as cataract surgery), that will continue to impact CMS' ability to make accurate determinations about appropriate levels of both cost and quality. While we recognize that the threshold (prior year's mean or median) and category weights are statutorily mandated, we believe CMS can and should use any means necessary to lower the proposed performance threshold and reweight the Cost category.

**MIPS Value Pathways (MVPs) – Opposition to Mandatory MVPs and Sunsetting of MIPS**

- While CMS has developed 7 new MVPs and is proposing that MVPs be available gradually, beginning with the 2023 performance year, the intent is to eventually sunset traditional MIPS after the end of the 2027 performance period. CMS further indicates that they are not proposing the timeframe in which MVP reporting would no longer be voluntary and the future sunset of MIPS in this proposed rule but a future proposal to sunset MIPS as we know it would be made in future rulemaking. ASCRS and OOSS continue to oppose any effort to make MIPS Value Pathways (MVPs) mandatory. We believe that physicians and practices should continue to have options, including the ability to continue to participate in MIPS. A physician, and not CMS, is best positioned to determine which measures are appropriate for his/her practice and patient population. Furthermore, forcing specialty physicians, like ophthalmologists, to report on mandatory MVPs would subject them to problematic population-health measures, which we reiterate have nothing to do with the specialty of ophthalmology or the care that is provided.

**Opposition to Elimination of Topped-Out Measures and Proposed Removal of 2 Ophthalmology “Topped-Out” Quality Measures**

- In general, ASCRS and OOSS continue to oppose the elimination of “topped-out measures.” We maintain that the continued reporting and measurement of these measures is important, and that CMS should continue awarding credit for maintaining high quality. It is important to note that high performance rates do not mean that a measure is no longer meaningful to a particular patient population or specialty and should stop being reported.
- In particular, ASCRS and OOSS oppose the proposed removal of 2 important ophthalmology measures that CMS has indicated are “topped-out” and therefore, subject for removal. It is important to note that there are other topped-out measures in the program that are topped-out but remain. These two ophthalmology measures, **QPP14: Age-Related Macular Degeneration (AMD): Dilated Macular Examination** and **QPP19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care** have large implications. Blindness due to diabetes and AMD are significant public health concerns and these measures call attention to the importance of HbA1c control for vision and regular eye exams for those with non-neovascular (dry) AMD before they progress to neovascular (wet) AMD.
- CMS has proposed the removal of 19 quality measures for the 2022 performance year, which could impact physicians and practices working to avoid CY 2024 penalties. It is extremely important that

clinically appropriate measures are available for practices, and especially for small practices that do not have EHR. Removing quality measures will impact the ability for these practices to reach the minimum measure requirement. For example, QPP317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented allows for many specialists to reach the required six measures. CMS is removing this measure in part due to it being a process measure. While we understand the prioritization of outcome measures, process measures applicable to a broad range of specialties that can be collected without EHR are important to maintain.

#### **Review of the Cataract Surgery Episode-Based Cost Measure**

- **ASCRS and OOSS remain concerned that the cataract surgery episode-based cost measure disincentivizes the use of drugs that are separately paid to promote a policy priority, such as the pass-through payment policy and the non-opioid pain management exclusion to packaging drugs used during surgical procedures. Therefore, we ask CMS to consider suspending the use of this measure in MIPS as it undertakes a full review of the measure and its specifications.** ASCRS and OOSS continue to believe that pass-through drugs, as well as drugs excluded from packaging under the non-opioid pain management exception, should not be included in the cataract cost measure. In both cases, policymakers have concluded that separate reimbursement outside of packaging is warranted to promote a defined policy priority. Because the current cataract cost measure creates a financial disincentive to use drugs that are included in the measure's specifications, the measure is inconsistent with the payment decision to unpackage such products. We have heard from our members that the increasing value of the Cost component in the MIPS score makes it difficult to use these separately reimbursed products. We are pleased that CMS has not added any additional ophthalmic pass-through drugs and that the agency will be reviewing this measure in the near future. Until that review is complete, and this issue addressed, ASCRS and OOSS ask CMS to consider suspending the Cataract Surgery Episode-Based Cost Measure to eliminate disconnect with the payment policies that support the use of pass-through and/or non-opioid pain management drugs.

#### **Measures and Scoring**

- **As indicated above, we continue to oppose the removal of so-called "topped-out" ophthalmology measures.** In general, we continue to oppose CMS' topped-out measure methodology and recommend continuing to award credit for maintaining high quality. We also request that CMS suspend topped-out measure scoring caps for 2022 due to the PHE.
- **Promoting Interoperability category.** We continue to recommend that physicians using a qualified clinical data registry that is fully integrated with their EHR system should be awarded full credit in this category.

#### **Advanced Alternative Payment Models (APMs)**

- **ASCRS and OOSS continue to support the development of specialty-specific Advanced APMs, as current models are primary care-based and may not be appropriate for specialists, such as ophthalmologists, or encourage their participation. We encourage the Center for Medicare and Medicaid Innovation (CMMI) and CMS to prioritize models for testing or implementation that have**

been recommended by the Physician-Focused Payment Model Technical Advisory Committee (P-TAC).

Full comments on these issues are below:

### MEDICARE PHYSICIAN FEE SCHEDULE

#### *Applying Increased E/M Values to Post-Operative Services in 10- and 90-day Globals*

ASCRS and OOSS continue our strong opposition to CMS' continued failure to increase the value of post-operative E/M visits included in 10- and 90-day global surgery packages to correspond with the increased values CMS finalized for standalone E/M office visits that took effect January 1, 2021. This policy is broadly opposed, not just by ASCRS and OOSS, but across all surgical specialties, the AMA, and Congress. As we have noted in joint letters from the surgical community, and from previous bipartisan letters from Congress, CMS must increase the value of the post-operative E/M services in global codes to correspond to increases in the standalone E/M codes that began on January 1, 2021.

Ophthalmology services are an excellent example of why CMS' current policy is flawed. One reason CMS uses to justify its decision to not increase the postoperative visits included in the global surgical payment is because the agency is not convinced the visits are happening. However, there is a process in place through the RUC that evaluates codes that may be "misvalued." The recent reevaluation of cataract surgery fees exemplifies how the process works to ensure codes are appropriately valued. In CY 2019, through the AMA RUC process, cataract surgery was revalued. ASCRS and AAO surveyed a sample of our membership and found that in addition to a slight time change, ophthalmologists were not providing 4 postoperative visits but rather 3. This information was presented to the RUC and the RUC, through their process, made a revalued cataract code recommendation to CMS. CMS agreed and accepted the RUC recommended value, which included 3 postoperative visits (one level 2 visit and two level 3 visits). Furthermore, the RAND study confirmed that ophthalmologists are indeed providing three postoperative visits following cataract surgery. Since CMS accepted the cataract surgery revaluation, there is no reason that ophthalmologists should not be paid at the same level E/M visit payments as other physicians providing standalone visits, when we are providing the same level of service per patient.

In fact, CMS is ignoring that it is required by the Medicare statute to reimburse all physicians the same amount for the same work regardless of specialty. By increasing the value of just the standalone E/M codes, and not applying the increase to the global codes, CMS is disrupting the relativity of the fee schedule. Further, each time E/M codes have been revalued since their inception in 1992, the post-operative E/M services in the global surgical codes have been increased as well. CMS should be consistent with its prior policy and follow the recommendation of the RUC to increase the values.

CMS continues to base its decision not to increase post-operative values in global codes on a flawed assertion that it cannot do so while it conducts its global codes data collection effort. **This ignores an explicit requirement in the MACRA statute that it study the global codes, while at the same time continue to update codes as necessary.** As an example, CMS implemented new values for cataract surgery codes for 2020 following the RUC's revaluation. Not only does this invalidate CMS' claim that it cannot update global codes, once again, the survey conducted as part of the RUC process verified three post-operative visits furnished with similar work as if they were standalone visits. These post-operative visits—and all others included in global

codes—should be paid at the same rate as standalone E/M codes. **Furthermore, if CMS is concerned that certain services are overvalued, they should be referred to the RUC as misvalued codes for review.**

**To reiterate our reasons why CMS must increase the value of post-operative E/M services in global codes:**

- **Failing to increase the value of post-operative E/M services is a direct threat to the overall relativity of the physician fee schedule.** As mandated by Congress, physician services are valued through the resource-based relative value system (RBRVS) that takes into account the relative work, practice expense, and malpractice insurance costs required to furnish a particular service. Since the inception of the fee schedule, post-operative E/M visits have been valued equally to standalone E/M office visits—and have been increased when E/M codes were previously revalued. To abandon this long-standing policy of valuing post-operative and standalone E/M visits for CY 2022 continues to disrupt the relativity of the fee schedule. **To maintain the relativity of the fee schedule and ensure that services with similar work, practice expense, and malpractice costs are valued equally, for CY 2022, CMS must increase the value of post-operative E/M visits included in global surgery bundles to be equal to the value of standalone E/M services.**
- **CMS’ policy violates the Medicare statute requiring Medicare to reimburse physicians equally for the same service, regardless of specialty.** Since 10- and 90-day global services are overwhelmingly provided by surgical specialties and not primary care physicians, failing to increase the value of post-operative E/M visits creates an illegal specialty differential. The work, practice expense, and malpractice costs of post-operative visits are equal to those components of standalone E/M services, and therefore, they should be valued at the same level. **To ensure CMS does not run afoul of current statute barring specialty differential payments, the agency should increase the value of post-operative E/M visits included in global surgery bundles along with standalone E/M services in CY 2022.**
- **AMA’s RUC continues to recommend that post-operative E/M codes in global services be increased to correspond with the increase in the standalone E/M codes.** CMS adopted RUC’s recommended values for standalone office visit codes following an extensive review and revaluation. CMS has made note of the extensive energy devoted to updating the codes and the robust survey process. As we have previously noted, ASCRS and other surgical specialties participated in the survey of E/M codes, and the responses of our members detailing the work related to furnishing these services are reflected in the final values. To ensure that post-operative visits were valued for the work furnished, the RUC recommended in a near unanimous vote (27-1) that the values of the E/M services bundled into global codes also be increased to the same levels as standalone codes. **Most importantly, CMS should follow the precedent set in 1997, 2007, and 2011, in accordance with the Medicare statute, when E/M codes were previously revalued, and increase the value of the post-operative visits included in the global packages as it did those three previous times.**
- **ASCRS and OOSS disagree with CMS’ continued rationale for failing to increase the value of E/M services in the global periods because of ongoing data collection related to post-operative care.** The MACRA statute instructed CMS to collect data on the number and level of visits furnished during the global period; however, it also specifically notes that the data collection does not preclude CMS from “revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services.” Therefore, CMS cannot argue that the ongoing data collection supersedes the

need to increase the E/M values in the global surgery bundles, particularly to preserve the relativity of the fee schedule and reimburse physicians equally for performing the same services. **Since the value of E/M codes, which are components of global surgery packages, have been revised, increasing the value of E/M services in global surgery codes is in line with CMS' requirement to update and revise codes and does not interfere with the global surgery data collection effort. Instead, CMS should refer specific services it believes to be overvalued to the RUC as part of the misvalued code initiative.**

- **Furthermore, the RUC is the most appropriate venue for revaluing surgical global codes.** As indicated above, CMS implemented the RUC-recommended value for cataract surgery (66984) in CY 2020. For that code, RUC survey data indicated that three post-operative visits are typically performed and represent the same work, practice expense, and malpractice costs as furnishing a standalone E/M visit. However, by failing to increase the value of post-operative visits included in global codes, CMS is arbitrarily devaluing not just E/M visits after cataract surgery, but all services without applying the same rigorous analysis employed by the RUC that determines the relative value of each individual service in the physician fee schedule. **If CMS believes that certain codes include post-operative visits that are not being performed, it should refer those specific codes to the RUC as potentially misvalued and requiring review, rather than applying a broad policy to devalue all post-operative E/M services.**

#### **Opposition to CMS' proposed values for CPT codes 669X1 and 669X2**

**ASCRS and OOSS strongly disagree with CMS' proposed work values for CPT 669X1 (10.31) and 669X2 (7.41). These are substantially below the RUC-recommended work values of 12.13 RVUs for CPT 669X1 and 9.23 RVUs for CPT 669X2, destroy the relativity between this family of procedures within the RBRVS, and does not recognize the necessary incremental work in addition to the corresponding standalone cataract or interocular lens procedures.**

**Furthermore, under CMS' current proposal, these sight-saving procedures may become more difficult for patients to access. We remind CMS, that the AMA RUC process remains the most accurate means for valuing physician work. We, therefore, urge CMS to accept the RUC-recommended work values of 12.13 RVUs for CPT 669X1 and 9.23 RVUs for CPT 669X2 to ensure continued patient access to these procedures. If CMS is unwilling to accept the RUC recommended values, then we suggest carrier pricing until the new technology review by the RUC.**

#### **Background**

The RUC identified CPT code 0191T (*Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion*) via the Category III codes with High Utilization screen (2018 estimated Medicare utilization over 1,000). In January 2020, the RUC recommended that the specialty societies develop a coding application for Category I status for CPT code 0191T and CPT code 0376T (each additional device insertion (List separately in addition to code for primary procedure)). In October 2020, the CPT Editorial Panel replaced two Category III codes (CPT codes 0191T and 0376T) with two new combination codes, CPT codes 669X1 and 669X2, to report extracapsular cataract Removal (complex and uncomplicated) with the insertion of anterior segment aqueous drainage device and one Category III CPT code 0X12T to report insertion of anterior segment aqueous drainage device without concomitant cataract removal.

### **669X1**

**ASCRS and OOSS maintain that CMS' recommended work RVU value of 10.31 is based on flawed methodology and is therefore unacceptable. We urge CMS to support the RUC-recommended work RVU value of 12.13 for CPT code 669X1, which is a modest value, based on the 25th percentile magnitude estimation of physician work supported by a comprehensive survey of 113 physicians who perform the procedure and are familiar with the work involved. If CMS is unwilling to accept the RUC-recommended value of 12.13 for CPT 669X1, then we suggest carrier pricing until the new technology review by the RUC.**

**CMS' recommended work RVU value of 10.31 for CPT code 669X1 is flawed, unreasonable, and based on an inaccurate assessment of time and intensity.** First, CMS states that it agrees with the RUC's assessment that CPT code 66982 and CPT code 669X1 are almost identical in time and intensity. However, this is not what the RUC indicated in their recommendation. Instead, the RUC-recommendation said that CPT code 66982 and CPT code 669X1 were similar in time based on the survey results but did not suggest that these services were similar in intensity.

Additionally, CMS failed to recognize that one reason the survey IST for CPT code 669X1 was shorter than the IST for the corresponding standalone CPT code 66982 is that more experienced surgeons are performing the combined procedure, resulting in shorter times in the survey. Furthermore, the work involved with complex cataract surgery (66982), and the cataract/intraocular lens portion of 669X1, are more variable from patient to patient, resulting in variable ISTs for the complex cataract surgery component of 669X1. In contrast, intraoperative maneuvers required for uncomplicated cataract surgery (66984), and the cataract/IOL portion of the corresponding combined code CPT 669X2, are much less variable.

The RUC understands that the insertion of the aqueous drainage device requires additional IST compared to the standalone cataract/intraocular lens surgery codes, especially as the procedure is performed on glaucoma patients that often have additional medical problems, which increases the intensity of the procedure.

**CMS' recommendation is solely based on time and should instead incorporate the additional clinical work and intensity required to perform CPT code 669X1.** CPT code 669X1 is more intense than 66982 because it includes both complex cataract surgery and the insertion of the intraocular anterior segment aqueous drainage device. The intensity based on the RUC-recommendations for **669X1 is 0.258**, whereas it is **0.180 for 66982**. To reiterate, CPT code 669X1 requires substantial time and intensity over and above that required for the complicated cataract/intraocular lens surgery, CPT code 66982. The physician work indicated below details the additional actions for inserting the aqueous drainage device that is required and separate from the cataract/IOL procedure.

1. Deepen the anterior chamber with viscoelastic.
2. Apply viscoelastic to the corneal surface.
3. Apply a gonioscope to the corneal surface.
4. Locate collector channels to identify sites for the drainage device insertion.
5. Lift the patient's head off the head rest and rotate it 30 degrees away from the surgeon.
6. Rotate the operating microscope 30 degrees towards the surgeon.
7. Reapply the gonioscope and adjust the microscope to visualize the chamber angle and nasal trabecular meshwork.

8. Insert the drainage device inserter through the main incision and across the anterior chamber towards the nasal chamber angle.
9. Retract the inserter protective sleeve to expose the drainage device.
10. Position the drainage device at the level of the trabecular meshwork and insert it into Schlemm's canal.
11. Release the device from the inserter.
12. Tap the tip of the device to seat it firmly.
13. Observe for blood reflux.
14. Remove the injector.
15. Deepen the chamber with additional viscoelastic.
16. Repeat steps 8-14 with a second device inserted approximately 2 clock hours away from the first. (Insertion of two devices is typical).
17. Reposition the patient's head vertically.
18. Reposition the operating microscope vertically.
19. Irrigate excess viscoelastic from the surface of the cornea.

**We, therefore, urge CMS to abandon the use of ratio of total times for the complex code pair CPT 66982 and CPT 669X1, and instead accept the RUC-recommended work RVU value of 12.13 for CPT 669X1. If CMS is unwilling to accept RUC-recommended value of 12.13 for CPT 669X1, then we suggest carrier pricing until the new technology review by the RUC.**

#### **669X2**

**ASCRS and OOSS oppose the CMS proposed value of 7.41 and support the RUC-recommend value of 9.23 for CPT 669X2, which is based on based on the increment in work between the RUC-recommended value for CPT 669X1 (12.13 WRVU) and the corresponding standalone cataract procedure CPT 66982 added to the work value of CPT 66984, to obtain a work value for CPT 669X2 of 9.23. If CMS is unwilling to accept the RUC-recommendation for CPT code 669X2, we urge CMS to use carrier pricing until the new technology review by the RUC.**

**CMS' proposed value for CPT code 669X2 is flawed because it is based on the proposed value for 669X1, which CMS assumes is accurate. As we have indicated above, CMS' use of a ratio of the survey total time results for CPT 669X1 to the total time for CPT 66982 accepts the impossible shorter IST time for the combined procedure and is therefore flawed.** The RUC determined a work RVU recommendation for CPT code 669X2 by using the increment between the 25th percentile magnitude estimation work RVU value for CPT code 669X1 and the current RUC-reviewed work RVU value for CPT code 66982. The RUC determined that the increment between the 25th percentile magnitude estimation work RVU value for CPT code 669X1 (work RVU = 12.13) and the current RUC-reviewed and confirmed work RVU value for CPT code 66982 (work RVU = 10.25) would result in an increment between those two codes of 1.88. The RUC added the 1.88 increment to 7.35, the current work RVU for 66984, which leads to a RUC-recommended work RVU value of **9.23**.

**We urge CMS to use the RUC-recommended methodology, which is logical and clinically sound, to account for a more reasonable value for CPT code 669X2. CMS' current proposal will make access to sight-saving eye surgeries more difficult for many patients. If CMS is unwilling to accept the RUC-recommended value of 9.23 for CPT 669X2, we suggest carrier pricing until the new technology review by the RUC.**

#### **Telemedicine**

ASCRS and OOSS greatly appreciate the flexibilities provided for Medicare telehealth and virtual care services through CMS' COVID-19 blanket waivers and interim final rules. These policies have enabled ophthalmic practices to provide ongoing essential medical care and treatment throughout the PHE. Using its authorities under the PHE and those granted by congressional action, CMS was able to assure that Medicare beneficiaries could receive care and treatment from their homes using a variety of technology, including audio-only telephones. Some of our most impactful telehealth visits (impactful to patients and to the entire health system) are for new patients. As we previously shared, our members have seen countless examples of urgent triage visits, 2nd opinion consults, and doctor/doctor consults, which enabled timely care for serious conditions. Conversely, these visits minimize unnecessary ED visits and travel for subspecialty care. We thank CMS for acknowledging Medicare beneficiaries and their need for additional access to care during the PHE.

ASCRS and OOSS support the proposal for extended coverage of certain telehealth flexibilities through the end of 2023, and we urge that this policy is finalized. In addition, we ask that the services added to the telehealth list during the PHE, including the CPT codes for audio E/M services (99441-99443), be included in the category of services which are proposed to remain on the telehealth list through 2023. The availability of audio-only services has had a profound impact on beneficiaries who lack the financial resources, local broadband infrastructure, or technological capabilities to utilize more traditional telehealth modalities.

We would like to highlight that during the PHE, many of our members invested in virtual platforms to continue providing patient care despite restrictions around in-office visits. Many terms need to be met to offer telehealth services, including properly educating staff, understanding supervision requirements, as well as state scope of practice, licensing, and any applicable state or local laws. For these reasons, we urge CMS to recognize the significant education and financial investments that practices have made to expand access to telehealth services by providing additional guidance that clearly defines supervision requirements, as well as state scope of practice and licensing, and any applicable state or local laws, to help better ensure the quality of care for telehealth services. Furthermore, due to the substantial time and monetary investments that have been made by practices to implement telemedicine platforms, we encourage CMS to consider extending coverage for telehealth services beyond the PHE to ensure our members can continue to maximize the benefits of telehealth and enhance patient access to care.

#### QUALITY PAYMENT PROGRAM

ASCRS and OOSS are concerned regarding any attempt to make substantial changes to MIPS at a time when our healthcare system and our physicians continue to be under significant strain due to the ongoing pandemic. We understand that the MACRA statute requires that the weight of the Cost and Quality performance categories be equal – 30% each, beginning with the 2022 performance period – and the performance threshold to be either the mean or median of the final scores for all MIPS eligible clinicians for the prior period, but ASCRS and OOSS believe the agency should use their authority and any options they have under the Extreme and Uncontrollable Hardship Exception to lower the proposed **75 points to the 2021 threshold of 60 points, and to reweight the Cost category to the weight it was prior to the pandemic, 15%, but at a minimum 20%.**

The pandemic has impacted MIPS participation through several performance years, which is a significant amount of time relative to how long the program has been in existence. We are certainly appreciative of the

many MIPS flexibilities that have been afforded physicians throughout this difficult time. As you are aware, we are now in the middle of another surge and there is a high probability that the PHE will be extended into 2022. The performance threshold was 30 points before the beginning of the PHE, and considering the last three years, moving up to 75 points is unreasonable. Therefore, we urge CMS to recognize the impact of the pandemic, and to not finalize the 75-point threshold and instead maintain the current 60-point threshold and establish a transition policy moving forward.

It is also troubling that CMS indicates that due to this threshold change, the overall percentage of physicians receiving a positive or neutral payment adjustment would decrease from 91.7% to 67.5%. The amount of MIPS-related costs to the practice, including physician and administrative time in addition to EMR/IT costs, is significant and to then receive a payment penalty as a result of a substantial increase in the performance threshold after three years of flexibilities and during the PHE, are not sustainable.

In addition, the Cost performance category has been significantly impacted by the pandemic's impact on cost data, and in recognition of this, CMS reweighted the category to zero percent for 2020. The medical community supported this change due to the concern that the physicians scores would not be fair and reliable due to geographic variation and patient case mix. As a result, there is now one less year for physicians to become familiar with the category and the cost measures. While we prefer for CMS to reweight the Cost category at 15%, which is consistent with our ask in our comments on the 2021 QPP proposals, at a minimum, CMS should maintain the current weight of 20%.

#### **MIPS Value Pathways (MVPs)**

**In the CY 2020 MPFS final rule, CMS stated its intent to apply the new MVP framework in the 2021 performance year. However, due to the PHE, CMS delayed the implementation of MVPs beginning with 2022 MIPS Performance/2024 MIPS payment year. ASCRS and OOSS supported CMS' delay of the implementation and continued our strong opposition to mandatory MVPs. In the CY 2022 proposed rule, CMS is indicating an eventual requirement that all physicians participate in MVPs and their intention to sunset traditional MIPS by the end of the 2027 performance and data submission periods. We strongly urge CMS to make MVPs a voluntary participation option when implemented.**

**It is crucial that MVPs be voluntary to preserve physicians' ability to report on the measures they believe are the most relevant to their practice and patients.** Ophthalmology has developed a comprehensive set of meaningful measures, including several outcome measures, that give ophthalmologists options for selecting those that are the most clinically relevant.

**Furthermore, there are several elements of CMS' vision for MVPs that would make them unacceptable to ophthalmologists if mandatory, such as the use of problematic population-health measures, as well as the burden associated with collecting data for patient-reported outcome measures.**

Finally, while CMS has yet to provide complete details for how the MVPs will be scored; it appears clinicians will still be subjected to different scoring in each category and would not receive credit in multiple categories for high-value measures or activities. **As we have in previous comments, we urge CMS to work with the medical community to streamline the program by simplifying scoring and allowing for cross-category credit as a means of truly reducing burden.**

To ensure clinicians may report on the measures and activities most meaningful to their practices, in the least-burdensome manner, CMS should consider the following issues when developing MVPs.

**MVPs Must Be Voluntary**

- **As we noted in our comments on the CY 2021 MPFS proposed and final rules, our opposition to the current framework outlined by CMS is that MVPs continue to be chiefly based on CMS' intent to eventually make them mandatory and phase-out MIPS.** We appreciate that CMS continues to seek feedback from stakeholders before making formal proposals or implementing the new framework. However, it also intends to build a robust inventory of MVPs and expects that eventually all MIPS eligible clinicians would be required to participate in MIPS either through an MVP or an APM Performance Pathway (APP). Given that the goal of the MIPS program is to provide a more flexible approach to quality reporting, clinicians participating in the program must continue to have options in how they participate in the program. It is critical that MVPs remain voluntary and that physicians maintain the ability to participate in either an MVP or remain in the traditional MIPS pathway, so they have continued **flexibility to choose the measures that are most appropriate for their practice and patient population.**
- **Physicians are best suited to select the measures that are most meaningful to their practices and patients.** While ophthalmology is solely focused on the diseases of the eye, there are several different subspecialties, and not all ophthalmologists of a particular specialty focus on the same population of patients. Given that diversity, it would be difficult to identify a limited set of measures and activities that would be useful to all ophthalmologists. This was quite evident when CMS initially developed a draft MVP for ophthalmology. As was discussed in our meetings with CMS regarding the draft proposal, not all ophthalmic specialties would have been able to participate. Instead, we encouraged the development of MVPs around conditions. In fact, the ophthalmic community recognized this fact several years ago, and has been successful in developing a focused set of measures—many of which are outcome measures—that reflect our members' practices and patient population. CMS should allow specialty societies, if they so desire, to work with CMS on a particular clinical condition, but these efforts should be clinician led. However, we continue to urge **CMS to allow physicians to select and report on the most clinically relevant measures and designate MVPs as voluntary participation options.**

**Eliminate Flawed Population-Health Measures**

- **CMS should rethink its continued plan to include flawed population-health administrative claims measures as a foundation in MVPs, and in the MIPS program at large.** As we have noted in our comments on previous rules and other requests for information, population-health measures, such as the all-cause hospital readmission currently used in MIPS for large practices, are primary care-based and nearly impossible for specialists, such as ophthalmologists, to influence or even predict what patients will be attributed. Ophthalmologists focus entirely on one organ or system. Ophthalmologists only treat patients' eye disease and do not manage their overall healthcare. Population-health measures are focused on managing the outcomes of a group of patients, usually through preventative care and care coordination, which is not possible for ocular disease. **Using these measures to determine the quality of ophthalmic care is entirely inappropriate and should not be part of the MIPS program, including the MVPs.**

- **Ophthalmologists' experience to date with population-health measures has been meaningless, and CMS has acknowledged this by excluding them and other specialists from the total per capita cost measure in the Cost category.** Oftentimes, as we saw under the legacy Value-Based Payment Modifier program, ophthalmologists were attributed measures related to cardiac, urinary, and pulmonary care simply because they happened to bill E/M codes. Our members had no way to predict what patients they would be attributed and could take no action to improve their scores. As referenced above, CMS has recognized that ophthalmologists and other specialists were being attributed the cost of care they did not provide and excluded them from the total per capita cost measure. Given that ophthalmologists and other specialists are excluded from that measure, it is inappropriate to consider subjecting them to other claims-based population-health measures. While we understand that CMS may view claims-based measures as a strategy to reduce administrative burden for physicians, ophthalmologists and other specialists view being scored—and potentially penalized—on these meaningless measures as a far greater burden than reporting on clinically relevant measures, such as cataract surgery outcome measures.

#### **Reduce Reporting Burden of Patient-Reported Outcome Measures**

- **ASCRS and OOSS continue to recommend CMS eliminate the burden associated with collecting data for patient-reported outcome measures proposed to be included in MVPs, and the MIPS program in general.** We have long supported the use of appropriate patient-reported outcome measures and participated in the development of several related to cataract surgery. These measures are valuable following cataract surgery since they can demonstrate that patients are experiencing improved quality of life, however, they are currently not feasible to use in MIPS because the data completeness threshold is so high, and it is impossible to administer the surveys to patients undergoing this high-volume procedure. The current patient-reported outcome measures, #303 and #304, are registry-only and will continue to require a 70% data completeness threshold in 2022 (80% in 2023) of all patients undergoing this high-volume procedure. The American Academy of Ophthalmology's IRIS Registry does not currently offer these measures because it does not have the resources to collect and score the volume of surveys it would receive in conjunction with these measures. In previous years, we have recommended that CMS modify the data completeness threshold for patient-reported measures to require just a representative sample or reinstate the measures group options available under PQRS that required these and the other cataract outcome measures only be reported on 20 patients. **We urge CMS to reduce the burden associated with patient-reported outcome measures if included in MVPs and MIPS in general.**

#### **Streamline Scoring Methodology**

- **Rather than force physicians to report on mandatory MVPs that may not reflect their clinical practice and maintain the complicated separate scoring methodologies for each category, we continue to recommend CMS work to streamline the existing MIPS program. Along with others in the medical community, ASCRS and OOSS have proposed a voluntary and flexible system that would award physicians credit across categories for clinically relevant measures and activities.** In comments on previous years' rules, we recommended that CMS take steps to make the scoring more predictable, such as eliminating different scoring methodologies for each category and aligning the points available with the weight of the category. We appreciate that CMS took some steps toward this in 2021 by

eliminating the confusing base and performance score of the Promoting Interoperability category. In addition, we encouraged CMS to identify areas where physicians could earn multi-category credit. For example, as we will discuss in more detail later in this letter, we continue to recommend physicians using a QCDR integrated with their EHR to collect Quality data also be awarded full credit in the Promoting Interoperability category, since they are using the CEHRT in a more relevant way than the measures in that category. **We continue to believe that these modifications would reduce confusion physicians often experience trying to adhere to the disparate requirements in each of the categories and make the program more meaningful for all physicians.**

Again, we maintain our opposition to mandatory MVPs and urge CMS to preserve physician choice.

### Quality Category

#### **Opposition to increasing data completeness criteria to 80% in 2023.**

- ASCERS and OOSS appreciate the CMS proposal to continue the data completeness criteria at 70% for the 2022 performance period but do not support CMS' proposal to increase the criteria to 80% beginning with the 2023 performance period and urge CMS to reconsider.
- As we indicated in our previous comments, the increased reporting requirement is not a way to reduce administrative burden for physicians. In fact, physicians may stop submitting data due to the administrative burden of data collection and reporting, and as we have stated previously, will not be able to report on patient reported outcomes. CMS might want to consider setting different data completeness thresholds depending on the measure, such as a patient-reported outcome measure.

#### **Support for Using Performance Benchmarks for 2022 MIPS Performance Period**

- **ASCERS and OOSS support CMS' proposal to use performance period benchmarks for the CY 2022 performance period rather than the baseline period historic data to score quality measures for the 2022 performance year due to the concern that it may not have a representative sample of historic data for CY 2020 due to the PHE flexibilities, which impacted the data submission for MIPS in 2020.**
- **Given the PHE potential impact on performance data, CMS should also look at the impact the use of 2019 – 2021 data will have on setting benchmarks and risk adjusted models.**

#### **Support for Removal of 3-Point Floor, With the Exception for Small Practices**

- ASCERS and OOSS support the CMS proposal to maintain the 3-point floor for quality scoring for small physician practices.

#### **Opposition to Removal of Bonus Points for Reporting on Additional Outcome Measures and End-to-End Reporting**

- ASCERS and OOSS do not support the CMS proposal to remove bonus points for additional outcomes measures. Physicians should continue to get additional credit for reporting on additional outcomes measures.

- ASCRS and OOSS do not support the CMS proposal to remove bonus points for end-to-end reporting. With the goal of incentivizing practices to report electronically, CMS should continue to reward physicians for using registries and reporting outside of claims.

***Opposition to Removing “Topped-Out Measures” and Request to Suspend Topped-Out Measure Scoring Caps for 2022***

- **As we have stated previously in these comments, ASCRS and OOSS continue to oppose CMS’ topped-out measure methodology and recommend that CMS continue to award credit to physicians who maintain high quality, particularly on outcome measures.** Under the topped-out measure methodology, CMS determines what measures are available by an arbitrary quantitative level that does not consider the clinical relevance of the measure or the volume of Medicare services it impacts. For example, while cataract surgery is a highly successful surgery, it requires intense training and physical skill to perform. While rare, complications could include total vision loss. Coupled with the high volume of cataract surgery performed on Medicare beneficiaries, CMS risks wide gaps in the number of Medicare services that are subject to quality measurement if it removes measures related to cataract surgery. In addition, it is critical to continue to measure the outcome of highly successful surgeries like cataract surgery to ensure surgeons are continuing to achieve good outcomes. Therefore, CMS should maintain cataract surgery outcome measures in the program, refrain from removing any further measures, and continue to award full credit to surgeons who maintain high quality. The ophthalmic community has worked to develop a robust set of outcome measures related to cataract surgery, and surgeons continue to provide high-quality care to their patients, as evidenced in their superior performance on these measures. **We continue to urge CMS to maintain clinically relevant measures related to cataract surgery in the MIPS program and to award full credit to physicians who maintain high quality.**
- **In particular, ASCRS and OOSS oppose the proposed removal of 2 important ophthalmology measures that CMS has indicated are “topped-out” and therefore, subject for removal. It is important to note that there are other topped-out measures in the program that are topped-out but remain.** These two ophthalmology measures, **QPP14: Age-Related Macular Degeneration (AMD): Dilated Macular Examination** and **QPP19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care** have large implications for ophthalmologists and their patients. Blindness due to diabetes and AMD are significant public health concerns and these measures call attention to the importance of HbA1c control for vision and regular eye exams for those with non-neovascular (dry) AMD before they progress to neovascular (wet) AMD.
- Due to the ongoing pandemic, we also request that CMS suspend the topped-out measure scoring caps for 2022. As we have already indicated, we oppose the elimination of topped-out measures, as well as capped scoring. Current determinations of topped-out performance may not be accurate due to the ever-changing program requirements from year to year. All these concerns are exacerbated considering the continuing PHE.

**Cost Category**

**Review of the Cataract Surgery Episode-Based Cost Measure**

- ASCRS and OOSS remain concerned that the cataract surgery episode-based cost measure disincentivizes the use of drugs that are separately paid to promote a policy priority, such as the pass-through payment policy and the non-opioid pain management exclusion to packaging drugs used during surgical procedures. Therefore, we ask CMS to consider suspending the use of this measure in MIPS as it undertakes a full review of the measure and its specifications. ASCRS and OOSS continue to believe that pass-through drugs, as well as drugs excluded from packaging under the non-opioid pain management exception, should not be included in the cataract cost measure. In both cases, policymakers have concluded that separate reimbursement outside of packaging is warranted to promote a defined policy priority. Because the current cataract cost measure creates a financial disincentive to use drugs that are included in the measure’s specifications, the measure is inconsistent with the payment decision to unpackage such products. We have heard from our members that the increasing value of the Cost component in the MIPS score makes it difficult to use these separately reimbursed products. We are pleased that CMS has not added any additional ophthalmic pass-through drugs and that the agency will be reviewing this measure in the near future. Until that review is complete, and this issue addressed, **ASCRS and OOSS ask that CMS consider suspending the Cataract Surgery Episode-Based Cost Measure to eliminate disconnect with the payment policies that support the use of pass-through and/or non-opioid pain management drugs.**

#### **Promoting Interoperability Category**

As CMS looks toward developing policies reducing the burden of the MIPS program, **we continue to recommend that the “all-or-nothing” methodology for this category be removed. We also urge CMS to consider a more diverse set of measures that offer more relevant options for specialists rather than measures that focus on the CEHRT functionalities rather than patient care. We also urge CMS to continue to limit regulatory requirements in this category, if physicians share data among themselves and with their patients. In addition, we continue to recommend that physicians who use QCDRs that integrate with their EHR be awarded full credit in this category.**

- **CMS should remove the “all-or-nothing” scoring of this category.** Congress intended for MIPS to award clinicians for attempting to participate in quality reporting programs, rather than penalize them for not achieving 100% success. In the other categories of MIPS, clinicians can earn some credit—and potentially minimize negative payment adjustments—by reporting what is achievable. Therefore, it seems inconsistent that to score **any** points in the Promoting Interoperability category, clinicians must report on all required measures, regardless of whether they are relevant to their practice. We appreciate that CMS is continuing to offer its small practice hardship exemption, which is valuable to many small ophthalmic practices that may struggle to afford or implement CEHRT in their practices. However, as we have stated previously, there is no incentive for practices to try and implement CEHRT into their practices if they are unsure they can be completely successful in the category. Awarding partial credit or allowing clinicians to attest to having certain functionality would reduce the burden associated with this category and may encourage more clinicians to participate. **We continue to recommend CMS modify this category and remove the “all-or-nothing” scoring and one size-fits all approach.**

- **We also continue to recommend that CMS award full credit in the Promoting Interoperability 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 focus on clinically relevant measures.**
- **We believe this recommendation aligns with our call to continue to streamline and simplify the MIPS program and provide multi-category credit.** A significant percentage of cataract surgeons and multi-specialty ophthalmology practices have already integrated their EHR systems with the IRIS registry. This allows them to make full use of their EHRs to keep track of surgical outcomes and ensure that patients with chronic disease are receiving regular care. We believe this tool meets the ideals of the MIPS programs as envisioned by Congress to take a holistic approach to quality reporting, rather than the rigid framework that CMS is proposing for the MVPs. **We continue to encourage CMS to award full credit in the Promoting Interoperability category for clinicians who have an EHR integrated with a QCDR and to identify additional opportunities for cross-category credit.**
- **ASCRS and OOSS support CMS’ proposal to remove attestation statements 2 and 3 from the program’s prevention of information blocking attestation requirement.**
- **ASCRS and OOSS also support the proposal to no longer require an application for physicians to apply for the small practice exception. An automatic hardship exception and reweighting will help to alleviate some of the burden.** However, many do not realize they can receive the exception if they simply do not report the PI category. This has been a problem, and **therefore, CMS needs to make it clear that reporting any PI performance will cancel the automatic hardship exemption.**
- **CMS is proposing that physicians must report “yes” to being in active engagement with a public health agency to electronically submit case reporting of reportable conditions. In addition, if the physician fails to report on any one of the two measures required for this objective or reports a “no” response for one or more of these measures, CMS is proposing that the physician would receive a score of zero for the Public Health and Clinical Data Exchange objective, and therefore, a total score of zero for the PI performance category.** The proposal to require “active engagement” to meet measure requirements is not clear. In the past, CMS has provided three options. In addition, and most importantly for ophthalmologists, CMS has provided necessary exclusions for physicians who cannot meet this measure because, for example, they do not administer immunizations. Therefore, CMS, should continue to provide the same exclusions as those offered in the 2021 performance period, and **CMS should make information on the use of these exclusions clear.**

#### **Advanced Alternative Payment Models (A-APMs)**

- **ASCRS and OOSS continue to recommend that CMS prioritize developing and implementing specialty-specific A-APMs.** Currently, most A-APM models are primary care-focused and do not measure any ophthalmic care. While some ophthalmologists participate in models, such as ACOs, they

are generally not involved in the management of the ACO and do not always contribute quality data to the ACO. A more frequent situation is that ophthalmologists do not have any A-APMs nearby to join, or local A-APMs do not include specialists. While we continue to believe that CMS should preserve a viable fee-for-service option in Medicare and the continuation of MIPS, because that is the best option for most ophthalmologists who provide surgical care on an episodic basis, **there should be some A-APM options available to any ophthalmologist who wants to participate.**

- **ASCRS and OOSS request that the Center for Medicare and Medicaid Innovation (CMMI) coordinate with the Physician-focused Payment Model Advisory Committee (P-TAC) and with specialties to seek and develop innovative voluntary payment and delivery care models.** As we have previously indicated, several specialties have submitted A-APM proposals to the P-TAC, and P-TAC has recommended several of these models for implementation, but CMS and its Innovation Center have not followed through on those recommendations. Instead, CMS has pursued multiple new models centered on primary care that were not vetted by P-TAC, or do not incorporate the feedback the panel has suggested. P-TAC has been open to the proposals put forward by different specialties that would increase the opportunities for a wider group of specialties beyond primary care to participate in new models. In an effort to develop a specialty-specific model, over the past two years, ASCRS has developed a proposed APM for Cataract Surgery that is based on innovative payment and a warranty, but due to the continued problems with advancing these types of models, along with feedback from many other physician specialties and the continued barriers for implementation, ASCRS has not formerly submitted the APM for consideration. Instead, we continue to gather information and consider our various options. **Therefore, ASCRS and OOSS continue to recommend, as we have previously, that CMS widen its approach, work with the specialty societies to develop innovative payment and care delivery model ideas which are voluntary and can be focused on conditions, and begin implementing those models for specialists.**

## CONCLUSION

In closing, we continue to be deeply concerned about the impacts of the PHE, which due to revenue reductions, has caused instability for many ophthalmic practices, the majority of which are small. Unfortunately, we are again bracing for steep Medicare reimbursement cuts in CY 2022, primarily due to budget neutrality adjustments that are a result of increased spending due to the increase in reimbursement for the standalone E/M codes in CY 2021. We urge CMS to apply the same increases to the standalone E/M codes to the E/M visits included in the 10- and 90-day global surgical codes. We also urge CMS to use its authority under the PHE to work with Congress to find a solution to ensure practices can remain fiscally sustainable as we continue through the PHE.

Additionally, we urge CMS to accept the RUC-recommended work RVU values of 12.13 for CPT 669X1 and 9.23 for CPT 669X2 to appropriately capture the additional time and intensity associated with those procedures. If CMS is unwilling to accept the RUC-recommended values for CPT codes 669X1 and 669X2, then we suggest carrier pricing until the new technology review by the RUC.

Finally, as a result of the continuing impacts of the PHE, we urge CMS to use their authority to apply the Extreme and Uncontrollable Circumstances Hardship Exception automatically for the 2021 MIPS Performance Period and this exception policy to lower the performance threshold from the proposed 75 points and maintain the current 60 points and reweight the Cost Performance category weight to 15%, but

**at a minimum, the current 20%. If CMS took these actions, it would help mitigate the growing financial instability that physicians have seen during the COVID-19 pandemic.**

Thank you again for the opportunity to provide comments on this proposed rule. If you need additional information, please contact Jillian Winans, ASCRS Senior Manager of Government Relations, at [jwinans@ascrs.org](mailto:jwinans@ascrs.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Richard S. Hoffman MD". The signature is fluid and cursive, with a long horizontal stroke at the end.

Richard S. Hoffman, MD  
President, ASCRS

Cathleen McCabe, MD  
President, OOSS