December 7, 2017

Measure Application Partnership
Clinician Workgroup
National Quality Forum
1030 15th Street NW
Suite 800
Washington DC 20005

Re: 2017 Measure Application Partnership Measure Under Consideration; MUC17-235, Routine Cataract Removal with Intraocular Lens (IOL) Implantation

To Whom It May Concern:

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 a particular interest in cataract and refractive surgical care.

We appreciate the opportunity to provide feedback on the Routine Cataract Removal with Intraocular Lens (IOL) Implantation episode cost measure (MUC17-235). ASCRS’ representative, Parag Parekh, MD, served on both the MACRA Episode-Based Cost Measures Technical Expert Panel (TEP) and the ophthalmic clinical TEP convened by CMS to advise its contractor, Acumen, on the development of these measures. While we are pleased that many of his recommendations have been incorporated into the cataract cost measure, the measures still need refinement in how the physician’s average cost is presented and to the readability and actionability of the feedback reports. **We support this measure with some conditions.**

Specifically, we support:

- The selection of CPT code 66984 as the trigger code;
- Excluding patients with significant ocular co-morbidities; and
- The selection of sub-groups based on site of service, laterality, and co-management included in the measure.

However, we believe CMS should consider an alternative metric to a total national average cost as the basis of comparison for a physician’s cost score, such as the difference between the physician’s expected cost versus the physician’s observed cost. Given the wide range in average costs for each of the episode sub-groups noted during the recent field test of this measure, the national average cost of cataract surgery identified, $2,676, is a misleading number to ophthalmologists. We suggest the measure be based on comparing physicians to how far they diverge from the expected cost, based on their mix of episode sub-groups and risk percentile.
Furthermore, we have also expressed concerns to CMS about the readability and actionability of the draft feedback report recently provided to physicians during a field test of the measures. Not only do the reports include the problematic national average figure discussed above, they also lack information about the measure specifications themselves, making it difficult for physicians and groups to understand how they are being evaluated. **While we understand the feedback reports are not under review by the MAP, we believe this is a significant issue CMS must address before using the measure to evaluate the cost of cataract surgery.**

Full details on these recommendations are included below.

**Trigger Code**

- ASCRS supports the use of CPT code 66984 as a trigger for the cataract episode measure. Routine cataract removal with 66984 requires homogeneous and comparable resources for nearly all patients. As a high-volume code, it will provide enough data to identify outlier physicians who are practicing outside of established patterns. **66984 is the only code submitted to the MAP as a trigger code. No other codes should be considered.**

- ASCRS does not support including other codes, such as complex cataract surgery, 66982, in this measure as it will not yield comparable enough data to measure a physician’s resource use accurately. Patients undergoing cataract surgery that requires the use of the complex cataract code may suffer from a wide variety of ocular co-morbidities, or other non-ocular co-morbidities, which could require varying levels of resource use depending on the condition. For example, patients taking Tamsulosin or similar medications very frequently require the use of iris retractors, leading to the use of code 66982 instead of the usual 66984. Furthermore, these patients often have complications requiring further surgery, such as a vitrectomy. **Complex cataract surgery may require additional supplies and increases the likelihood of potential complications, resulting in a range in value too significant to provide a homogenous patient group for cost measures and should not be used as a trigger code.**

**Exclusions**

- ASCRS supports the use of criteria to exclude patients with significant ocular co-morbidities from the cost measure. We support the use of the exclusionary criteria from quality measure 191, Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery. The criteria excludes patients with documentation of significant ocular conditions. The exclusions include such chronic conditions as diabetic retinopathy, macular degeneration, and glaucoma.

- The rational for excluding these patients is that since patients with significant ocular co-morbidities are excluded from quality measurement, they should also be excluded from cost measurement. The developers of quality measure 191 excluded these patients because ocular co-morbidities play a significant role in whether the patient will have a predictably good outcome and if complications may arise. Surgeons do not have control over a patient’s co-morbidities and should not be held accountable for additional costs in an episode if a patient suffers from one of these conditions. **If physicians are not measured on the quality outcomes of these surgeries, therefore, they should not be held responsible for the cost of these surgeries.**

- These exclusions ensure a greater level of risk adjustment than has previously been incorporated in cost measures, such as current measure total cost per capita and Medicare spending per beneficiary.
While we are aware CMS includes a basic level of risk adjustment calculation for existing cost measures, and for the proposed episode-based measures, CMS has not been able to demonstrate that its risk adjustment impacts the cost of cataract surgery. This risk adjustment includes factors such as beneficiary age, dual-eligibility, and some co-morbidities, but does not include ocular co-morbidities. Cataract surgery is performed on a relatively older patient base, and while some co-morbidities may require additional resource use as discussed above, ocular co-morbidities play a much larger role in determining the resource use and likelihood of a good outcome than do the factors used in CMS’ current risk adjustment. Using the exclusionary criteria from the cataract quality measure is a much more accurate means of risk adjustment to ensure that physicians are not held accountable for the cost of care related to factors outside their control.

**Episode Sub-Groups**

- **ASCRS supports the inclusion of all of the submitted sub-groups, which relate to site of service, laterality, and co-management.** We believe the eight sub-groups in the cataract episode measure represent significant differences in the cost of cataract surgery—largely related to Medicare’s own billing and reimbursement policies—and should be separated for basis of comparison in this measure.

- **Cataract surgery can be performed in either hospital outpatient departments (HOPDs) or ambulatory surgery centers (ASCs), with reimbursements for ASCs well below HOPDs.** Cataract surgery is reimbursed 45% less in the ASC than in the HOPD. While some ophthalmologists have the option of building and owning their own ASC, some states with certificate of public need laws limit the number of existing ASCs or prevent physicians from opening new ASCs, so they may be forced to operate in HOPDs. In addition, some physicians, especially solo practitioners, may not have the resources to construct and manage their own ASC, and must operate in whatever facility, either ASC or HOPD, is available. Despite these limitations and given the choice, ophthalmic surgeons would likely prefer to operate in the lower cost ASC. ASCs are not subject to the same requirements as HOPDs, such as extensive pre-operative testing, that are not relevant to treating ophthalmic disease. In addition, patients may prefer to undergo surgery in ASCs, which are generally easier to navigate since they are smaller, less intimidating, and have shorter wait times. Ophthalmic surgeons want to make the cost-effective choice, but cannot always do so. Given that, the episodes must include sub-groups for ASCs and HOPDs, since the site of service is not always in the control of the physician.

- **ASCRS supports the submitted sub-groups for laterality because they reflect whether the surgeon removed cataracts in either one or both eyes during the episode window.** Patients frequently develop cataracts in both eyes, and while both eyes are rarely operated on at the same time, many patients find it convenient to have the second surgery shortly after the first, usually still within the 90-day global post-operative period. Medicare has specific billing rules for physicians performing multiple procedures on the same patient related to pre- and post-operative care, therefore, the expected cost of cataract surgery performed during the global period of previous cataract surgery would be substantially different from two surgeries performed more than 90 days apart.

- **ASCRS supports the submitted sub-groups for co-management because they reflect whether or not the post-operative care for the cataract surgery was furnished by another provider.** Ophthalmology is unique among other specialties as post-operative care for cataract surgery patients may be performed by another ophthalmologist or an optometrist. This arrangement is generally at the request of, and for the convenience of, the patient. This usually occurs when a patient may have to travel some distance to
receive cataract surgery and does not want to make that trip for subsequent post-operative visits, his or her own ophthalmologist does not perform cataract surgery, or he or she prefers to continue care with the optometrist. While the surgeon may not provide all the care to the patient, he or she will be attributed the episode by billing 66984. The surgeon may not be aware if some of the practitioners who are co-managing the case are providing care with unreasonable costs outside established practice patterns. **Sub-grouping co-managed cases allows the surgeon to be aware of how other practitioners may be impacting his or her cost scores, and take action if necessary.**

Consider an Alternative to a National Average Price for a Final Measure Determination

As noted above, we support the measure sub-groups, which were determined by the clinical TEP. The physicians on the TEP selected those sub-groups to separate and avoid comparing surgeries where fundamentally different factors are contributing to the amount Medicare is reimbursing in total for the episode that are not always in the control of the physician. Given that fact, it is confusing to the physician receiving feedback on cost performance to see one dollar figure representing his or her “average” cost compared to a national average. We believe physicians would better understand their performance on the measure and be able to take action in response if they were shown how their average observed cost compared to their average expected cost.

- **The cataract episode should compare each physician or TIN’s average observed cost to that same physician or TIN’s average expected cost and not compare overall to a national average.** The clinical TEP determined that the eight sub-groups broadly represent the main drivers of cost in relation to cataract surgery. CMS and Acumen have determined risk-adjusted expected costs for each of the sub-groups. Each of a physician’s attributed episodes’ observed costs are then compared to the expected cost for the respective sub-group and assigned a ratio to represent the divergence between the expected and observed costs. The ratios for each of the episodes are then averaged to determine the frequency of the physician’s divergence from the expected cost. **We support this approach as it ensures that the varying costs of the sub-groups outside of the physician’s control, such as the facility fee, are not impacting the physician’s score.**

- **However, the steps following the calculation of the average ratio should be re-thought to make the final average cost more meaningful to the physician or group practice.** Based on field test reports released earlier this fall, the ratios of observed and expected costs are converted back to a dollar figure and compared to a national average. Hearing from several of our members who have reviewed their feedback reports, they question how their final average cost and the national average costs were determined, and how it relates to the actual reimbursement they received for the surgery. While we understand that the supplemental methodology documents released in conjunction with the field test discuss this process, they were neither easy to understand or access. In addition, physicians are aware that geographic differences contribute to the reimbursement level, and may question why they should be compared to a national dollar average.

- **To overcome this issue, we recommend the physician’s score be based on his or her own expected and observed costs, and not based on a misleading national average.** For example, if a surgeon’s case mix means that 70% of his or her surgeries are performed in the ASC, unilateral, and not co-managed, and 30% are performed in the HOPD, unilateral, and not co-managed, then his or her expected cost should be a weighted average of those two sub-groups. Then, the surgeon’s actual observed costs are compared to that expected average of a 70/30 mix of those two sub-groups. The average cost for this surgeon would be substantially different from a physician who performed 90% of surgeries in an HOPD.
and 10% in an ASC. The surgeon would then be evaluated on the extent, above or below, that he or she deviates from the expected cost for his or her specific case mix. We believe this is a much more useful value to a physician than a national average.

Improve Report Readability and Actionability

We believe the feedback reports for these measures provided to physicians need substantial improvements to make them more understandable and actionable. In conversations with ASCRS members who received draft feedback reports on the measures during the recent field test, most reported difficulty understanding what the measure was evaluating, and how they could use the report to make changes that may impact their overall cost of providing cataract surgery. While we understand that the MAP is not considering the feedback reports at this time, we believe it is important to provide additional rationale for what issues have led us to determine support with conditions.

- Feedback reports on cost measures are inherently different than feedback reports for quality measures. For quality reporting, the physician and clinical staff must be familiar with the measure specifications and submit data only on patients that meet the specific criteria related to diagnoses and services performed. When they receive their feedback reports on quality measures, they are able to digest the information with the pre-existing knowledge of which patients are included in the measure.

- Cost measures, however, are calculated by CMS on administrative claims, and physicians may not know in advance what patients will be attributed to them or what costs are included in the measure. While the specifications of this measure would make it largely predictable for ophthalmologists to know which episodes are included, the field test report does not include this information, and accessing it is difficult. Physicians and practices would have had to know to visit another CMS website, and then download two more files to determine the measure methodology, trigger code, exclusions, and services included in the episode to understand why those specific patients were included in the measure—all before even beginning to consider their cost outcomes. In addition, some of the terminology used in the reports could be misinterpreted and should be defined in the report.

The feedback report format should be improved in the following ways:

- Provide a summary of the measure specifications at the beginning of the feedback report. While we appreciate that CMS and Acumen have made extensive information about the development and methodology of the measure available, it is not easily accessible and requires substantial time to read and digest. As noted above, a physician is likely unaware of the specifications of the cost measure when he or she receives the report. However, the physician will likely know how his or her cost of care may differ from other physicians based on factors that influence the cost, but may not be within their control, such as if the physician performs surgery in an HOPD with a higher facility cost, or often performs glaucoma surgery in conjunction with cataract surgery. The measure has accounted for those differences, but they are not immediately apparent when viewing the feedback report. The feedback reports should include a brief executive summary of the measure specifications that include the trigger code, episode window, explanation of sub-groups, and a brief word on exclusions and where to find the full list of excluded diagnoses.

- Provide a short description of the rationale for the breakdown of the sub-groups. As mentioned above, most ophthalmologists have a sense of what factors are driving the costs of cataract surgery,
and how they may differ from other surgeons. An ophthalmologist performing cataract surgery in an HOPD is aware that the facility charge is significantly higher than that of surgery performed in an ASC. While they will notice there is a breakdown of the costs for each sub-group, without accessing the separate methodology, they may not be able to determine that only surgeries of the same sub-groups are being compared. One or several sentences could be added to the paragraph above the cost breakdown to explain why the sub-groups are present, and how it factors into the overall score. There is some discussion of the concept of sub-groups in general on the Appendix C, “How to Interpret this Report” tab, but the description is not specific to the cataract episode and the factors the developers were considering for the episode being displayed. **While we realize more specific information is included in the methodology document, busy surgeons who receive these documents do not have the time to search for separate information to understand the reports. Without a clear explanation of the measure specifications embedded with the report, physicians will likely not view them as credible or useful.**

- Include a glossary of terms in the report to reduce confusion and misunderstanding. There are several examples of terms used in these reports that could be interpreted in different ways, and should be explained to improve readability and actionability. For example, the physician is compared to other physicians in the same “risk percentile,” which is represented with a numerical value. There is no explanation in the report of what is encompassed in the percentile or what the percentile represents. Does the higher the percentile value mean the included beneficiaries are an intrinsically riskier group, or the opposite? In addition, several of our members have questioned the use of the term “bilateral” for the sub-groups and interpreted it as having cataract surgery on both eyes on the same day. This is not typically done, which leads physicians to question the validity of the data. A short glossary that explained that the second eye’s surgery occurred within the 90-day post-operative period after the first eye’s surgery would add immediate clarity, without the physician having to seek additional resources. **We urge CMS and Acumen to work with the clinical TEP to identify and define other terms that may not be immediately familiar to a physician reviewing the report.**

**Conclusion**

We appreciate the opportunity to provide comment on the cataract episode currently under consideration. While we support the measure’s trigger code, exclusions and sub-groups, we believe more refinement for the final score calculation is necessary to ensure physicians will understand the feedback and be able to take an appropriate action in response. **We believe physicians would find a comparison of their observed costs to their expected costs much more meaningful than a final comparison to a national average cost.** We urge the MAP to incorporate our feedback as it considers this measure.

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Should you have any questions regarding our comments, please do not hesitate to contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

Sincerely,

Bonnie An Henderson, MD
President, ASCRS