Submissions to the Committee on Ways and Means, Subcommittee on Health
Regarding Statutory and Regulatory Burdens on Optimized Efficiency and Patient Care

Date:

Name of Submitting Organization:
American Society of Cataract and Refractive Surgery (ASCRS)

Address for Submitting Organization:
4000 Legato Rd. Ste. 700
Fairfax, VA 22033

Name of Submitting Staff:
Nancey McCann,
Director of Government Relations

Submitting Staff Phone:
703-591-2220

Submitting Staff E-mail:
nmccann@ascrs.org

Statutory X Regulatory X

Please describe the submitting organization's interaction with the Medicare program:

The American Society of Cataract and Refractive Surgery (ASCRS) represents nearly 9,000 ophthalmologists who treat a high percentage of Medicare beneficiaries through traditional Part B Medicare fee-for-service and Medicare Advantage (MA) plans.

Please use the below template as an example of a submission regarding statutory or regulatory concerns, and submit any further concerns past those listed below in a separate Microsoft Word document in the same format. Submissions must be in the requested format or they will not be considered.

In the case of listed Appendices, please attach as PDF files at the end of the submission, clearly marked as "Appendix [insert label]".

In the case of a multitude of submissions, it is recommended that they be submitted in order of priority for the submitting organization or individual.

Short Description:

2017 is the first performance year (to impact 2019 payments) of the Merit-Based Incentive Payment System (MIPS), created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). While CMS has provided flexibility in the first year, and proposes to extend it for the second year, there are several statutory changes Congress should make, as well as provide oversight of CMS' implementation of the program, to ensure ophthalmologists can participate fully and succeed in the program.

Summary:

- **Physicians and practices need additional time to understand and implement the MIPS program.**

MACRA is the biggest change to Medicare physician payments in decades, and thus will require the implementation of new administrative processes and clinical workflows. 2017 data does not have to be submitted until March of 2018, so practices—and CMS itself—will not have feedback on the program until well into the second performance year.

- The Cost category retains primary care-based measures that use an attribution methodology that potentially holds physicians responsible for care they did not provide, and CMS has yet to develop an appropriate risk-adjustment methodology. In addition, episode-based measures, such as cataract surgery, are not tested or well understood by physicians. **While CMS has weighted the category at 0% for the first year, and proposes to do so again for the 2018 performance year, based on the MACRA statute, the weight will increase to 30% in 2019.**

- **Removing potentially topped-out measures may leave specialists without any relevant quality measures, and may mean high-volume procedures, such as cataract surgery, are not being measured by the MIPS program.** Ophthalmologists had a high level of participation and achievement in the PQRS program, and continue to provide high-quality surgical care. Under CMS' proposals, measures with high achievement could be removed from the program.

- **Based on the MACRA statute, CMS is proposing to determine MIPS eligibility—and make payment adjustments—based on all items and services furnished under Part B.** This could inaccurately determine physicians' participation in Medicare, such as determining whether the physician falls under the low-volume threshold. In addition, this could limit patient access to Part B drugs administered in the office if the physician receives a MIPS penalty, and thus CMS must reduce the reimbursement payment on the drugs, as well. In future years of the program, the MIPS penalty could outpace the current average sales price plus the 6% payment physicians currently receive for administering these drugs in the office.

Related Statute/Regulation:

- The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)
- 2017 Quality Payment Program final rule
- 2018 Quality Payment Program proposed rule

Proposed Solution:

- **Congress should amend the MACRA statute to provide for an additional three years of transition flexibility. The statute currently allows for two years, and without modification, would automatically require CMS to implement the program fully by setting the MIPS final score threshold at the mean or median of the previous year's performance. Congress should delay the requirement to move to setting the MIPS final score using the previous year's mean or median by three years, and allow for additional years of 0% weighting for the Cost category to allow for new episode-based measures that are relevant to the specialty to be developed. Congress should also give CMS additional flexibility in setting the weights of the other categories.**

- **Congress should provide oversight of CMS' effort to develop episode-based measures to ensure the process is meeting the goals of improved attribution, risk adjustment, and reduced provider burden.**

- **Congress should amend MACRA to specify that the Secretary "may" remove certain topped out measures, rather than the current wording that the Secretary "shall."**

- **Congress should amend MACRA to specify that MIPS eligibility and payment adjustments be based solely on physician services.**