September 11, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

RE: [CMS-1832-P] Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the members of the American Society of Cataract and Refractive Surgery and the Outpatient Ophthalmic Surgery Society, we are writing to provide comments on the proposed CY26 Medicare Physician Fee Schedule and Quality Payment Program (QPP) as published in the *Federal Register* on July 16, 2025. We appreciate the opportunity to provide our comments.

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

The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical society that represents over 4,000 ophthalmologists, nurses, and administrators who specialize in providing high-quality ophthalmic surgical services in cost-effective ASC environments. The programs and services of OOSS are designed to ensure top-quality and sustainable patient care and safety in surgical environments that support ever-changing technology and regulation.

While ASCRS and OOSS recognize that the proposed rule provides a positive Medicare physician payment adjustment for both the qualifying participant and non-qualifying participant conversion factors, we note that the proposed efficiency adjustment and changes in the indirect practice expense methodology result in substantial cuts for anterior segment surgeons. In addition, ASCRS and OOSS recognize the need to ensure the Medicare program is efficient and reflects the current clinical landscape, however, the proposed efficiency adjustment and changes to the indirect practice expense methodology are based on faulty assumptions and do not account for specific practice patterns for ophthalmologists and, in particular, cataract surgeons who maintain private practices where they continue to provide care to their patients. We strongly urge CMS to reconsider these policies to more accurately reflect practice patterns, while maintaining access for patients to continue to receive quality ophthalmic care.

ASCRS and OOSS appreciate the opportunity to provide the following comments on the proposed 2026 Medicare physician payment updates and policies, including the efficiency adjustment, revised indirect practice expense methodology, global surgical services, and the QPP provisions. Below, we provide an

overview of the actions we urge CMS to take as part of this PFS rulemaking. Context and rationale are provided in the sections that follow.

Medicare Physician Fee Schedule Policies

Conversion Factor and Medicare Physician Payment

- ASCRS and OOSS urge CMS to continue to work with Congress on a long-term solution to the Medicare physician payment system challenges that include continuous reimbursement cuts coupled with the lack of an update adjusted for inflation despite increasing expenses.

Medicare Economic Inflation

- ASCRS and OOSS urge CMS to work with Congress to ensure the annual physician payment update is appropriately adjusted for inflation.

Budget Neutrality

- ASCRS and OOSS urge CMS to include a prospective budget neutrality correction in the final CY26 conversion factor to account for the $1 billion overestimation in the utilization of the G2211 complexity add-on code.

Updates to Practice Expense (PE) Indirect Methodology – Site of Service Payment Differential

- ASCRS and OOSS strongly oppose the proposed practice expense methodology change as it fails to consider: 1) ophthalmologists have a high percentage (70.4%) still practicing in a private practice, and 2) most ophthalmic global surgery packages include in-office visits for pre- and post-operative care that continue to require indirect overhead expenses such as rent, utilities, and a dedicated medical, billing, and administrative staff.

Efficiency Adjustment

- ASCRS and OOSS urge CMS not to finalize the -2.5% efficiency adjustment proposal as it 1) fails to acknowledge that high-volume codes, such as cataract surgery, get revalued frequently at the RUC, leading to consistent review of efficiency, time, and relevant valuation adjustments, 2) alarmingly calls for continued adjustments every three years without a minimum value, while high-volume codes continue to be revalued during the RUC process, 3) wrongly assumes that physician time and intensity decrease as physicians perform more procedures, and 4) could jeopardize patient safety by changing the fundamental standard of care away from quality and toward efficiency of care.

Calculating Procedure Shares within a Global Surgery Package

- ASCRS and OOSS urge CMS to maintain the current proportion of procedure shares in global codes, as we believe the current 80% for procedure shares is an appropriate representation of the work required for the surgical procedure versus post-operative care in ophthalmic surgical procedures.

Post-operative visit valuations

- ASCRS and OOSS urge CMS to follow the precedent set in 1997, 2007, and 2011 (in accordance with the statute) when increased E/M values were applied to post-operative visits included in the global packages.

Quality Payment Program Policies

MIPS Performance Threshold

- **ASCRS and OOSS support the maintenance of the performance threshold at 75 points for the 2026–2028 performance years.**

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

- **ASCRS and OOSS continue to oppose any effort to make MIPS Value Pathways (MVPs) mandatory. 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.**
- **ASCRS worked collaboratively on a cataract surgery-specific MVP and submitted it to CMS in January 2024.** Eyecare is a diverse field with subspecialties with little patient or condition overlap. **In response to CMS's stated desire to limit the number of MVPs, ASCRS also compromised and submitted to CMS recommended subspecialty grouping within a single Ophthalmic MVP.** While CMS made some improvements since the Comprehensive Ocular Care MVP Candidate was released in late 2023, **we were disheartened to see that our efforts at improving the coverage of this MVP and to create a workable model through compromise with CMS were largely ignored.** We urge CMS to work collaboratively and in good faith to develop workable MVPs for *voluntary reporting,* rather than MVPs that leave entire subspecialties with insufficient measures.

MVP Proposals and RFIs

- **ASCRS and OOSS support CMS's proposals to allow groups to attest to whether they are single- or multispecialty and to allow small practices to forgo subgroup reporting.**
- ASCRS and OOSS support CMS's proposal to apply defined topped out measure benchmarking to MVPs with modification: **we recommend use of flat benchmarks for all 7-pt capped measures in MVPS.**
- RFI on Procedural Codes for MVP Assignment: **ASCRS and OOSS strongly urge CMS to maintain group ability to attest to their specialty status and choose the most appropriate MVP for their practice.**
- RFI on Core Elements: **ASCRS and OOSS are deeply concerned with this RFI.** CMS continues to combine many subspecialties into a single MVP. Patients looking for a cataract surgeon do not care how that surgeon compares to an ophthalmologist that solely treats glaucoma. **Patients want to know how their clinician rates compared to other clinicians providing that same service.**

RFI: Transition Toward Digital Quality Measurement

- While ASCRS and OOSS appreciate the thought of transitioning to more automatic quality data collection, we oppose the transition to fully dQM-based quality measurement as it will significantly increase the burden of accurate reporting. This is particularly true for small and rural practices, which are lower resourced settings.

MIPS Cost Category Proposals

- Proposed Two-Year Informational-Only Feedback Period for New Cost Measures: **ASCRS and OOSS applaud and greatly appreciate CMS's proposal to implement a two-year informational-only feedback period for new cost measures.**
- Proposed Modification to Total Per Capita Cost Measure Attribution: ASCRS and OOSS strongly support CMS's proposal to exclude advanced practice nonphysician practitioners from the TPCC if they are part of a group where all other clinicians are excluded based on the specialty exclusion criteria, and **we urge CMS to implement this proposal retroactively beginning with the 2025 performance year**.
- Post-field Test Transparency in Pre-Rulemaking Cost Measure Development**: ASCRS and OOSS remain concerned with the lack of post-field test transparency in pre-rulemaking cost measure development**. For some cost measures, significant changes (including changes that would put additional specialties at risk for measure attribution) are made after field testing. In the future, we strongly urge CMS to do the following: 1) perform additional field testing when post-field testing refinements could significantly impact attribution, 2) publish a list of the number and percentage of specialists attributed to each cost measure when it is proposed, and 3) clearly enumerate any post-field testing changes in easy-to-understand language.

MIPS Promoting Interoperability Proposals and RFIs

- eCR Suppression Proposal: **ASCRS and OOSS support this proposal.**
- Security Risk Analysis Proposal: **ASCRS and OOSS support this proposal *with modification* and offer two potential solutions to allow sufficient risk management time for practices that perform their SRA as part of their end-of-year reviews.**
- RFI on Query of PDMP Measure Performance Rate: **ASCRS and OOSS strongly urge CMS to wait until the PDMP ecosystem is ready for universal integration.**
- RFI on Performance Rate-based Measurement: **ASCRS and OOSS are concerned with the concept of transitioning these measures to performance rate-based as the current issues with clinician-PHA data exchange stem largely from communication between EHRs and PHAs, not from clinicians. This is evidenced by the need to suppress the 2025 eCR measure due to CDC pause in onboarding.**
- RFI on Data Quality: The biggest issue in data quality we have seen is in calculation errors by vendors (EHRs and registries). We recommend working with ONC to ensure certified products calculate measure scores accurately and are responsive to customer tickets about incorrect measure calculation.

MIPS Improvement Activities Category: Mid-Year Suppression of Improvement Activities

- **ASCRS and OOSS urge the Administration to abide by its own regulations and to both reverse the suspension and not finalize the removal of these IAs under Removal Factor 7.**

We recommend that CMS propose to remove IAs in future proposed rules using the appropriate regulatory rationale.

Advanced Alternative Payment Models (APMs)

- **ASCRS and OOSS continue to support the development of specialty-specific Advanced APMs, and ASCRS has developed the Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS)** so that cataract surgeons can deliver same-day bilateral cataract surgery to appropriate patients at a lower cost. We urge CMS to test the BPBCS model and implement it for voluntary participation.

Ambulatory Specialty Model (ASM)

- While we appreciate CMS's decision to look into models that could be more applicable to specialists, **ASCRS and OOSS are deeply concerned with and oppose the proposal to make the ASM mandatory for all eligible specialty physicians in selected geographic areas beginning in 2027.**

MEDICARE PHYSICIAN FEE SCHEDULE

Update to the CY 2026 Medicare PFS Conversion Factor

As required by law, the CY26 proposed rule establishes two conversion factors—one for those qualifying participants (QP) in advanced Alternative Payment Models (APM) and another for those participating in the traditional Merit-based Incentive Payment System (MIPS) or nonqualifying participants. As proposed, the conversion factor for QPs in APMs is $33.59, while the conversion factor for those in traditional MIPS is $33.42. The conversion factors reflect a 0.75% update for QPs and a 0.25% update for non-qualifying participants, a 2.5% update as enacted by the One Big Beautiful Bill Act, and a 0.55% budget neutrality update.

While ASCRS and OOSS recognize and appreciate the positive payment adjustment, we remain concerned that long-term Medicare payment reform has yet to be enacted. **We urge the Agency to continue to work with Congress on a long-term solution to the Medicare physician payment system challenges that include continuous reimbursement cuts coupled with a lack of an updated adjustment for inflation despite increasing expenses.**

Inflation Update

The cost of running an ophthalmic practice has far outpaced the price Medicare pays for the services our members deliver. According to the American Medical Association (AMA), physician payments have declined by 33% from 2001–2025, accounting for inflation.[1]

[1] *Medicare physician pay has plummeted since 2001. find out why.* American Medical Association. (2025, April 21). https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why#:~:text=The%20big%20problem%20is%20that,reform%20the%20Medicare%20payment%20system.

Ophthalmic practices—mostly small, solo, and two-to-four-physician offices—continue to struggle with the high cost of skilled labor, medical supplies and equipment, and rents, just like all other Medicare providers, such as hospitals, skilled nursing facilities, and hospices. However, these other Medicare providers receive positive annual payment updates that reflect their costs due to inflation. For example, hospitals, hospices, skilled nursing facilities, ambulatory surgery centers, etc., receive a market basket adjustment that increases their payments relative to a measure of inflation (e.g., Consumer Price Index (CPI)). As the Agency is aware, the forecast for the Medicare Economic Index (MEI)—a measure of inflation faced by physicians with respect to their practice costs and general wage levels—is projected to be 2.3% in 2026. [2]

The lack of a meaningful rate increase that accounts for rising practice costs, such as the MEI, has made running a practice increasingly costly. The increased costs, coupled with significant administrative burdens, have made it more challenging to continue to deliver high-quality care to Medicare patients at current payment levels**.**

These concerns have also been raised by the Medicare Payment Advisory Commission (MedPAC). In its June 2025 *Report to Congress*, MedPAC issued a report on physician services.[3] Their report stated the following:

> *"MEI growth has consistently exceeded fee schedule payment-rate updates. From 2000 to 2023, the cumulative increase in fee schedule updates totaled 14 percent compared with MEI growth of 52 percent (Figure 1-2). The growing gap between statutory fee schedule updates and MEI growth means that Medicare payments per service (unadjusted for increases in intensity, coding, and other changes) have declined substantially in inflation-adjusted terms over time."*

Recognizing the disparities in the increase in clinicians' costs versus the current payment rates, MedPAC recommends:

> *"The Congress should replace the current law updates to the physician fee schedule with an annual update based on a portion of the growth in the Medicare Economic Index (MEI) (such as MEI minus 1 percentage point)."*

ASCRS and OOSS urge CMS to work with Congress to ensure the annual physician payment update is appropriately adjusted for inflation.

---

[2] MedPAC. (n.d.). Reforming physician fee schedule updates and improving the accuracy of relative payment rates. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf

[3] MedPAC. (n.d.). Reforming physician fee schedule updates and improving the accuracy of relative payment rates. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf

Budget Neutrality

For years, ASCRS and every other medical specialty society have outlined the flaws with the budget neutrality requirements within Medicare, including the current budget neutrality threshold. In recent years, the Agency's addition of the Healthcare Common Procedure Coding System (HCPCS) code G2211 and the Office/Outpatient Evaluation and Management (E/M) Visit Complexity Add-on code (complexity code) has significantly impacted the budget neutrality portion of the conversion factor.

Earlier this year, the AMA outlined concerns related to the overestimation of the utilization of the complexity code. The code was established as an add-on payment to office visits to capture the longitudinal relationship between a physician and patient for a single, serious, or complex condition. In the CY24 Medicare Physician Fee Schedule Final Rule, CMS estimated that the G2211 code would be used for 38% of all office/outpatient E/M codes. However, AMA's analysis of the first three quarters of 2024 claims data shows that the G2211 code was only used for 10.5% of all office/outpatient E/M codes. This drastic overestimation accounts for approximately $1 billion.[4] **ASCRS and OOSS join the AMA in urging CMS to include a prospective budget neutrality correction in the final CY26 conversion factor that accounts for the overestimation of the complexity add-on code utilization.**

Updates to Practice Expense (PE) Indirect Methodology—Site of Service Payment Differential

In the proposed rule, CMS states that there has been a significant shift in healthcare delivery and practice patterns from physicians practicing in private (fully or partially owned) practices to physicians practicing in hospital-owned practices and physicians employed directly by a hospital. **While other specialties may have a larger portion of physicians practicing in hospital-owned practices or physician-employed directly by a hospital, ophthalmologists continue to have the highest percentage of private practices of all specialties. In fact, according to the AMA's Policy Research Perspectives for 2024, 70.4% of all ophthalmologists are in private practice.[5]**

Rather than use the AMA's Physician Practice Information (PPI) survey data, CMS is proposing to change the methodology in determining indirect expenses "for each service valued in the facility setting under the PFS, we are proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs." CMS cites the June 2025 MedPAC report to Congress in its rationale for changing the practice expense methodology. However, CMS fails to note that MedPAC asserted that "indirect PE RVUs for facility services should be targeted toward clinicians who do not pay indirect PE costs because they do not maintain or finance a separate practice."[6] The proposed policy is an arbitrary approach to address the differential in site of service payments. In its recommendations, MedPAC states that, "Medicare claims data could be used to determine whether a

[4] *Overestimate tripled budget-neutrality medicare physician pay cut*. American Medical Association. (2025b, May 30). https://www.ama-assn.org/practice-management/medicare-medicaid/overestimate-tripled-budget-neutrality-medicare-physician-pay#:~:text=This%20unwarranted%20budget%20neutrality%20cut,learn%20how%20Medicare%20pay%20cuts:

[5] American Medical Association. (2025). *Physician practice characteristics in 2024*. Policy Research Perspectives. https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf

[6] Medicare Payment Advisory Commission. (2025). Reforming physician fee schedule updates and improving ... https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf

given clinician primarily practices in a facility or a service is furnished primarily in a facility, or a combination of both."[7] The proposed PE methodology change fails to follow MedPAC's recommendations and, instead, arbitrarily calls for a reduction to the portion of PE RVUs allocated based on work RVUs in the facility setting to half the amount used in the non-facility setting for all those services performed in a facility setting without consideration of specialty practice profiles or global surgery packages. **ASCRS and OOSS strongly oppose the proposed practice expense methodology change as it fails to consider: 1) ophthalmologists have a high percentage of physicians (70.4%) still practicing in a private practice, and 2) most ophthalmic global surgery packages include in-office visits for pre- and post-operative care that continue to require indirect overhead expenses such as rent, utilities, and a dedicated medical, billing, and administrative staff.**

Ophthalmologists have the highest percentage of private practice of all specialties

CMS's assertions of a shift in healthcare delivery are grossly overstated and fail to consider specialty-specific practice patterns. CMS does not take into account specialties that have a high percentage of privately owned practices, such as ophthalmology. We remind CMS that ophthalmologists do more than perform surgery all day. In addition to pre- and post-op visits associated with cataract and other ophthalmic surgical procedures, they also see patients for other ophthalmic conditions, including glaucoma and general eye exams. They do so in their privately-owned offices that require expensive equipment and other overhead expenses, such as medical, billing, and administrative staff.

Proposed PE methodology change fails to account for pre- and post-operative visits conducted in a privately owned office-based setting

Cataract surgery is reimbursed as a global surgery package, which typically allocates 10% of the global code to pre-operative care, 70% of the global surgery time to intraservice time, and 20% of the global surgery package to post-operative care. While the intraservice time of cataract surgery is performed in an ambulatory surgery center (ASC) or a hospital outpatient department (HOPD), 30% of the global surgery fee is for pre- and post-operative visits, which, for ophthalmology, are conducted in a privately owned office-based setting. As previously stated, most ophthalmologists are in private practice and require medical staff to provide care for cataract surgery patients and billing and administrative staff to accurately bill for the services provided. CMS's proposed methodology change does not account for the office-based component of the global surgical package. The proposed PE methodology change fails to consider the pre- and post-operative care that takes place in an office.

Efficiency Adjustment

In the proposed rule, CMS argues that "non-time-based codes, such as codes describing procedures, radiology services, and diagnostic tests, should become more efficient as they become more common, professionals gain more experience, technology is improved, and other operational improvements (including but not limited to enhancements in procedural workflows) are implemented." Therefore, CMS is proposing to apply an efficiency adjustment of -2.5% to work RVUs and the corresponding intraservice portion of physician time inputs for non-time-based services. **ASCRS and OOSS strongly oppose this proposal.**

[7] Medicare claims data could be used to determine whether a given clinician primarily practices in a facility or a service is furnished primarily in a facility, or a combination of both.

Many ophthalmology codes are regularly revalued by RUC

In the rationale for implementation of the efficiency adjustment, CMS states that "the average is 17.69 years since the last review of a code" by the American Medical Association RVS Update Committee (RUC). However, CMS fails to acknowledge that high-volume codes, such as cataract surgery, are continuously revalued. During the revaluation, the process consistently evaluates the time and intensity needed to perform a particular service. This revaluation is, essentially, an efficiency review that has yielded decreases in RVUs and reimbursement for cataract surgery and other ophthalmic codes.

In the proposed rule, CMS questions the validity and accuracy of the RUC process in determining appropriate valuations for codes. **ASCRS and OOSS firmly believe the RUC fairly and accurately values codes, particularly cataract and other ophthalmic surgery codes.** The RUC reviews high-volume codes frequently, and the time required and number of post-operative visits are assessed through standardized surveys, which result in an accurate valuation of the components of the global surgical package. For example, in 2019, the Extracapsular Cataract Removal (66984) and Complex Cataract Surgery (66982) codes were revalued by the RUC. Ophthalmologists were surveyed, the medical societies presented their results, and both codes' valuations were significantly reduced, based on the decrease in surgical time and number of postoperative visits required following surgery. The RUC process applies to all codes, with a primary focus on the intraservice time required to perform a service, reviewing postoperative visits, and correcting any inaccuracies.

Physicians penalized by use of the MEI Productivity Adjustment

CMS proposes using a five-year look-back period using the MEI productivity adjustment, which results in a negative 2.5% adjustment for CY26 across all non-time-based codes. We remind CMS that physicians do not get an MEI adjustment as part of the annual conversion factor update, like those applied for inpatient and outpatient perspective payment systems. Therefore, physicians should not be penalized using the MEI productivity adjustment. **ASCRS and OOSS strongly oppose the use of the MEI productivity adjustment as the method used to determine the efficiency adjustment.**

Concerns regarding the application of the efficiency adjustment in addition to frequent RUC revaluations for ophthalmic procedures

If finalized, CMS proposes to apply the efficiency adjustment every three years without a minimum value floor. As proposed, cataract codes will be subject to the arbitrary efficiency adjustment in *addition* to the ongoing revaluations at the RUC. As previously stated, cataract codes, along with other high-volume and perceived misvalued codes, are revalued by the RUC frequently. Requiring cataract and other ophthalmic codes to be subject to both the CMS efficiency adjustment every three years, without a minimum value, in addition to the frequent revaluations at the RUC, is unnecessary, unsustainable for providers, and could jeopardize patient access to care.

Intensity does not necessarily change due to an increase in surgeries performed

The proposed efficiency adjustment is based on CMS's assumption that "both the intraservice portion of physician time and the work intensity (including mental effort, technical effort, physical effort, and risk of patient complications) would decrease as the practitioner develops expertise in performing the specific service." **ASCRS and OOSS vehemently reject the Agency's assumptions.** While cataract and other ophthalmic procedures have seen advances in technology, the mental, technical, and physical efforts required for successful surgery continue to be significant, necessitating appropriate RVUs to reflect the

high level of intensity required for successful patient outcomes. Cataract surgery requires immense concentration and attention. Cataract surgeons perform surgery entirely through a microscope due to the small operating field, which allows for no room for error. Regardless of the number of cataract surgeries performed, the intensity of the work required for successful outcomes remains constant and must not be minimized by an arbitrary efficiency adjustment.

As proposed, the efficiency adjustment: 1) fails to acknowledge that high-volume codes, such as cataract surgery, get revalued frequently at the RUC, leading to consistent review of efficiency, time and relevant valuation adjustments, 2) alarmingly calls for continued adjustments every three years without a minimum value while high-volume and perceived misvalued codes continue to be revalued during the RUC process, and 3) wrongly assumes that physician time and intensity always decreases as physicians perform more procedures.

ASCRS and OOSS strongly urge CMS not to finalize this arbitrary proposal that could jeopardize patient care. As proposed, CMS aims to squeeze efficiencies out of every non-timed-based code without consideration of the ongoing revaluation in the RUC process, without recognizing that many high-volume codes are already efficient in the work needed to provide patient care, and without recognizing that some services, particularly cataract surgery and other ophthalmic procedures, continue to require a high-level of intensity to perform a successful surgery.

Strategies for Improving Global Surgery Payment Accuracy

Calculating procedure shares within a global surgery package

In the proposed rule, CMS solicits comments on procedure shares within a global surgery package. CMS has requested comments on three options for calculating procedure shares: one that focuses on RVUs, another that utilizes the no-pay code 99024, and the third that focuses on time. ASCRS and OOSS have strong concerns related to the RVU proposal. As the AMA RUC states in their comment letter to CMS, global surgical package RVUs were not established using a stepwise approach, and therefore, it is impractical to try to extrapolate the procedure shares by subtracting the RVUs of the post-operative visits from the total global RVU. ASCRS and OOSS also have significant concerns related to the proposal based on time. Focusing solely on time does not appropriately account for the intensity associated with the actual procedure. As previously stated, cataract surgery is a high-intensity procedure. Without consideration of procedure intensity, CMS is significantly diminishing the procedure shares of the global surgery package.

Concerns with CMS's policy option using the no-pay code 99024

In the proposed rule, CMS seeks comment for their preferred method that would "multiply the number of post-operative visits typically provided for the global procedure HCPCS code (defined as the median count of post-operative visits reported to CMS using no-pay code 99024 among procedures without overlapping global periods with other global surgical services) by the average valuation per post-operative visit calculated for the mix (that is, number and level) of post-operative visits." While this option provides the highest procedure shares, we have concerns about using 99024 as the basis for this option. In a June 2025 report, the Office of the Inspector General (OIG) audited 105 global surgeries, including cataract surgery, to determine whether physicians accurately report 99024 for postoperative

visits.[8] The audit shows that physicians are underreporting 99024 for reporting postoperative visits. Using an underutilized code as the basis for determining the procedure shares of a global surgery package is unreliable and inappropriate due to the flaws in the use of the 99024 code.

Co-management guidelines

In the CY25 proposed rule, CMS accurately noted that ophthalmology continues to use transfer of care modifiers -54, -55, and -56 appropriately. For over 20 years, ASCRS and the American Academy of Ophthalmology (AAO) had joint voluntary guidelines on co-management and formal transfer of care. However, in August 2016, ASCRS established its own guidelines that focus on patient choice.[9] The guidelines provide circumstances in which co-management or transfer of care is appropriate between an operating surgeon and a non-operating provider, as well as explicit instructions on documentation of the patient consent and formal transfer of care.

The circumstances under which formal or informal transfer of care is appropriate included in the ASCRS Co-Management Guidelines, are the following:

- The patient's inability to return to the operating ophthalmologist's office for follow-up care
- The operating ophthalmologist's unavailability
- Patient prerogative to consent to co-management or transfer of care to minimize travel or comfort with a non-operating provider
- Change in post-operative care due to the development of complications or intercurrent disease

When patients request to return to their non-operating practitioner and co-management is deemed appropriate by the operating ophthalmologist, the patient makes an informed decision in writing to be seen by the non-operating practitioner for post-operative care.

Under the current reimbursement arrangement, the surgeon receives 80% of the global period reimbursement, while the provider delivering post-operative care receives 20%. **ASCRS and OOSS urge CMS to maintain the current proportion of procedure shares, as we believe the current 80% for procedure shares is an appropriate representation of the work required for surgical procedures versus post-operative care.**

Number of post-operative visits

Throughout its consideration of global surgery packages, CMS continues to question the number of actual postoperative visits that occur within each global surgery period. ASCRS has repeatedly responded to the Agency's concerns with respect to cataract surgery. The post-operative values have been verified in multiple analyses and were reaffirmed in the CY 2022 PFS Final Rule. We remind CMS that cataract surgery was revalued in 2019 with an effective date of January 1, 2020. CMS adopted the RUC-recommended value, which confirmed that ophthalmologists were providing three post-operative visits, rather than the previous four post-operative visits, in the 90-day global period (one level 2 visit and two

[8] *CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries*. Department of Health and Human Services Office of Inspector General. (2025, June). https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf

[9] *Co-management guidelines*. ASCRS. (n.d.). https://ascrs.org/advocacy/regulatory/guidelines/co-management-guidelines

level 3 visits). Furthermore, CMS's RAND study confirmed that ophthalmologists were indeed providing three post-operative visits following cataract surgery in the 90-day global period.

Post-operative visit valuations

Through the enactment of the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress established that Medicare payments to physicians must consider the relative work, practice expense, and malpractice insurance costs required to furnish a particular service, and Medicare reimburses physicians equally for the same service, regardless of their specialty.

Since the implementation of the increased valuations of the E/M codes, **ASCRS and OOSS have repeatedly commented on the need to increase the value of post-operative E/M visits included in 10- and 90-day global surgical packages to correspond with the increased values for standalone E/M office visits as finalized in the CY 2021 PFS.** In prior years, when E/M values were improved, CMS correctly translated those updated values to the post-operative E/M services in the global surgical codes. However, in the CY 2021 PFS, CMS failed to apply its existing policy, violating the statute and threatening the overall relativity of the PFS.

As previously stated, the AMA, the surgical community, and other stakeholders have demonstrated that CMS's policy runs counter to the law. Bipartisan lawmakers have raised concerns and requested that CMS restore relativity across PFS services by improving the E/M values in global codes. **CMS should follow the precedent set in 1997, 2007, and 2011 (in accordance with the statute) when increased E/M values were applied to post-operative visits included in the global packages.**

QUALITY PAYMENT PROGRAM

I. Performance Threshold

ASCRS and OOSS strongly support CMS's proposal to maintain the performance threshold to avoid a penalty as 75 points for the 2026–2028 performance years/2028–2030 payment years. We applaud CMS for considering the unintended burdens of an increase in the performance threshold on small and rural practices and subsequent unintended consequences of increasing healthcare consolidation due to inability for practices operating on small margins to avoid penalties.

Our only recommendation on this proposal is that, in future years, CMS remain nimble on whether to use the mean or the median in case the data is skewed by unforeseen circumstances.

II. MIPS Value Pathways (MVPs)

Application of Defined Topped Out Measure Benchmarking to MVPs

ASCRS and OOSS appreciate CMS's proposal to apply the defined topped out measure benchmarking rules to MVPs with limited measure choice and a high proportion of topped out measures. However, **to ensure equitable scoring rules and incentive participation in MVP, we ask CMS to use flat benchmarks to score *all* 7-point capped measures in MVPs**.

Definition of Multispecialty Group

ASCRS and OOSS strongly support the modified definition of multispecialty groups to take into account the clinical focus of care. This will help ensure that ophthalmology practices that also employ optometrists or PAs are not inappropriately defined as a multispecialty group.

Determination of Single- vs Multispecialty Group Status

ASCRS and OOSS strongly support CMS's proposal to allow groups to attest to their specialty composition during the registration process. This will ensure that inappropriate multispecialty designations are not made due to the incomplete picture provided by claims data. **We strongly urge CMS to maintain this policy in all future years.**

Participation Options for Multispecialty Group Small Practices

ASCRS and OOSS strongly support CMS's proposal to allow small multispecialty practices to report as a group, rather than a subgroup. This will ensure that small practices are not subject to undue reporting burden. **We strongly urge CMS to maintain this policy in all future years.**

RFI: Procedural Codes for MVP Assignment

CMS is requesting feedback on how to use procedural codes to not only determine specialty, but also to assign MVPs in the future. This is despite acknowledging that the attestation "process would also alleviate the concerns associated with determining a group's specialty composition due to inaccurate representation of the clinician specialty information on the claims data." **ASCRS and OOSS strongly urge CMS to maintain group ability to attest to their specialty status and choose the most appropriate MVP for their practice. We have serious concerns about assigning clinicians to a specific set of measures based on claims data given that claims data has numerous limitations and, therefore, often does not accurately capture a clinician or group's specific scope of practice.**

Should CMS continue to pursue using claims, there must be a simple process for groups to modify CMS's assignment by attesting to their group's composition and practice areas.

RFI: Core Elements in an MVP

CMS is requesting feedback on adopting MVP-specific core quality measures that would be required for reporting that MVP. While we understand that CMS wants to increase conformity in measure selection, **ASCRS and OOSS are deeply concerned with this RFI.** Since the beginning of discussion on MVPs years ago, CMS has been steadfast that they do not want too many MVPs. As discussed in our discussion of the Complete Ophthalmologic Care MVP below, this has led to many subspecialties being combined into a single MVP. These subspecialties often have little to no overlap in clinical practice.

When establishing MVPs in the 2020 MPFS rule, CMS put strong emphasis on providing patients with useful information. CMS even stated, "We are dedicated to putting patients first and providing the information they need to be engaged and active decision-makers in their care." Despite this, CMS has consistently resisted efforts to transform MVPs into meaningful participation frameworks.

Patients looking for a cataract surgeon do not care how that surgeon compares to an ophthalmologist that solely treats glaucoma. Patients want to know how their clinician rates compared to other clinicians providing that same service.

If this policy is pursued, there are only two measures that are even possible for every ophthalmic subspecialty to report—measure 226 (tobacco use) and measure 374 (closing the referral loop). These measures are not applicable to every ophthalmologist, however. Some clinicians are the referral of last resort. This means that they do not refer patients to other clinicians and, therefore, cannot report measure 374. Moreover, when the required measures eventually get topped out due to high focus and reporting, CMS will propose to remove those measures. With no replacement available, CMS will not be able to make the MVP compliant to this policy.

ASCRS and OOSS strongly recommend that CMS allow physicians to focus solely on their specific patient population and the conditions they treat, rather than continuing to try to fit all ophthalmologists in a single box. Trying to make ophthalmology one-size-fits-all is directly impeding CMS's ability to provide meaningful information to patients.

Complete Ophthalmologic Care MVP

ASCRS and OOSS continue to have serious concerns about the complete ophthalmologic care MVPs. Since 2019, we, along with other ophthalmic medical societies, have diligently worked to provide feedback, suggested improvements, and offer compromises to the several ocular care MVP drafts that CMS has put forth. This issue is important to our members. Most ophthalmologists do not have Advanced Alternative Payment Models (APMs) available to them and thus must participate in MIPS. Given the large percentage of ophthalmologists participating in MIPS, this MVP is likely to have a significant impact on our profession in the future.

While CMS has made some improvements since the Comprehensive Ocular Care MVP Candidate released in late 2023, we were disheartened in 2024 to see that our efforts at improving the coverage of this MVP and to create a workable model through compromise with CMS were largely ignored. The Complete Ophthalmologic Care MVP remains insufficient to allow for success for many ophthalmic subspecialists, particularly for those unable to report through a QCDR due to logistical or EHR vendor issues. Many subspecialties have no measures on the conditions they treat available in this MVP and can only be scored on general measures, such as Tobacco Use Screening (see Tables 1–3, subspecialties marked with †).

There are multiple subspecialties in ophthalmology that have little-to-no overlap in the conditions they treat. Because of this, a *complete or comprehensive* ophthalmologic care MVP is not functionally feasible. **In response, ASCRS and the Academy worked collaboratively to develop an MVP candidate specifically for cataract surgery—the most performed surgical procedure in Medicare—which we submitted in January 2024 and which we have included in Appendix A.** By focusing this MVP specifically on cataract care, the only ophthalmic subspecialty with an available cost measure, we allowed for germane and outcomes-oriented measurement and comparison for cataract surgery. This allows identification of areas for improvement that are actionable on the practice-level and at the clinician-level.

CMS responded to our submission by stating their intent to have MVPs be more broadly applicable at the specialty level.

In May 2024, we worked with the AMA to advocate for a compromise solution to achieve both CMS's goal of a more comprehensive ophthalmic care MVP and our goal of ensuring that every ophthalmologist has an equal opportunity to succeed. We submitted our new set of recommendations (Appendix B) alongside the AMA's and others in the House of Medicine. In this submission, we included a broader range of specialty-specific measures and attempted, to the extent possible, to ensure each ophthalmic subspecialty was sufficiently represented in the Quality category measures we included. Although CMS added a few of our suggested measures, many ophthalmic subspecialties remain without sufficient quality measures or only have access to general measures.

CMS intended MVPs to allow for meaningful comparisons of clinical care using meaningful measurement relevant to clinician scope-of-practice. *Limiting* clinicians to only reporting on general measures (like Tobacco Use Screening) does not allow for a meaningful comparison of clinically relevant care or outcomes.

We are specifically concerned about the following issues:

- The only Cost measure available to ophthalmologists is the Cataract Removal with Intraocular Lens (IOL) Implantation measure.
    - This is only applicable to a subset of ophthalmologists and, as such, if included in a *comprehensive* ocular care MVP, it would unfairly disadvantage cataract surgeons compared to other subspecialties. This creates inequality in measurement as clinicians who are not scored on cataract cost will have more weight assigned to Quality and Promoting Interoperability—two categories that are more predictable and, in practice, more able to meaningfully evaluate value-based care.
    - We have seen significant issues with scoring this measure. Until those issues are resolved, there will not be a valid Cost category measure for ophthalmology or any ophthalmic MVP.
- Insufficient coverage of subspecialty quality measures:
    - Available measures are not meaningful for some subspecialties.
    - The low percentage and number of benchmarked measures that are not topped out which are available to each subspecialty.
- The burdens and high expenses of fully testing Qualified Clinical Data Registry (QCDR) measures at the clinician-level prior to inclusion in the MVP.
- Patient-Reported Outcome Measures in this MVP are excessively burdensome for survey collection, scoring, and feedback.
- Population health measures are not applicable to ophthalmology.

Insufficient Cost Measures to Evaluate Comprehensive Ophthalmologic Care

The cost measure in the Complete Ophthalmologic Care MVP applies only to cataract surgery. Given the issues we describe in the MIPS Cost section of this comment letter, this puts cataract surgeons at a disadvantage compared to other ocular care providers. Although cataract surgery is one of the more commonly performed procedures in Medicare patients, it is not performed by all ophthalmologists. For instance, retina, oculoplastic, uveitis, and neuro-ophthalmology rarely, if ever,

perform cataract surgery. Moreover, even some comprehensive ophthalmologists who perform cataract surgery are low volume and do not meet the case minimum threshold for the cost measure. These clinicians will have more weight assigned to Quality and Promoting Interoperability—two categories that are more predictable and, in practice, more able to meaningfully evaluate value-based care.

Given the complexity of properly representing ophthalmic subspecialties in both the Cost and Quality performance categories, we continue to believe it appropriate to limit the first ophthalmic MVP to cataract surgery. The MVP candidate submission prepared jointly by the Academy and ASCRS focuses specifically on cataract surgical care and allows for outcomes-oriented measurement and comparison for cataract surgery.

Insufficient Coverage of Subspecialty Quality Measures

We remind CMS that ophthalmology is not a homogenous profession. There are multiple subspecialties that have little-to-no overlap in the conditions they treat. **Both ASCRS and OOSS continue to feel that there is insufficient representation of the breadth of ophthalmic subspecialties in the Complete Ophthalmologic Care MVP that CMS finalized last year.**

In Tables 1–3 below, we outline the number of available measures for each ophthalmic subspecialty by collection type listed in this MVP. As demonstrated in these tables, the measures included in the Complete Ophthalmologic Care MVP disadvantage ophthalmic practices in MIPS by limiting the maximum Quality score achievable under this MVP.

In fact, under this MVP, large practices in only four subspecialties are able to achieve 40/40 points for Quality if reporting via eCQMs + QCDR measures. If reporting on MIPS CQMs + QCDR measures, only three subspecialties are able to achieve 40/40 points for the Quality category. Finally, via claims, none of the ophthalmic subspecialties are able to achieve 40/40 points. The tables embedded in this letter are based on the 2025 benchmarks.

Even more concerning, only four subspecialties (only via eCQMs + QCDR measures) have four or more available measures that are both benchmarked and not topped out. No subspecialty has four or more via MIPS CQMs + QCDR nor Claims measures. **Thus, it is very likely that the maximum score achievable under CMS's Ophthalmic Care MVP will continue to decline in future years.**

Not only does the set of limited germane quality measures erect hurdles for ophthalmic subspecialties to avoid a MIPS penalty, but it also limits their ability to track and improve their performance on clinically relevant measures over time.

By requiring clinicians to exclusively report on these measures, CMS directly and disproportionally disadvantages physicians in particular subspecialties, practice locations, and practice settings. Small and rural practices are less likely to have the resources available to adopt EHRs. These types of practices are further disadvantaged under this MVP as they are not able to report eCQMs and thus are limited to manual measures that are largely topped out (see Tables 2 and 3). Moreover, due to the smaller number of patients seen, singular adverse events have a substantially greater impact on small practices than large practices in this MVP because they are unable to choose measures with less clustered performance rates.

Finally, given the lack of subspecialty-specific MIPS measures, we strongly urge CMS to leverage additional IRIS Registry measures in supporting clinically meaningful eyecare-related MVPs.

Improve MVP Adoption by Streamlining Quality Category Scoring Methodology

While there is no one-size-fits-all approach to MVPs that will work for every medical specialty, we believe that modifying MVP scoring policy would, at minimum, acknowledge the variation in care provided by subspecialists and to different patient populations.

Subspecialty MVP Measure Sets

While we appreciate CMS beginning to organize MVP quality measures by subspecialty, organization itself will not solve the problem of insufficient measures for subspecialists. Instead, we suggest that CMS apply special scoring rules for subspecialties for which there are fewer than four available quality measures. This would be assessed at the collection type level.

If there are fewer than four quality measures in an MVP subspecialty category-collection type, then clinicians of that subspecialty would only be required to report those measures, rather than being forced to use generic measures in the MVP that are not relevant to their care or to not participate in the MVP at all.

Topped Out Measure Scoring within MVPs

We appreciate CMS's proposal to apply the defined topped out measure benchmarking rules to MVPs with limited measure choice and a high proportion of topped out measures. However, **to ensure equitable scoring rules and incentive participation in MVP, we ask CMS to use flat benchmarks to score *all* 7-point capped measures in MVPs**.

New or Existing Measures or Measures without a Benchmark

Given the limited choice of available measures within MVPs, measures without a benchmark reported under the MVP should be scored using a 7-point floor (similar to the current policy for scoring measures in their first year in MIPS).

Table 1. Example Number of Quality Measures by Subspeciality: eCQM + QCDR Measures

Subspecialty	Available Quality Measures	% Not Benchmarked (Number)	% Topped Out (Number)	%7-point Capped (Number)	Benchmarked & *not* 7-pt Capped	Benchmarked & *not* Topped Out
Cataract/Anterior Segment	8	12.5% (1)	25% (2)	12.5% (1)	6	5
Cornea/External Disease†	4	0% (0)	25% (1)	25% (1)	3	3
Glaucoma	8	12.5% (1)	12.5% (1)	12.5% (1)	6	6
Refractive†	4	0% (0)	25% (1)	25% (1)	3	3
Oculofacial Plastics/ Reconstructive†	4	0% (0)	25% (1)	25% (1)	3	3
Pediatric Ophthalmology and Strabismus†	2	0% (0)	0% (0)	0% (0)	2	2
Neuro-Ophthalmology	5	0% (0)	20% (1)	20% (1)	4	4
Retina/Vitreous	8	12.5% (1)	20% (2)	20% (2)	5	5
Uveitis/Immunology†	4	0% (0)	25% (1)	25% (1)	3	3

†No specialty-specific measures. (there are up to 5 general measures: Q117, Q130, Q226, Q374, Q487)

Table 2. Example Number of Quality Measures by Subspeciality: MIPS CQM + QCDR Measures

Subspecialty	Available Quality Measures	% Not Benchmarked (Number)	% Topped Out (Number)	%7-point Capped (Number)	Benchmarked & *not* 7-pt Capped	Benchmarked & *not* Topped Out
Cataract/Anterior Segment	10	30% (3)	50% (5)	30% (3)	4	2
Cornea/External Disease	5	20% (1)	80% (4)	40% (2)	2	0
Glaucoma	8	12.5% (1)	50% (4)	25% (2)	5	3
Refractive†	4	0% (0)	100% (4)	50% (2)	2	0
Oculofacial Plastics/ Reconstructive†	5	20% (1)	80% (4)	40% (2)	2	0
Pediatric Ophthalmology and Strabismus†	3	33% (1)	67% (2)	0% (0)	2	0
Neuro-Ophthalmology†	5	20% (1)	80% (4)	40% (2)	2	0
Retina/Vitreous	12	25% (4)	50% (6)	25% (4)	4	2

Uveitis/Immunology	**5**	**20% (1)**	**80% (4)**	**40% (2)**	**2**	**0**

†No specialty-specific measures. (there are up to 5 general measures: Q117, Q130, Q226, Q374, Q487)

Table 3. Example Number of Quality Measures by Subspeciality: Claims

Subspecialty	**Available Quality Measures**	**% Not Benchmarked** (Number)	**% Topped Out** (Number)	**%7-point Capped** (Number)	**Benchmarked & *not* 7-pt Capped**	**Benchmarked & *not* Topped Out**
Cataract/Anterior Segment†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Cornea/External Disease†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Glaucoma	**2**	**0% (0)**	**100% (2)**	**100% (2)***	**0**	**0**
Refractive†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Oculofacial Plastics/ Reconstructive†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Pediatric Ophthalmology and Strabismus†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Neuro-Ophthalmology†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Retina/Vitreous†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Uveitis/Immunology†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**

†No specialty-specific measures. (there is up to 1 general measure: Q226); *Measure 141 has proposed defined topped out measure benchmarking

Develop Voluntary Condition-Based/Procedure MVPs

In the past, CMS has expressed concern that the number of MVPs desired is too high. In ophthalmology, we are highly subspecialized and cannot reliably or meaningfully be scored in a specialty-wide MVP. **Therefore, we urge CMS to consider the adoption of more subspecialty and condition-based MVPs. ASCRS and the American Academy of Ophthalmology submitted a draft Cataract Surgery MVP to CMS in January 2024.**

Future of the QPP

Sunset of Traditional MIPS

In this proposed rule, CMS reiterates their intent to sunsetting traditional MIPS and fully transitioning to MVPs by performance year 2029. **ASCRS and OOSS strongly oppose sunsetting traditional MIPS. MVPs must remain voluntary.**

- **As we noted in our comments on the CY 2021, 2022, 2023, 2024, and 2025 MPFS rules, our opposition to the current framework outlined by CMS is that MVPs continue to be chiefly based on CMS's 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, CMS also intends to require all MIPS eligible clinicians to participate in MIPS either through an MVP or an APM Performance Pathway (APP), while no longer offering traditional MIPS. Given that the goal of MIPS 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. For example, the retina subspecialty focuses specifically on diseases at the back of the eye, neuro-ophthalmologists focus on visual problems related to the nervous system (not the eyes), and cataract and refractive surgeons focus on the front of the eye.

  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 developed the initial and subsequent drafts of an eyecare MVP. As was discussed in our meetings with CMS and our comment letters, not all ophthalmic subspecialties would be able to participate.

  The "Complete Ophthalmologic Care" MVP CMS finalized last year made it clear that CMS does not intend MVPs to allow sufficient quality measure choice for all ophthalmologists to participate. In fact, four ophthalmic subspecialties have no relevant eyecare measures included in the MVP.

  We have encouraged the development of MVPs around conditions and procedures. In fact, we even submitted a Draft Cataract MVP to CMS. The ophthalmic community 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 or procedure, but these efforts should be *clinician-led.* **It is inappropriate to require clinicians to take part in a program in which it is impossible for them to succeed.**

  In addition to our comments and our draft Cataract MVP submission, we worked with CMS last year to assemble a Comprehensive Ocular Care MVP that would more completely cover the ophthalmic scope-of-practice. CMS largely ignored our recommendations, and the result is an MVP that does not have a single ophthalmic quality measure for four ophthalmic subspecialties. **We are deeply concerned with CMS's apparent unwillingness to collaborate with medical societies in good faith surrounding MVP development.** 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.**

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.

CMS Should 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. Ophthalmologists should be excluded from these measures and population-health measures should not be included in any ophthalmic 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 then reporting on clinically relevant measures, such as cataract surgery outcome measures.

CMS Must 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 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, QPP303 and QPP304, are registry-only and will continue to require a 75% data completeness threshold 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 included in MVPs and MIPS in general.**

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

Finally, although MVPs are meant to be a cohesive, integrated reporting pathway, 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.**

III. MIPS Quality Category

Data Completeness Threshold

ASCRS and OOSS applaud CMS's decision to maintain the data completeness threshold at 75% through performance year 2028 and **strongly urge CMS to reconsider any future increases**. We appreciate CMS's acknowledgement that there are technical and interoperability challenges pertaining to data aggregation and quality reporting. In addition, we previously voiced our concerns surrounding increased burden and barriers to MIPS reporting, particularly for small and rural practices.

ASCRS and OOSS continue to ask CMS to prioritize reasonable achievability in any future discussions.

We reiterate that we have seen even the current data completeness threshold pose significant burden to practices, for example, when a practice switches EHRs during the performance year.

When a practice switches EHRs, the vast majority of the time, the new EHR will not include data from encounters that occurred prior to the transition in the measure calculation. The logical next step would be to ask a registry to aggregate the data for submission. This is often logistically difficult for registries to do with limited resources. Alternatively, a practice could report data directly from each EHR to CMS for CMS to aggregate, but CMS has previously finalized that data must be aggregated prior to submission. That leaves practices to aggregate the data themselves. **This creates substantial burden that no amount of experience with MIPS has been able to ameliorate, particularly since practices cannot always decide when to switch EHRs** (e.g., their EHR is decertified, the practice is acquired, their planned transition to a new EHR is delayed, etc.).

CMS has previously stated that increasing the data completeness threshold would not pose a substantial burden to MIPS ECs unless they are manually extracting and reporting quality data**. If a practice in the situation we described plans to submit eCQMs, they often cannot aggregate this data as a single submission to CMS, leaving the practice to manually extract the data which can be prohibitively burdensome.** Situations like this are common, and practices rely on the current data completeness threshold to allow them to meet reporting requirements.

A typical ophthalmologist sees about 100 patients per week. If we extrapolate that to a 52-week year, we can estimate approximately 5,200 patients. To determine statistical significance, most researchers use a 95% confidence level. This means that, 19 times out of 20, a sample of the specified size would yield a

similar result. If we choose a tight margin of error (only 1%) and a 95% confidence interval, the size of the patient sample for this ophthalmologist would be 3,374 patients (65% of the patients seen by the ophthalmologist during the course of the year). For a general measure like Documentation of Current Medications in the Medical Record, a 65% sample would be representative.

Although the sample size percentage increases as the population size decreases, this is meant for a random sample. What we are seeing from practices in situations such as the one outlined above is not a sample, but rather a census of available patient data. This means that the practice is reporting all measure data available in their current EHR**. A census of available patient data meets CMS's goal** of ensuring that data submitted on quality measures are complete enough to accurately assess quality performance*. If, on the other hand, a practice becomes required to manually extract and aggregate large amounts of quality measure data themselves, it is reasonable to expect unintentional errors.* **It is clear from this common example that higher data completeness thresholds do not always yield more accurate depictions of quality performance.**

We agree that it is important that quality data represent a clinician's true performance, rather than a cherry-picked sample. Circumstances, like EHR switches during the performance year, can make high data completeness thresholds not only hard to meet, but also difficult to meet *accurately.* For the reasons outlined above, we strongly urge CMS to maintain the current data completeness threshold of 75% for all future years. **If CMS wishes to increase the data completeness threshold in future years, we recommend the following options to ensure that practices are able to continue to report quality data in good faith:**

- CMS-facilitated quality data aggregation: Allow practices to report quality data from multiple EHRs with an indication that they should be aggregated to determine the measure's final score.

- Shortened performance periods for special circumstances: If a practice switches EHRs during the performance period or encounters an unforeseen data completeness-related issue, allow the practice to report on the longest period of consecutive data available. For example:
    - If a practice switches EHRs in March and is unable to submit yearlong aggregate data, the practice would have 9 consecutive months of data available in the new EHR, on which they could report 100% data completeness.
    - If a practice switches EHRs in October, the first EHR would have 9 consecutive months of data available.
    - For practices unable to switch during the first or last quarter of the year (would have less than 9 consecutive months of data), allow the practice to apply for a Quality Category EUC.

- Extreme and Uncontrollable Circumstance Quality Category Exceptions: for practices that switch EHRs during the performance period or encounters an unforeseen data completeness-related issue.

Patient-Reported Outcome Measures

As outlined above, there are instances in which increasing data completeness requirements *directly* intensifies administrative burden for physicians and does not align with the Patients Over Paperwork Initiative. This is particularly true for patient-reported outcome (PRO) measures as it is difficult to obtain sufficient patient responses under current thresholds. **In acknowledgment of the widespread difficulty**

in obtaining PRO responses from patients, we recommend CMS consider setting lower data completeness thresholds for patient-reported outcome measures.

Support for Maintaining 3-Point Scoring for Small Practices

ASCRS and OOSS support CMS's decision to maintain the policy to assign a measure score of 3 points for small practices reporting on measures that are not benchmarked, do not meet data completeness, or do not meet case minimum.

Support for Maintaining 6-Point Bonus for Small Practices

ASCRS and OOSS support CMS's decision to maintain the 6-point quality category bonus for small physician practices in all future years.

Scoring for Topped Out Measures in Certain Specialty Sets: Proposed Measure Addition and Proposed Application to MVPs

ASCRS and OOSS support the proposal to apply the defined topped out measure benchmark scoring to the Medicare Part B Claims collection type for Measure 141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care.

ASCRS and OOSS also strongly support the proposal to apply this scoring methodology to measures in MVPs as well as specialty sets in traditional MIPS. We agree that MVPs, like specialty sets, limit a clinician's measure choice and can hinder their ability to successfully participate in MVP reporting. *However, we note that MVP reporting itself is problematic for clinicians.* Please refer to the MVP section of our comments for further discussion.

We would also like to point out that this scoring methodology, although a good *first step* towards addressing the problem of topped out measure scoring for clinicians with limited germane quality measures available, does not address concerns for subspecialties. Specialty measures sets are not subspecialty-specific. Because of this, even specialty sets with sufficient non-topped out measures for the specialty can lack sufficient appropriate measures for subspecialists. Therefore, we ask CMS to evaluate whether or not there is limited measure choice and a high proportion of topped out measures at the subspecialty (taxonomy) level as well.

Topped Out Measure Scoring for Measures Outside of Identified Specialty Sets

The dwindling number of available specialty-specific or germane quality measures is an issue that is exacerbated by the topped out measure lifecycle. **As we have stated previously in these comments, ASCRS and OOSS continue to oppose CMS's 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.**

Proposed Quality Measure Modifications and Removals

- ***Measure 12: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation***

  ASCRS and OOSS support revising the numerator language from "within 12 months" to "during the measurement period." This clarification will result in a more appropriate calculation of this measure.

- ***Measure 117: Diabetes: Eye Exam***

  ASCRS and OOSS strongly oppose the proposed removal of QPP117: Diabetes Eye Exam for the MIPS CQM collection type. This is an important measure for ophthalmologists. Removing this measure will disproportionately and negatively impact small and rural ophthalmic practices, which are less likely to be able to afford CEHRT adoption and thus unable to report via the eCQM collection type**. We strongly encourage CMS to maintain the availability of this measure via the MIPS CQM collection type to continue to allow meaningful measurement of ophthalmologists and ophthalmic subspecialists in small and rural practices.**

  ASCRS and OOSS support the updated denominator exclusion. We agree that patients missing both eyes should be excluded, as they would not qualify for an eye exam.

  ASCRS and OOSS support the numerator revision, as an autonomous eye exam is an acceptable standard of care in diabetic patients.

- ***Measure 141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care***

  ASCRS and OOSS request clarification on the proposal for this measure, as the proposed substantive change was not stated in the rule. The rule states, "Added: timing for documenting the plan of care." However, timing is currently included in the numerator definition as "within the 12-month performance period." While we were able to discuss the intended proposal with the measure steward and have no objections to the change, for most commenters, without a specified proposal, it is impossible to comment on the proposed change for this measure, and therefore no finalized change can be made.

- ***Measure 191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery***

ASCRS and OOSS oppose the update to the denominator exclusion to include the list of diagnoses that qualify as significant ocular conditions. While we appreciate the clarification on this measure, we note that the proposed modification represents a removal of eight exclusionary diagnoses—several of which are related to or specified forms of diagnoses in the current eCQM measure specification. As such, we strongly urge the maintenance of the following diagnoses in the denominator exclusion:

- Chronic Iridocyclitis
- Glaucoma Associated with Congenital Anomalies and Dystrophies and Systemic Syndromes
- Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis
- Other Background Retinopathy and Retinal Vascular Changes
- Other Disorders of Optic Nerve
- Other Endophthalmitis
- Other Proliferative Retinopathy
- Visual Field Defects

- ***Measure 374: Closing the Referral Loop: Receipt of Specialist Report***

  ASCRS and OOSS support the updated guidance for the measure. We agree that in the case of a procedure or exam (e.g., diabetic eye exam), a procedural report from the specialist is sufficient to close the referral loop.

  ASCRS and OOSS oppose the numerator revision requiring the referring clinician to receive a report from the *first* clinician to whom the patient was referred. Patients may choose to see a different clinician within the same specialty (other than the one to whom they were initially referred), or it may be necessary for the patient to see a different specialist or subspecialist altogether. For example, a patient could be referred to a specialist but ultimately schedule an appointment with another clinician in the same specialty due to availability. There are numerous reasons why requiring the referring clinician to receive a report from the *first* clinician would not be practical or appropriate.

- ***Measure 389: Cataract Surgery: Difference Between Planned and Final Refraction***

  ASCRS and OOSS support the proposed change to this measure with modification. We agree that the measure should only include those patients with recently obtained planned refractions. We ask that clinicians have the option of assessing and documenting the planned refraction on the day *of* the procedure, not just within 90 days *prior* to the procedure.

- ***Measure 419: Overuse of Imaging for the Evaluation of Primary Headache***

  ASCRS and OOSS oppose the removal of this quality measure from MIPS. Removal of this measure may to lead to an overuse of CT and MRI services,[10] which in addition to increasing patient exposure to unnecessary radiation, would also result in higher health system costs.

- ***Measures 500 and 501: Acute Posterior Vitreous Detachment (PVD) Measures***

[10] Minchin M, Roland M, Richardson J, Rowark S, Guthrie B. Quality of care in the United Kingdom after removal of financial incentives. N Engl J Med2018;379:948-57. doi:10.1056/NEJMsa1801495 pmid:30184445

ASCRS and OOSS ask that if the proposed changes to these measures are finalized and new benchmarks are created, CMS apply the 7-point scoring floor used for first-year MIPS measures. This would be appropriate for these measures, given the substantive changes resulting in no direct comparison to previous benchmarks. It is also important to avoid disincentivizing the reporting of two important measures, which would functionally reduce the already limited pool of measures available to ophthalmologists.

RFI: Transition Toward Digital Quality Measurement

While ASCRS and OOSS appreciate the thought of transitioning to more automatic quality data collection, **we oppose the transition to fully dQM-based quality measurement.** As a specialty with a low percentage of employed physicians and a large percentage of small practices, it can be difficult for our members to transition to EHRs or afford upgrades. This has caused challenges with eCQM implementation for some practices. Further evolving the system to a new form of measurement would create potentially insurmountable hurdles for small practice MIPS participation. Moreover, eCQMs are not entirely automatic and burden-free. We have heard from our members that there are frequent issues with eCQM calculations that require careful monitoring and significant time commitment to get resolved. By adding a new and less centralized quality measurement, especially as a requirement rather than an option, CMS will significantly increase the burden of accurate reporting. This is particularly true for small and rural practices, which are lower resourced settings.

IV. MIPS Cost Category

Proposed Two-Year Informational-Only Feedback Period for New Cost Measures

ASCRS and OOSS applaud and greatly appreciate CMS's proposal to implement a two-year informational-only feedback period for new cost measures. We thank CMS for listening to our concerns in previous years regarding transparency in cost measure development and testing. This proposal will provide the much-needed opportunity for clinicians to carefully examine the implementation of new cost measures and provide feedback so that CMS can address any issues before they impact final scores.

Pre-Rulemaking Cost Measure Development, Review, and Opportunities for Public Comment

Along with the proposed two-year informational period, we encourage CMS to continue to implement steps to ensure transparency in development and testing of new cost measures. We propose the following:

- Additional field testing and reports for cost measures that undergo post-field testing refinement that could reasonably be expected to subject additional specialties to a cost measure.
- Publish a list of the number and percentage of specialists that are attributed to a cost measure in field testing and after post-field testing refinements (for all two-digit specialty codes).

We also strongly recommend CMS and Acumen take advantage of specialty attribution exclusions to ensure specialists who do not manage a condition, but only treat complications, are not inappropriately attributed to measures. This is particularly important for episode-based chronic condition measures as this type of inappropriate attribution is a known and continuing issue. In ophthalmology, the only chronic conditions for which we control the costs are ophthalmic chronic conditions. **We request that ophthalmologists be specifically excluded from attribution under all existing and future non-ophthalmic chronic condition measures.**

Cost Measure Feedback Reports

We remain concerned that more clarity is required in the cost measure feedback reports. The Cost category has not yielded predictable results based on practice patterns and best practices. The feedback reports our members have received from CMS have offered little insight. We have seen the Cataract Cost Measure score distributions and benchmark range cut-offs change dramatically, but we do not have sufficient information to determine anything further.

In the 2018 proposed rule, CMS requested advice on how to provide cost feedback to clinicians and how to improve upon QRUR and sQRUR reports. At the time, we requested the ability to identify how and when services were attributed to clinicians and where the services occurred (ASC vs HOPD).

While we appreciate the increased ease in which clinicians can access their cost reports (linked on their MIPS Score Report) and the patient-level drill down appendix, the data we now have under MIPS is extremely difficult for even seasoned MIPS professionals to interpret and to gain actionable insights from. **ASCRS and OOSS strongly recommend CMS conduct extensive testing and training to ensure resource use reports are understandable, user friendly, and actionable.**

Cost Measure Specifications

ASCRS and OOSS strongly recommend CMS review the form and content of the Cost Measure specifications. We have seen many ambiguities and several components that are implemented in a way that conflicts with the measure specification.

For example, in the current Cataract Cost Measure specifications, CMS states the "Cataract Removal with IOL Implantation episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo … cataract removal with IOL implantation during the performance period." However, the measure does not evaluate procedures performed during the performance period, but rather procedures with a cost episode window that ends during the performance period.

It is imperative that the cost measure specifications be both accurate and understandable.

Cost Measure Scoring

ASCRS and OOSS appreciate CMS's decision to maintain the cost measure scoring methodology that was finalized in 2025. Though we remain concerned about the outsized impact of small differences in procedure costs, particularly since cataract surgery is a highly cost-efficient procedure, we look forward to seeing the positive impact of this methodology on clinicians' scores.

Proposed Change to the Total Per Capita Cost Measure and Treatment of Advanced Practice Nonphysician Practitioners

ASCRS and OOSS strongly support CMS's proposal to exclude advanced practice nonphysician practitioners from the TPCC if they are part of a group where all other clinicians are excluded based on the specialty exclusion criteria. We appreciate CMS listening to our concerns regarding inappropriate attribution of the TPCC to specialty groups employing NPs, PAs, and CCNSs. **To ensure valid comparisons of the cost of primary care, we encourage CMS to implement this proposal retroactively beginning with the 2025 performance year.**

Cost Measure Attribution Issues

Throughout the history of cost measurement—from the Value-based Modifier to MIPS episode-based cost measures—attribution of measures to the appropriate clinicians has created difficulties. Because of the problems posed by inappropriate cost measure attribution, in the 2020 Final Rule, CMS finalized Total Per Capita Cost (TPCC) measure exclusions for specialists (based on HCFA Specialty codes) who do not provide primary care.

Solve Inappropriate Cost Measure Attribution Through Specialty Exclusions

The addition of these specialty exclusions to the TPCC measure has allowed CMS to more accurately identify primary care relationships and compare cost of care. **We ask CMS to employ specialty exclusions in episode-based cost measures as well.** We have seen inappropriate attribution of MIPS chronic condition cost measures that is not completely solved by the attribution rules requiring the prescription of at least two condition-related prescriptions to at least two patients. We believe a simpler and more effective method of ensuring specialists can only be attributed cost measures relevant to their scope of practice is to use specialty exclusions.

Cataract Surgery Episode-Based Cost Measure

ASCRS and OOSS are concerned with the Cataract Cost Measure specification. This measure is meant to measure the resource use of cataract surgery with implantation of an IOL. We have taken every opportunity to comment during the measure's comprehensive reevaluation and during the 2025 proposed rule comment period. As the subspecialty society that specifically represents cataract surgeons, we are very concerned that the majority of our comments and recommendations are not reflected in the current measure specification.

Trigger Codes

We appreciate that CMS has made no proposed changes to the trigger codes. We urge CMS to maintain 66984 as the only trigger for the cataract episode-based cost measure.

Other cataract codes are for complex cataracts that are likely to be more expensive due to factors outside of clinician control. Complex cataract may require additional supplies and increases the likelihood of potential complications.

Part B Drugs Included in Service Assignment

ASCRS and OOSS continue to oppose the inclusion of Dextenza and IHEEZO in the costs evaluated under this measure.

- ***Dextenza***

  As we previously commented and continue to maintain, given that Dextenza has the ability to reduce or eliminate the need for Medicare Part D postoperative topical corticosteroids, a class of medication used routinely after cataract surgery, ASCRS and OOSS urge CMS to remove Dextenza from the Cataract Episode Measure.

- ***IHEEZO***

  ASCRS and OOSS reiterate opposition to the inclusion of pass-through drugs in this measure. No pass-through drugs, including IHEEZO, should be included in cost measure calculations. The extra cost will disincentivize surgeons from using the drugs and negatively impact the utilization data CMS collects on pass-through drugs during the pass-through period.

As we have previously detailed, including *any* pass-through drug in any cost measure defeats the purpose of pass-through status. CMS uses pass-through status to collect unbiased utilization data by removing the concern of drug cost from clinical decision making for new and innovative medications. This utilization data is ultimately used in the formula to update the APC payment once the drug comes off pass-through and is bundled into the facility payment. The time period in which the new medication is on pass-through status also allows physicians time to become familiar with the new treatment option and its benefits. By including pass-through drugs in cost measures, CMS has reintroduced concerns about cost and resultant MIPS penalties, thereby biasing utilization data collection and defeating the purpose of pass-through status for those medications.

We have heard from membership that ***the inclusion of pass-through drugs in the episode-based MIPS Cataract Cost Measure factors into their decision-making and disincentivizes utilization while the drug is on pass-through, regardless of the drug's clinical merits***.

This is not just a theoretical concern. We also voiced this concern when Omidria was on pass-through status and included in the Cataract Cost measure because we had concrete examples of cataract surgeons choosing not to use Omidria or, at minimum, choosing not to use Omidria for Medicare Part B patients because of the inclusion of the pass-through drug in the MIPS Cataract Cost Measure. **We ask CMS not to bias the data collected during the pass-through period.**

The inclusion of pass-through drugs in *any* cost measure will also discourage continued medication innovation and improvements. Developing a new drug for FDA approval is an expensive, time-consuming, and risky endeavor for manufacturers. A key factor in their decisions to develop drugs is a reasonable assurance that there will be a market for the drug once it is approved. Without certainty that this market will not be curbed during the drug's pass-through period by inclusion in MIPS cost measure scores, manufacturers will become more hesitant to continue innovating in impacted areas.

Given the negative impact on the validity of pass-through utilization data on clinicians' ability to assess new Part B drugs without fear of penalty, and on innovation, we urge CMS to eliminate the inclusion of drugs on pass-through status on *any* current and future MIPS cost measure.

Diagnoses in List of Exclusions

ASCRS and OOSS continue to be concerned with the list of exclusion codes for this measure. We commented previously to oppose the removal of certain diagnoses, and despite our depth of experience and rationale, out of the conditions we requested be maintained in the exclusions list, only one of the diagnosis umbrellas (traumatic cataract codes) remained excluded. **We urge CMS to reestablish the following conditions as exclusionary diagnoses under the cataract cost measure:**

- **Pseudoexfoliation Glaucoma and Syndrome**
  There is an increased risk of complications during cataract surgery in patients with pseudoexfoliation. Not all patients will require iris hooks or iris retraction rings; therefore, these surgeries would be coded as 66984. Yet some of these patients may have zonular weakness and have higher rates of vitrectomy and other complications that require additional medical and surgical treatment. Vitreous loss is 5–10 times more common in these eyes. These patients are also at risk for later postoperative complications, such as IOL/posterior bag dislocation, which depending on the severity, can happen during the 90-day global period. This leads to additional office visits and referrals to retinal surgeons and/or surgeons who perform IOL fixation surgery. Codes include:
  - H40.141 (OD) Pseudoexfoliation Glaucoma
  - H40.142 (OS)
  - H40.143 (OU)

- **Other Age-Related Cataracts**
  Not every patient with pseudoexfoliation has glaucoma. Patients with pseudoexfoliation without glaucoma are still at higher risk for complications during cataract surgery. According to the American Academy of Ophthalmology, the ICD-10 code for pseudoexfoliation of lens capsule is H25.89 other age-related cataracts. If doctors are coding this correctly, other age-related cataracts must be included in the exclusion list. Codes include:
  - H25.89 other age-related cataracts

- **Mature Cataracts**
  Cataract surgery on a severe, mature cataract is far more complex and riskier than an average cataract. Even though it is not coded at 66982, surgery on a severe cataract has a higher chance of complications, including corneal failure or vitreous prolapse, leading to the need for additional referrals and follow up surgery during the 90-day post op period. Mature cataract is also coded H25.89. Codes include:
  - H25.89 other age-related cataracts

- **AMD – Wet and Dry**
  All patients with AMD are at higher risk for needing additional treatments and office visits after cataract surgery. That is why the anti-VEGF injections are excluded from the cost measure. *However*, these patients still require retina specialist office visits and diagnostic testing (i.e. OCT, FA, etc.) that drives up the cost after surgery. *All* forms of AMD should be excluded. Dry AMD can convert to Wet AMD at any time, including during the 90-day post op period. Furthermore, AMD may be under-diagnosis at the time of cataract surgery, as these patient's dense cataracts may prevent adequate view on exam or OCT for proper diagnosis. Codes include:
  - Nonexudative (Dry) AMD codes: H3531
  - Exudative (Wet) AMD codes: H3532

We also strongly recommend that the following conditions be added as exclusionary diagnoses under the cataract cost measure:

- **Herpes Virus**
  Surgery and the local trauma to ocular tissues related to the act of uncomplicated cataract surgery

can reactivate the herpetic virus (HSV) in patients with latent disease. Reactivation can lead to out-of-control inflammation in some patients after surgery requiring referrals to corneal or uveitis specialists, as well as the PCP and/or a rheumatologist. Furthermore, patients can go to emergency rooms or urgent care offices, or need additional blood work or diagnostic testing, all of which will increase the costs, even though the initial surgery was uncomplicated. Codes include:

- B00.50 Herpesviral ocular disease, unspecified
- B00.51 Herpesviral iridocyclitis
- B00.52 Herpesviral keratitis
- B00.53 Herpesviral conjunctivitis
- B00.59 Other Herpesviral disease of the eye

- **Zoster Virus**
  Surgery and the local trauma to ocular tissues related to the act of uncomplicated cataract surgery can reactivate the varicella roster virus (VZV) in patients with latent disease. Reactivation can lead to out-of-control inflammation in some patients after surgery requiring referrals to corneal or uveitis specialists, as well as PCP and/or a rheumatologist. Furthermore, patients can end up in the emergency room or urgent care offices, all of which increase the cost, even though the initial surgery was uncomplicated. Codes include:
  - B02.30 Zoster ocular disease, unspecified
  - B02.31 Zoster conjunctivitis
  - B02.32 Zoster iridocyclitis
  - B02.33 Zoster keratitis
  - B02.34 Zoster scleritis
  - B02.39 Other herpes zoster eye disease

- **Retinal Degeneration**
  Patients with peripheral retinal degenerations have a higher chance of retinal tears and detachments, even with uncomplicated cataract surgery. The additional office visits with a retina surgeon and additional treatments including laser retinopexy, pneumatic retinopexy, pars plana vitrectomy, or scleral buckling surgery would drive up the cost after surgery. Codes include:
  - H33.3 Hereditary retinal degeneration
  - H35.5 Peripheral retinal degeneration with retinal break
  - H35.4 Peripheral retinal degeneration
  - H35.41 Lattice degeneration of retina

- **Anterior Scleritis**
  Surgery and the local trauma to ocular tissues related to the act of uncomplicated surgery can lead to anterior scleritis. Scleritis typically occurs in patients with underlying autoimmune diseases (sometimes prior to officially being diagnosed by the PCP). These patients tend to have significant inflammation and require visits to the PCP and rheumatologist (or urgent care/emergency room); additional blood work and diagnostic testing may also be needed. They are sometimes referred to a uveitis specialist to help with diagnosis and control of the underlying inflammation process. Other forms of scleritis have been placed on the exclusion list for these reasons, including posterior scleritis, brawny scleritis, and “other” scleritis. All forms of scleritis

can be exacerbated at the time of uncomplicated cataract surgery, including anterior scleritis. We believe that anterior scleritis was overlooked. Codes include:

- H15.01 Anterior Scleritis
- H15.011 OD
- H15.012 OS
- H15.013 Bilateral

- **Posterior Polar Cataracts**
  Posterior Polar Cataracts (officially called posterior subcapsular polar cataracts) are well documented to have higher risk and complication rates during cataract surgery. With higher vitrectomy rates, these patients often need second surgeries and/or additional treatment within the postop period for treatment of pressure-related and associated vireo-retinal sequelae. Codes include:
  - H25.041 (OD) Posterior polar cataract
  - H25.042 (OS)
  - H25.043 (OU)

- **(Recurrent) Corneal Erosions**
  Patients with certain underlying corneal dystrophies or history of trauma are prone to RCE, which can require additional medical or surgical treatment, such as PRK, stromal micro puncture, and amniotic membrane placement during the post-op 90-day global window. Uncomplicated cataract surgery can exacerbate these conditions. In addition, preservatives in the post-operative drops may subject the cornea to increased risk of erosions and worsening of keratitis sicca after surgery. Codes include:
  - H18.831 (OD). RCE
  - H18.832 (OS)
  - H18.833 (OU)

- **Punctate Keratitis**
  Uncomplicated cataract surgery can exacerbate keratitis. In addition, preservatives in the post-operative drops may subject the cornea to increase risk of punctate keratitis after surgery. Treatment for this diagnosis could include amniotic membrane placement. Codes include:
  - H16.141 (OD) Punctate Keratitis
  - H16.142 (OS)
  - H16.143 (OU)

- **Neurotrophic Keratitis**
  Uncomplicated cataract surgery can exacerbate keratitis. In addition, preservatives in the post-operative drops may subject the cornea to increase risk of neurotrophic keratitis after surgery. Treatment for this diagnosis could include amniotic membrane placement. Codes include:
  - H16.231 (OD)
  - H16.232 (OS)
  - H16.233 (OU)

- **Exposure Keratoconjunctivitis**
  Uncomplicated cataract surgery can exacerbate keratitis at the time of surgery. In addition, preservatives in the post-operative drops may subject the cornea to increased risk of exposure keratitis after surgery. Treatment for this diagnosis could include amniotic membranes placement. Codes include:
  - H16.211 (OD)
  - H16.212 (OS)
  - H16.213 (OU)

- **Filamentary Keratitis**
  Uncomplicated cataract surgery can exacerbate keratitis. In addition, preservatives in the post-operative drops may subject the cornea to increase risk of filamentary keratitis after surgery. Treatment for this diagnosis could include amniotic membrane placement. Codes include:
  - H16.121 (OD)
  - H16.122 (OS)
  - H16.123 (OU)

- **Lagophthalmos**
  Patients with lagophthalmos typically have dry eyes due to corneal exposure issues. Uncomplicated cataract surgery can exacerbate keratitis. In addition, preservatives in the post-operative drops may subject the cornea to increase risk of punctate keratitis after surgery. Patients may need referral to an oculoplastics specialist. Treatment for this diagnosis could include amniotic membrane placement. Codes include:
  - H02.2 Lagophthalmos
  - H02.20 Unspecified lagophthalmos
  - H02.201 RUL
  - H02.202 RLL
  - H02.203 OD unspecified lid
  - H02.204 LUL
  - H02.205 LLL
  - H02.206 OS Unspecified lid
  - H02.20A OD upper and lower lids
  - H02.20B OS upper and lower lids
  - H02.20C Bilateral upper and lower lids

  - H02.21 Cicatricial Lagophthalmos
  - H02.211 RUL
  - H02.212 RLL
  - H02.213 OD Unspecified lid
  - H02.214 LUL
  - H02.215 LLL
  - H02.216 OS Unspecified lid
  - H02.21A OD upper and lower lids
  - H02.21B OS upper and lower lids
  - H02.21C bilateral upper and lower lids

- H02.22 Mechanical Lagophthalmos
- H02.221 RUL
- H02.222 RLL
- H02.223 OD Unspecified lid
- H02.224 LUL
- H02.225 LLL
- H02.226 OS Unspecified lid
- H02.22A OD upper and lower lids
- H02.22B OS upper and lower lids
- H02.22C Bilateral upper and lower lids

- H02.23 Paralytic Lagophthalmos
- H02.231 RUL
- H02.232 RLL
- H02.233 OD Unspecified lid
- H02.234 LUL
- H02.235 LLL
- H02.236 OS unspecified lid
- H02.23A OD upper and lower lids
- H02.23B OS upper and lower lids
- H02.23C Bilateral upper and lower lids

- **Exophthalmic Conditions**
  These conditions are usually related to other underlying diseases. Exophthalmos can result in exposure to keratitis, which requires additional treatment and office visits. Codes include:
  - H05.2 Exophthalmic Conditions
  - H05.20 Unspecified exophthalmos
  - H05.21 Displacement (lateral) of the globe
  - H05.211 OD
  - H05.212 OS
  - H05.213 Bilateral

  - H05.24 Constant exophthalmos
  - H05.241 OD
  - H05.242 OS
  - H05.243 Bilateral
  - H15.0 Scleritis
  - H15.00 Unspecified scleritis
  - H15.001 OD
  - H15.002 OS
  - H15.003 Bilateral

V. MIPS Promoting Interoperability (PI) Category

Maintenance of Automatic Small Practice PI Hardship

ASCRS and OOSS support CMS's decision to maintain the automatic small practice PI hardship exception. This automatic hardship exception and reweighting has helped to alleviate some of the burden experienced by small practices reporting MIPS.

Proposed Measure Suppression Policy

ASCRS and OOSS strongly support CMS's proposal to adopt a measure suppression policy beginning with the 2026 MIPS performance year. Given the circumstances we have seen with the e-Case Reporting measure this year, this proposal is both timely and necessary.

Proposed Suppression of the 2025 e-Case Reporting (eCR) Measure

ASCRS and OOSS strongly support CMS's proposal to suppress the 2025 eCR measure. Given the pause in the CDC's onboarding of new EHRs, we have heard from many ophthalmologists that they were unable to move from Active Engagement Option 1 to 2 this year. Suppressing this measure will ensure that clinicians and groups will not face a penalty on this measure or in the PI category due to circumstances outside of their control, while still being able to receive credit for their hard work on the remaining PI measures.

Measure Modification Proposals

- ***SAFER Guide Attestation***

ASCRS and OOSS support modifying this attestation to require use of the updated 2025 High Priority SAFER Guide.

- ***Security Risk Analysis (SRA)***

ASCRS and OOSS agree that addressing risks and vulnerabilities found in SRAs is crucial for protecting patient records in this era of ever-increasing cyber threats. Our only concern with the proposed modification is the lack of flexibility around the amount of time practices have to implement security measures.

Many practices perform their annual SRA near the end of the calendar year to assess that year and prepare for the next. In these scenarios, it is nigh impossible to implement new security measures during that calendar year. **Therefore, we support this proposal *with modification* and offer two potential solutions:**

1. **Allow practices completing their SRA in quarter 4 of the calendar year 90 days to perform risk management.**
   This would modify the end of the attestation statement to the following:

   > "…actions included in the security risk analysis measure may occur any time during the calendar year in which the EHR reporting period occurs. **If the security risk analysis occurs in quarter 4 of the calendar year, risk management must occur within 90 days."**

OR

2. **Require practices to complete their SRA during the calendar year and to attest to completing risk management during the following calendar year.** We offer this as it may simplify attestation processes and decrease the number of last-minute submissions we would see with option 1. This would modify the end of the attestation statement to the following:

> "…the ~~**actions included in the**~~ security risk analysis ~~**measure**~~ may occur any time during the calendar year in which the EHR reporting period occurs. **The risk management for that SRA must occur by the end of the following calendar year.**"

New Bonus Measure Proposal: Public Health Reporting Using TEFCA

ASCRS and OOSS support the addition of this bonus measure as long as all currently existing bonus measures are maintained.

RFI: Query of PDMP Measure Performance Rate

ASCRS and OOSS are opposed to any transition of the Query of PDMP measure from attestation-based to performance rate-based. While CMS cites evidence that "49 of the 54 PDMPs taken steps to integrate PDMP data into EHRs, HIEs, and PDS systems," we emphasize that they have not taken steps with every certified EHR. PDMPs are simply not ready to fully onboard all EHRs at this time. **Therefore, ASCRS and OOSS think it would be inappropriate to score clinician and practice performance rates on this measure, as those performance rates may not be calculable by their EHR. We strongly urge CMS to wait until the PDMP ecosystem is ready for universal integration.**

RFI: Query of PDMP Measure Addition of All Schedule II Medications

ASCRS and OOSS do not believe this will have any significant impact on ophthalmology, but we are concerned about the burden this would place on our neurology and psychiatry colleagues who must prescribe monthly schedule II medications for their patients. As such, **we recommend that, *for maintenance medications*, checking the PDMP need only be done once per year, rather than for every instance of the prescription.**

RFI: Performance Rate-based Measures

ASCRS and OOSS appreciate the opportunity to provide feedback on the future direction of the PI Public Health and Clinical Data Exchange objective and reporting to public health agencies (PHAs). **We are, however, concerned with the concept of transitioning these measures to performance rate-based and using the MIPS PI category as a lever to increase clinician-PHA data exchange. The current issues with clinician-PHA data exchange stem largely from communication between EHRs and PHAs, not from clinicians.** There are significant barriers to improving seamless data exchange with PHAs including:

- Incomplete or out-of-date state lists of reportable conditions
- PHAs with insufficient resources to onboard new clinicians or EHRs in a timely manner
- Significant state-by-state variation in:

- Reportable conditions
- Whether a condition must be reported only if a patient is diagnosed or tests positive, or if a condition must be reported even if it is only suspected
- The types of providers allowed to participate
- The data the PHA requests and the vocabulary standards used

These state-by-state variations and widespread barriers make it difficult for clinicians to comply with current requirements in the Public Health and Clinical Data Exchange Objective. **Rather than using the PI performance category as a lever to increase data exchange with PHAs, HHS's efforts should remain focused on improving the state PHA infrastructure. This need is evidenced by the need to suppress the 2025 eCR measure due to CDC pause in onboarding.** In addition, due to the varying resources available in each state's PHA, information is often not up to date on the state's website. **One method to reduce the burden on clinicians is to create an *up-to-date*, centralized repository of each state's readiness and their participation requirements (e.g., provider type, EHR, case volumes, conditions treated).**

RFI: Data Quality

As discussed in our response to the RFI on the transition to dQMs, the biggest issue in data quality we have seen is in calculation errors by vendors (EHRs and registries). Ensuring accurate data is reported to CMS requires vigilance and prompt efforts to resolve issues throughout the year. Although MIPS regulations are not the right lever to remedy this issue, it is an important issue to solve. We recommend working with ONC to ensure certified products calculate measure scores accurately and are responsive to customer tickets with regard to incorrect measure calculations.

VI. MIPS Improvement Activities Category

Category Weight and Performance Period

ASCRS and OOSS appreciate the consistency in category weight and reporting period for the Improvement Activities Category for performance year 2026. We also strongly support CMS's decision to continue to award small practices double points for each improvement activity (IA).

Mid-Year Suppression of Improvement Activities (IAs)

In this proposed rule, CMS states that the IAs proposed for removal are being removed under Removal Factor 7. Specifically, CMS states that:

> "Removal Factor 7, Activity is Obsolete, supports our proposals to remove these activities as they do not reflect CMS's current prioritization of best clinical practices and are no longer available for implementation as they have been suspended for CY 2025."

However, the IA Suspension Policy finalized in the 2022 QPP Final Rule only allows CMS to suspend an IA when the IA is found to pose a patient safety risk or to be obsolete (context being the program required for an IA had expired). Since no patient safety risk was identified, the IAs must have been suspended under the pretext that they were "obsolete." The only time CMS has defined "obsolete" in the context of an IA was when CMS finalized IA Removal Factor 7 in the 2020 QPP Final Rule. Specifically, CMS

defined "obsolete" as the following: "We consider an activity 'obsolete' when it is no longer available, and therefore, cannot be completed by MIPS eligible clinicians as an improvement activity." None of the suspended IAs were reliant on or based on programs that are no longer available. None of the suspended IAs met the conditions required to be obsolete.

Therefore, under this proposed rule, CMS is stating that they are proposing to remove these IAs because the IAs are not available because CMS arbitrarily, and with no explanation, decided they were obsolete earlier. Given the concrete definition of "obsolete" provided in CMS's own regulations, an IA cannot be considered obsolete with the only evidence for its obsolescence being that CMS called the IA obsolete.

We note that, nowhere in any established regulation has CMS created a policy that IAs could be removed or suspended because CMS leadership prioritized something else. Regardless of prioritization, the medical experience of physicians who are practicing is vital to solicit, value, and take into consideration.

Under the Administrative Procedures Act, if a regulation is already in effect, all regulatory agency actions to "formulate, amend or repeal" a rule must follow the public notice and comment procedures. **The suspension of these IAs violated both CMS regulation and federal law.**

Moreover, the suspension of these IAs sets a dangerous precedent that, effectively, the opinion of non-clinicians should usurp medical expertise and that programs can be changed at a whim. This undermines the ability of the administration to faithfully implement its priorities, the practice of medicine, and increases the burden of accepting Medicare.

We urge the Administration to abide by its own regulations and to both reverse the suspension and not finalize the removal of these IAs under Removal Factor 7. We recommend that CMS propose to remove IAs in future proposed rules using the appropriate regulatory rationale.

Proposed Removal of IA_AHE_5: MIPS Eligible Clinician Leadership in Clinical Trials or CBPR

CMS states that they are proposing to remove this IA under Removal Factor 7 (which is inappropriate, as described above) and that "this activity does not reflect CMS's current high prioritization of measurable clinical outcomes as well as the topics of prevention, nutrition, and well-being." **ASCRS and OOSS would like to emphasize that clinical trials specifically lead to measurable clinical outcomes, in fact, that is the purpose of clinical trials—to measure the clinical impact of a medication or treatment regimen.** This has been an important IA, and for several ophthalmic practices, has incentivized participation in trials that advance medical treatment. Moreover, with the administration's emphasis on improving public trust and advancing new treatments, incentivizing clinicians to participate in clinical trials and recognizing the effort put forth in doing so should be in line with those priorities. As such, **ASCRS and OOSS urge CMS to maintain this important IA.**

Proposed Removal of IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols

CMS states that they are proposing to remove this IA under Removal Factor 7 (which is inappropriate, as described above) and that "this activity does not reflect CMS's current high prioritization of measurable clinical outcomes as well as the topics of prevention, nutrition, and well-being." **ASCRS and OOSS are confused because this IA is explicitly and solely about nutrition. Given the administration's emphasis on nutrition and fresh food consumption, this IA should not be removed.**

VII. Advanced Alternative Payment Models (A-APMs)

Proposed Change to QP Calculation: Inclusion of All Covered Professional Services

ASCRS and OOSS support this proposal as it will make it marginally easier for specialists to be included in advanced APMs. However, we remain concerned with the dearth of specialty models and with the lack of cooperation with the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Lack of Specialty-Specific A-APMs

ASCRS and OOSS continue to recommend that CMS prioritize implementing *voluntary* specialty-specific payment models that have already been developed by physician specialties, like the ASCRS Episode-based Cataract Surgery Proposal, rather than attempting to develop new payment models. Currently, most A-APM models are primary care-focused. While some ophthalmologists participate in models, such as ACOs, they are generally not involved in the management of the ACO and are not always able to contribute much quality data. 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 has developed the Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS) so that cataract surgeons can deliver same-day bilateral cataract surgery to appropriate patients at a lower cost for both patients and Medicare. Instead of each member of the Cataract Surgery Team (the surgeon, facility, and anesthesiologist) receiving separate payments for each individual service, the Team would receive a single bundled payment for all services the patient needs as part of the surgery, and the patient would have a single cost-sharing amount for those services. The bundled payment would give the Team the flexibility to redesign the way surgery is delivered to achieve the best outcomes at the lowest possible cost. The BPBCS would cover the costs of both the surgery and the complications that most commonly occur following surgery; neither Medicare nor the patient would pay more if those complications occurred. We urge CMS to test the BPBCS model and implement it for voluntary participation.

AMBULATORY SPECIALTY MODEL (ASM)

While we appreciate CMS's decision to look into models that could be more applicable to specialists, **ASCRS and OOSS are deeply concerned with the proposal to make the ASM mandatory for all eligible specialty physicians in selected geographic areas beginning in 2027.** As noted in the Advanced APM section above, CMS has neglected to work with specialty societies and specialist physicians in the design and implementation of advanced APM models. **The proposed ASM is evidence of this, as participants would be required to report on a subset of measures, many of which may not be clinically relevant to the participants' practices or the care they furnish.**

Our most urgent concern with the proposed ASM implementation is the proposal to make it mandatory. ASCRS and OOSS would like to express our strongest possible concern with this proposal. **It is irresponsible and inequitable to subject physicians to mandatory downside risk in an untested and unsupported model**. With Medicare payments already severely lagging behind inflation, it is already difficult for some clinicians and practices to remain financially secure with a high volume of Medicare patients. By mandating downside risk, CMS will further encourage clinicians to stop accepting Medicare patients, increasing barriers to care and risking the health and well-being of the Medicare population.

Unless CMS makes the ASM *voluntary*, eliminates downside risk in the testing period, *and* provides participating clinicians and practices the resources and capital needed to establish the infrastructure, data and analytic capabilities, and staffing required for participation, this model will disincentivize the desired care transformation and, instead, incentivize leaving Medicare altogether.

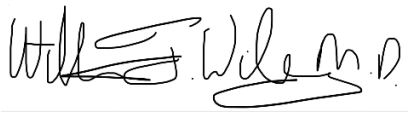
We encourage CMS to work with specialty societies and physicians to develop clinically valuable models and to test those models on a voluntary basis. Not all models will produce the desired results, but using a collaborative development and voluntary testing approach will induce greater engagement and more robust feedback on how to improve both models and patient care.

CONCLUSION

ASCRS and OOSS appreciate the opportunity to provide comments. We urge CMS to carefully consider our comments as it finalizes the CY26 Physician Fee Schedule and Quality Payment Program rule. Please direct all questions to Amanda Grimm Wiegrefe, MScHSRA, Associate Director of Government Affairs, ASCRS, awiegrefe@ascrs.org or Michael Romansky, JD, Washington Counsel, OOSS, mromansky@OOSS.org.

Sincerely,

Francis Mah, MD
President
American Society of Cataract and Refractive Surgery



William Wiley, MD
President
Outpatient Ophthalmic Surgery Society

APPENDIX A

January 29, 2024

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

Re: CMS Comprehensive Ocular Care MVP Candidate

Dear Administrator Chiquita Brooks-LaSure:

The American Academy of Ophthalmology (Academy)[i], American Society of Cataract and Refractive Surgery (ASCRS)[ii], American Society of Retina Specialists (ASRS)[iii], American Glaucoma Society (AGS)[iv], and The Retina Society[v] are submitting joint comments on CMS's Comprehensive Ocular Care MIPS Value Pathway (MVP) Candidate.

We appreciate this opportunity to provide comments on CMS's Comprehensive Ocular Care MVP Candidate.

Most ophthalmologists do not have Advanced Alternative Payment Models (APMs) available to them and, thus, must participate in MIPS. Given the large percentage of ophthalmologists participating in MIPS, this MVP is likely to have a significant impact on our profession.

While CMS has modified the current MVP candidate from the original draft displayed in Table 34 of the 2020 Quality Payment Program (QPP) proposed rule, this MVP candidate remains insufficient to allow for success for most ophthalmic subspecialties.

There are multiple subspecialties in ophthalmology that have little-to-no overlap in the conditions they treat. Because of this, a *comprehensive* ocular care MVP is not feasible. **In response, ASCRS and the Academy have worked collaboratively to develop an MVP specifically for cataract surgery – the most performed surgical procedure in Medicare – which we have included in Appendix B.** By focusing this MVP specifically on cataract care, we allow for germane and outcomes-oriented measurement and comparison for cataract surgery. This allows identification of areas for improvement that are actionable on the practice-level and at the clinician-level.

We are specifically concerned about the following issues:

- The only Cost measure available to ophthalmologists is the Routine Cataract Removal with Intraocular Lens (IOL) Implantation measure.
    - This is only applicable to a subset of ophthalmologists and, as such, if included in a *comprehensive* ocular care MVP, it would unfairly disadvantage cataract surgeons compared to other subspecialties. This creates inequality in measurement as clinicians who are not scored on cataract cost will have more weight assigned to Quality and Promoting Interoperability – two categories that are more predictable and, in practice, more able to meaningfully evaluate value-based care.

    - For performance year 2022, we saw significant issues with scoring this measure. Until those issues are resolved, there will not be a valid Cost category measure for ophthalmology or any ophthalmic MVP.
- Insufficient coverage of subspecialty quality measures:
    - Available measures are not meaningful for some subspecialties.
    - The low percentage of benchmarked measures that are not topped out which are available to each subspecialty.
- The burdens and high expenses of fully testing Qualified Clinical Data Registry (QCDR) measures at the clinician-level prior to inclusion in the MVP.
- Patient-Reported Outcome Measures in this MVP are excessively burdensome for survey collection, scoring, and feedback.
- Population health measures are not applicable to ophthalmology.
- Improvement Activities that are important to the specialty are not included.
- Future of MVPs and participation in traditional MIPS within the QPP

I. Cataract Surgery Episode-Based Cost Measure

Insufficient Cost Measures to Evaluate Comprehensive Ocular Care

The cost measure in this MVP candidate applies only to cataract surgery. Given the issues we describe below, this puts cataract surgeons at a disadvantage compared to other ocular care providers. Although cataract surgery is one of the more commonly performed procedures performed in Medicare patients, it is not performed by all ophthalmologists. For instance, retina, oculoplastic, uveitis, and neuro-ophthalmology rarely, if ever, perform cataract surgery. Moreover, even some comprehensive ophthalmologists who perform cataract surgery are low volume and do not meet the case minimum threshold for the cost measure. These clinicians will have more weight assigned to Quality and Promoting Interoperability – two categories that are more predictable and, in practice, more able to meaningfully evaluate value-based care.

Given the complexity of properly representing ophthalmic subspecialties in both the Cost and Quality performance categories, we believe it appropriate to limit the first ophthalmic MVP to cataract surgery. The MVP candidate submission prepared jointly by the Academy and ASCRS focuses specifically on cataract surgical care and allows for outcomes-oriented measurement and comparison for cataract surgery.

Issues with the Routine Cataract Removal with IOL Implantation Measure

We are concerned that the Cost category has not yielded predictable, meaningful, or valid results based on practice patterns and best practices and encourage CMS to consider the stakeholder feedback received in the review of Wave 1 measures and the feedback received in response to the publication of the 2023 MUC list, particularly for the cataract cost measure included in this MVP Candidate.

In reviewing the results of this measure from the 2022 performance period, we were made aware of errors including omitted operating room charges, potential duplication of charges, and inclusion of costs related to the treatment of comorbid ocular conditions.

We heard that a cataract surgeon scored in the 10th decile for the cataract surgery measure and, upon further investigation, realized that their patient-level data file shows missing operating room fees. Clearly, there should be operating room charges because the measure captures surgeries done in the hospital outpatient department or ambulatory surgery center. Ophthalmologists cannot and should not be held accountable for the facility's billing practices. If the facility chooses not to bill its claim in a timely manner or has claim errors, it should not be reflected in the ophthalmologist's cost score. If episodes with clearly incomplete billing are being factored into the average cost per episode, then the benchmarks and deciles are wrong. Incorrect benchmarks and deciles hurt the physicians with accurate and complete billing because those physicians appear to be more costly and get pushed to lower deciles. **CMS should conduct an audit to examine the extent of the problem for this specific measure and seek input from the relevant national medical specialty societies on a policy to exclude from benchmarks any episodes that are missing critical elements, such as operating room charges.** Due to the invalid benchmarks for PY 2022, ophthalmologists scored on the cataract cost measure have received inaccurate cost category performance scores. **We urge CMS to reweight the cost category to 0 percent of the total MIPS score for those scored on the cataract cost measure for PY 2022, update MIPS payment adjustments accordingly, and reprocess any claims already paid at the incorrect payment adjustments.**

Considering this measure represents 30% of this MVP candidate's score, it is of the utmost importance to evaluate and score it correctly. We request that CMS review the methodology and calculation and ensure it is being operationalized as intended. We believe it would be prudent to field test future changes to this measure prior to their implementation.

Issues with Cost Category Feedback Reports for the Routine Cataract Removal with IOL Implantation Measure

More information must be provided in the Cost measure feedback reports. In reviewing the feedback received by our members for performance year 2022, we had difficulty identifying actionable insights. Physicians and specialty societies have not received sufficient data on the cataract cost measure to be able to make meaningful changes to reduce costs, and it is not clear that the cataract cost measure has contributed to cost control since its implementation. **All we are currently provided is Cost measure score distributions, benchmark range cut-offs, and costs associated with a patient's trigger.** Lastly, the duplication of services in the patient-level feedback reports created widespread confusion and mistrust in the way in which the measure was calculated and, subsequently, the program.

To be able to recommend meaningful changes, we need additional context, including:

- **Date of service: Currently we only have the date of the trigger**
- **Provider who billed the service**
- **Subgroup of episode**
    - **For example, the Cataract Cost measure: ASC vs HOPD and bilateral vs unilateral**
- **National average costs**
    - **Overall average cost**
    - **Part B drugs**
    - **ED visits, etc.**
- **Expected cost for each episode**

We strongly recommend CMS improve the usability of Cost measure feedback reports and conduct extensive testing and training to ensure the reports are understandable, user friendly, and actionable. Without this, the Routine Cataract Removal with IOL Implantation measure becomes a meaningless addition to any MVP as there is no path for improvement or evaluation of practice patterns.

II. Insufficient Coverage of Subspecialty Quality Measures

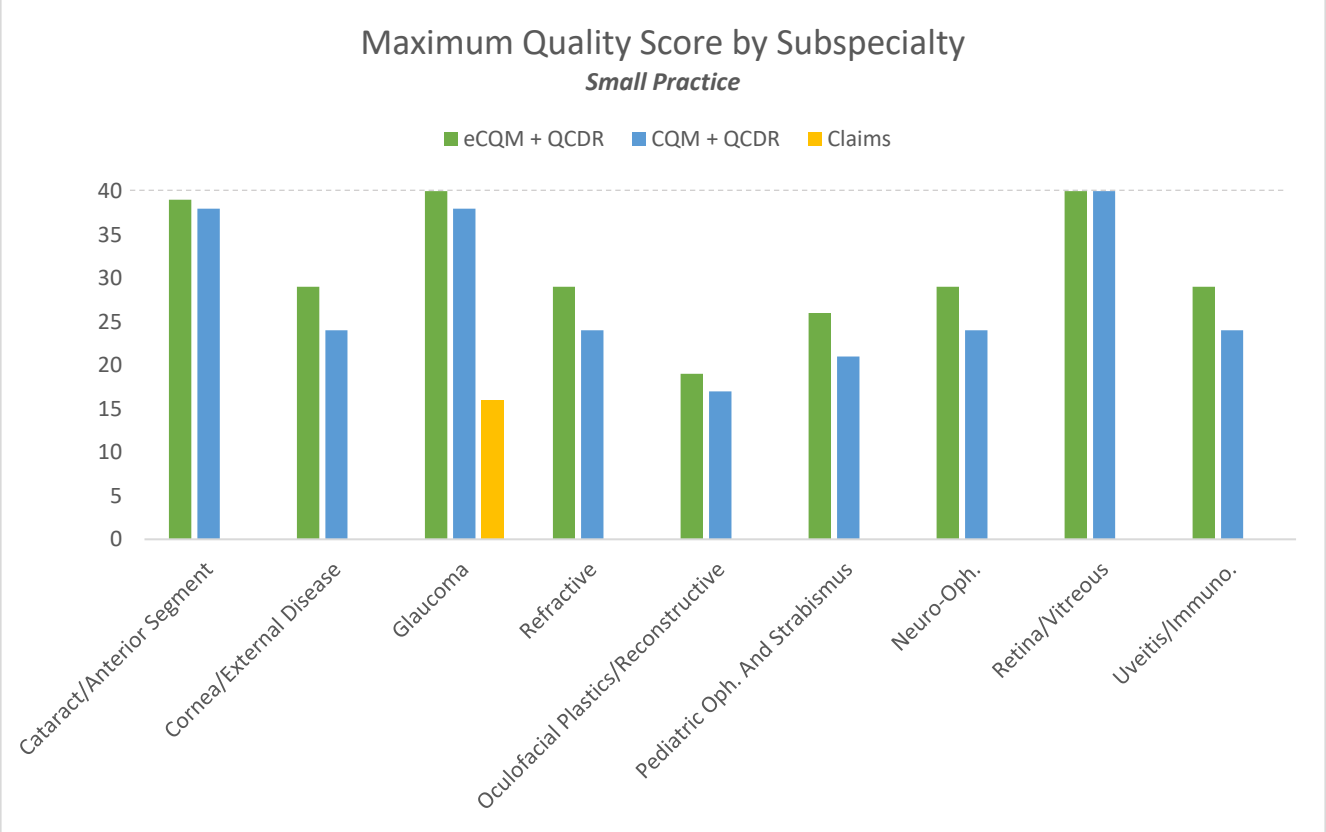
We remind CMS that ophthalmology is not a homogenous profession. There are multiple subspecialties that have little-to-no overlap in the conditions they treat. After reviewing the Comprehensive Ocular Care MVP Candidate from CMS, our organizations continue to feel that there is insufficient representation of the breadth of ophthalmic subspecialties. See Appendix A for a subspecialty-specific breakdown of the quality measures included in CMS's Comprehensive Ocular Care MVP Candidate.

In Tables 1-3 below, we outline the number of available measures for each ophthalmic subspecialty by collection type listed in this MVP candidate. As demonstrated in these charts and tables, the measures in CMS's Comprehensive Ocular Care MVP Candidate will disadvantage ophthalmic practices in MIPS by limiting the maximum Quality score achievable under this MVP.

Both pediatric/strabismus and oculofacial plastic subspecialists are limited to two clinically relevant quality measures if reporting eCQM and QCDR measures. In fact, only two subspecialties would be able to achieve 40/40 points for Quality in this MVP candidate. For these subspecialties, there are, at most, five benchmarked measures that are *not* 7-point capped. The tables and graphs that are embedded in this letter are based on the newly released 2024 benchmarks. Not only does the combination of limited germane quality measures and the percentage of 7-point capped measures erect hurdles for ophthalmic subspecialties to avoid a MIPS penalty, but it also limits their ability to track and improve their performance on clinically relevant measures over time.

By requiring clinicians to exclusively report on these measures, CMS would directly and disproportionally disadvantage physicians in particular subspecialties, practice locations, and practice settings. Small and rural practices are less likely to have the resources available to adopt EHRs. These types of practices would be further disadvantaged under this MVP candidate as they would not be able to report eCQMs and, thus, would be limited to lower scoring manual measures (see Tables 2 and 3). Moreover, due to the smaller number of patients seen, singular adverse events will have a substantially greater impact on small practices than large practices in this MVP because they will be unable to choose measures with less clustered performance rates.

Finally, given the lack of subspecialty-specific MIPS measures, we strongly urge CMS to leverage IRIS Registry measures in supporting clinically meaningful eye care-related MVPs.




Maximum Quality Score by Subspecialty
Large Practice
eCQM + QCDR
CQM + QCDR
Claims
40
35
30
25
20
15
10
5
0
Cataract/Anterior Segment
Cornea/External Disease
Glaucoma
Refractive
Oculofacial Plastics/Reconstructive
Pediatric Oph. And Strabismus
Neuro-Oph.
Retina/Vitreous
Uveitis/Immuno.

Table 1. Example Max Quality Scores by Subspeciality: eCQM + QCDR Measures

Subspecialty	Available Quality Measures	% Not Benchmarked (Number)	% Topped Out (Number)	%7-point Capped (Number)	Max Quality Score
Cataract/Anterior Segment	4	25% (1)	0% (0)	0% (0)	39/40 (small practice) 30/40 (large practice)
Cornea/External Disease	3	33.3% (1)	0% (0)	0% (0)	29/40 (small practice) 20/40 (large practice)
Glaucoma	6	33.3% (2)	16.7% (1)	0% (0)	40/40 (small practice)* 40/40 (large practice)*
Refractive	3	33.3% (1)	0% (0)	0% (0)	29/40 (small practice) 20/40 (large practice)
Oculofacial Plastics/ Reconstructive	2	50% (1)	0% (0)	0% (0)	19/40 (small practice) 10/40 (large practice)
Pediatric Ophthalmology and Strabismus	2	0% (0)	0% (0)	0% (0)	26/40 (small practice) 20/40 (large practice)
Neuro-Ophthalmology	3	33.3% (1)	0% (0)	0% (0)	29/40 (small practice) 20/40 (large practice)
Retina/Vitreous	6	16.7% (1)	16.7% (1)	0% (0)	40/40 (small practice) 40/40 (large practice)
Uveitis/Immunology	3	33.3% (1)	0% (0)	0% (0)	29/40 (small practice) 20/40 (large practice)

***(exactly 4 benchmarked measures not 7-point capped)**

Table 2. Example Max Quality Scores by Subspeciality: MIPS CQM + QCDR Measures

Subspecialty	Available Quality Measures	% Not Benchmarked (Number)	% Topped Out (Number)	%7-point Capped (Number)	Max Quality Score
Cataract/Anterior Segment	8	62.5% (5)	25% (2)	12.5% (1)	38/40 (small practice) 32/40 (large practice)
Cornea/External Disease	4	75% (3)	25% (1)	25% (1)	24/40 (small practice) 12/40 (large practice)
Glaucoma	7	57.1% (4)	14.3% (1)	14.3% (1)	38/40 (small practice) 32/40 (large practice)
Refractive	4	75% (3)	25% (1)	25% (1)	24/40 (small practice) 12/40 (large practice)
Oculofacial Plastics/ Reconstructive	3	100% (3)	0% (0)	0% (0)	17/40 (small practice) 5/40 (large practice)
Pediatric Ophthalmology and Strabismus	3	66.7% (2)	33.3% (1)	33.3% (1)	21/40 (small practice) 12/40 (large practice)
Neuro-Ophthalmology	4	75% (3)	25% (1)	25% (1)	24/40 (small practice) 12/40 (large practice)
Retina/Vitreous	9	33.3% (3)	44.4% (4)	33.3% (3)	40/40 (small practice) 37/40 (large practice)
Uveitis/Immunology	4	75% (3)	25% (1)	25% (1)	24/40 (small practice) 12/40 (large practice)

Table 3. Example Max Quality Scores by Subspeciality: Claims

Subspecialty	Available Quality Measures	% Not Benchmarked (Number)	% Topped Out (Number)	%7-point Capped (Number)	Max Quality Score
Cataract/Anterior Segment	**0**	--	--	--	**0**
Cornea/External Disease	**0**	--	--	--	**0**
Glaucoma	**1**	**0% (0)**	**100% (1)**	**0% (0)**	**16/40 (small practice) 10/40 (large practice)**
Refractive	**0**	--	--	--	**0**
Oculofacial Plastics/ Reconstructive	**0**	--	--	--	**0**
Pediatric Ophthalmology and Strabismus	**0**	--	--	--	**0**
Neuro-Ophthalmology	**0**	--	--	--	**0**
Retina/Vitreous	**0**	--	--	--	**0**
Uveitis/Immunology	**0**	--	--	--	**0**

III. The Burden of QCDR Measure Testing Requirements

We appreciate the inclusion of QCDR measures in the MVP. However, we are concerned about the burden placed upon a specialty society measure developers like the Academy and its IRIS® (Intelligent Research In Sight) Registry, to fully test the measures at the clinician level before acceptance.

While the Academy is in the process of testing IRIS Registry measures, requiring this level of measure testing as a condition of inclusion in the MVP adds significant and uncompensated costs to the process. They estimate it would cost around $75,000 to fully test the five QCDR measures in this MVP candidate.

The Academy currently offers all members free access to the IRIS Registry because they believe in the technology's power as a tool to improve the quality of care. Without financial consideration from CMS to offset the additional costs of fully testing measures, the ability to maintain their current level of support will become harder to sustain.

IV. Reduce Reporting Burden of Patient-Reported Outcome Measures

The patient-reported outcome measures (PROMs) included in this MVP candidate are extremely burdensome. While we understand CMS's reasoning behind the data completeness threshold, **the 75 percent data completeness threshold creates a prohibitive obstacle for clinicians reporting on PROMs as it is difficult to persuade patients to engage in surveys.** We have long supported the use of appropriate PROMs and participated in the development of several related to cataract surgery (measures 303 and 304). These measures are an important indicator of quality, but they require administration of surveys to patients after a high-volume procedure.

It is extremely burdensome and unreasonable to require clinicians to survey 75 percent or more of their patients. In addition to the burden placed on clinicians and practices in administering and encouraging

patients to complete the surveys, *it is exceedingly difficult to get patients to engage in the collection of patient-reported outcomes*.

Patients are bombarded with experience and satisfaction surveys from their healthcare providers and from other service industries. As a result, patients develop survey fatigue and we question the value of spending their time on completing another survey. This makes collecting surveys on a large population burdensome to both patients and providers.

In fact, the Academy's IRIS Registry is unable to offer two patient-reported cataract outcome measures, measures 303 and 304, for MIPS reporting because it is too burdensome, not only for IRIS Registry participants, but also for the IRIS Registry itself to manage the large volume of patient surveys.

These measures were initially developed by the Academy to be reported on a reasonable and valid sample of 20 patients. As such, we previously recommended that CMS modify the data completeness threshold for patient-reported measures to require just a sample or to reinstate the measures group options that were available under the Physician Quality Reporting System and required these and the other cataract outcome measures only be reported on 20 patients.

As stated in the 2018 QPP Final Rule, the Medicare Access and CHIP Reauthorization Act of 2015 does not specify the amount of information that a clinician must report on each measure. **The statute gives the Secretary and CMS the flexibility to ensure that quality reporting does not get in the way of quality care. Therefore, our organizations urge CMS to commit to a lower burden path to allow clinicians to report PROMs on a smaller sample of 20 patients.** Doing so would reduce burden, increase flexibility, and encourage broader reporting on PROMs.

V. Population Health Measures are Not Applicable to Ophthalmology

We continue to remind CMS that claims-based population health measures are not applicable to ophthalmologists and we recommend they not be included in any MVP related to ophthalmic care. Ophthalmologists only treat the eye; ophthalmologists should not be scored on patient admissions as patients are not admitted to the hospital for ocular concerns. In general, we oppose the concept of administrative claims-based quality measures because these measures have high potential for holding clinicians accountable for care they do not provide, meaning clinicians have limited ability to influence their performance on them.

VI. Key Improvement Activities are Not Included

We believe that certain important improvement activities (IAs) should be added to this MVP candidate. Specifically, we are surprised that **IA_AHE_7 (Comprehensive Eye Exams)** is not included in an eye care MVP. This IA encourages practices to participate in programs that provide free comprehensive eye exams to patients in need. We encourage CMS to include this health equity IA in any eye care-related MVP.

We also strongly encourage CMS to add IA_EPA_1 (24/7 Access) and IA_PSPA_7 (Use of QCDR data for ongoing practice assessment and improvements). Ensuring access to care is important for all specialties to ensure high-quality care in urgent medical situations or to ensure a seamless transition from one care setting to another. In addition, ophthalmology has one of the preeminent QCDRs in the nation. The results from

participants have not only driven improvement on the individual clinician and practice level, but also at the level of the profession.[1]

Finally, we urge CMS to add IA_PSPA_2 (Participation in MOC Part IV) to any ophthalmic MVP. This IA has been well-defined for ophthalmology in a way that is meaningful for the profession.

VII. Future of MVPs in the QPP

MVPs were only implemented for their first year under the program in 2023. When the CMS Innovation Center considers the implementation of a new model, they pilot that model and collect data on its efficacy at achieving desired aims prior to widespread implementation. **We ask CMS to take that same cautious and methodological approach to MVPs.**

CMS has explicitly stated that MIPS will sunset and be fully replaced by MVPs in future years, but there has been no public testing or piloting of these new models. If testing has been conducted, we ask CMS to share the information and data generated by these tests publicly so that all stakeholders may evaluate how MVPs will function in real-world scenarios.

We believe that, moving forward, MVPs must remain voluntary, streamline scoring methodology under MIPS, and be condition- or procedure-based.

MVPs Must Remain Voluntary

In the CY 2022 Medicare Physician Fee Schedule final rule, CMS states that they "intend for MVPs to become the only method to participate in MIPS in future years". **Our organizations strongly urge CMS to maintain MVPs as a voluntary participation option in all future years.**

- Given that the goal of MIPS 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. For example, the retina subspecialty focuses specifically on diseases at the back of the eye, neuro-ophthalmologists focus on visual problems related to the nervous system (not the eyes), and cataract and refractive surgeons focus on the front of the eye.

  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 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 subspecialties would have been able to participate.

[1] https://www.aao.org/iris-registry/data-analysis/requirements#:~:text=IRIS%20Registry%20Publications

In this version of the MVP candidate, it remains clear that an MVP encompassing all of ophthalmology would severely limit the ability of ophthalmologists to perform well under MIPS. In the Comprehensive Ocular Care MVP Candidate, 13 of the 17 available quality measures are either not benchmarked or topped-out in at least one collection type. In addition, not all ophthalmic subspecialties have measures available in the MVP candidate.

- As an alternative to using MVPs to drive value and reduce burden, CMS could leverage QCDRs to achieve these goals. QCDRs have been developed and supported by clinical specialty societies across the house of medicine. They have a demonstrated track record of reducing clinician burden, identifying deficiencies or disparities in care that require corrective action, and establishing best clinical practices.

  Furthermore, unlike other submission types employed in MVPs, QCDRs provide participants with more prompt and regular performance feedback during the performance year, allowing for more immediate identification of quality gaps for improvements in patient outcomes. This level of response and adaptability is aligned with CMS's larger goals to ensure Medicare beneficiary access to high-quality, low-cost care.

  Given the immense value QCDR participation provides, we believe that CMS should incentivize QCDR participation.

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. The Academy's IRIS Registry has developed a comprehensive set of meaningful measures, including outcome measures, that gives ophthalmologists options for selecting those that are the most clinically relevant. This, in turn, gives patients, the public, and payers useful insight into specific conditions important to them.

Streamline Scoring Methodology

Rather than mandate that physicians report on MVPs that may not reflect their clinical practice and maintain the complicated separate scoring methodologies for each category, we recommend CMS work to maintain and streamline the existing MIPS program. Although MVPs are meant to be a cohesive, integrated reporting pathway, clinicians will still be subject to different scoring in each category and would not receive credit in multiple categories for high-value measures or activities.

Along with others in the medical community, ASCRS has proposed a voluntary and flexible system that would award credit to physicians 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.

In addition, we encouraged CMS to identify areas where physicians could earn multi-category credit. For example, our organizations have recommended that CMS award full Promoting Interoperability category credit to physicians using a QCDR integrated with their EHR to collect Quality data; this would reflect an acknowledgment that these clinicians are using the CEHRT in a way that truly improves the practice of medicine. **We believe these modifications would reduce the confusion that physicians often experience trying to adhere to the disparate requirements in each of the categories and make the program more meaningful for all physicians.**

Develop Condition-Based/Procedure MVPs

In the past, CMS has expressed concern that the number of MVPs desired is too high. In ophthalmology, we provide, in many instances, highly sub-specialized care for our patients. Because of this, ophthalmologists cannot reliably or meaningfully be scored in a specialty-wide MVP. **Given the complexity of accurately representing ophthalmic subspecialties in both the Cost and Quality performance categories of an MVP,** we urge CMS to consider the adoption of more subspecialty- and condition-based MVPs. Not doing so will cause some physicians to be disproportionately disadvantaged for reasons unrelated to the value of care they provide.

ASCRS and the Academy have developed a Cataract MVP (Enhancing Optimal Care for Cataract Surgery), which is included in Appendix B. The undersigned organizations support the implementation of this MVP as a replacement to the proposed Comprehensive Ocular Care MVP.

CONCLUSION

In closing, we do not support and continue to be deeply concerned about CMS's Comprehensive Ocular Care MVP Candidate. We encourage CMS to consider the myriad reasons why a comprehensive model for ophthalmology will not work. **Moving forward, we believe that the future of any ophthalmology MVPs must be subspecialty- or condition-specific, and that traditional MIPS be continued for equity across the diverse spectrum of physicians and patients. Therefore, the Academy and ASCRS have worked collaboratively to develop an MVP specifically for cataract surgery which is included in Appendix B.**

Thank you again for the opportunity to provide comments on the Comprehensive Ocular Care MVP Candidate. We look forward to working together as ASCRS and the Academy work collaboratively on creating a Cataract MVP. If you need additional information, please contact Brandy Keys, MPH, Academy Director of Health Policy at bkeys@aao.org and Mark Cribben, ASCRS Director of Government Relations at mcribben@ascrs.org.

Sincerely,

Michael X. Repka, MD, MBA
Medical Director for Governmental Affairs
American Academy of Ophthalmology

Parag Parekh, MD, MPA
ASCRS Chairman, Government Relations Committee

Michael M. Lai, MD, PhD
ASRS Federal Affairs Committee, Chair

Leon W. Herndon, MD
President, American Glaucoma Society

Jennifer I. Lim, M.D., FARVO
President, The Retina Society

[i] The Academy is the largest association of eye physicians and surgeons in the United States with a nationwide community of 20,000 members. The Academy protects sight and empowers lives by setting the standards for ophthalmic education, supporting research, and advocating for patients and the public.

[ii] 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.

[iii] The American Society of Retina Specialists is the largest organization of retina specialists in the world, representing over 3,000 physicians in all 50 US states, the District of Columbia, Puerto Rico, and 63 countries. The Society serves as a national advocate and primary source of clinical and scientific information and education for its members.

[iv] The American Glaucoma Society (AGS) has 1,700 members and provides the voice of the glaucoma community in the US. AGS is the leading professional society for glaucoma subspecialists, surgeons, and researchers who are dedicated to improving the lives of people with glaucoma through education, research, advocacy, and leadership. As part of our educational mission, we are pleased to work with you and your colleagues to promote Medicare policies that help prevent, diagnose, and most effectively treat glaucoma and other causes of vision impairment and blindness.

[v] The Retina Society's mission is to reduce worldwide visual disability and blindness by promoting the education and professional interaction of vitreoretinal specialists, providing optimal care for patients with vitreoretinal diseases, and encouraging, through clinical and basic research, the discovery and development of new means to further patient care

Appendix A: Subspecialty-specific breakdown of the quality measures included in CMS's Comprehensive Ocular Care MVP Candidate

Quality performance category:
The table below illustrates the include quality measures for this MVP candidate.

Cataract/Anterior Segment

Quality Measures	Benchmarked?	Topped Out?	7-point Cap?
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery (eCQM, MIPS CQM) High Priority, Outcome	Yes	**MIPS CQM: Yes** eCQM: No	MIPS CQM: No eCQM: No
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q303: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (MIPS CQM) High Priority, Outcome	**NO**	N/A	N/A
Q304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery (MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: No** eCQM: Yes	**MIPS CQM: N/A** eCQM: No	**MIPS CQM: N/A** eCQM: No
Q389: Cataract Surgery: Difference Between Planned and Final Refraction (MIPS CQM) High Priority, Outcome	Yes	MIPS CQM: No	MIPS CQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		

Cornea/External Disease

Quality Measures	Benchmarked?	Topped Out?	7-point Cap?
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	**MIPS CQM: N/A** eCQM: No	**MIPS CQM: N/A** eCQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		

Glaucoma

Quality Measures	Benchmarked?	Topped Out?	7-point Cap?
Q012: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation (eCQM)	Yes	**Yes**	No
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care (Medicare Part B Claims, MIPS CQM) High Priority, Outcome	Yes	**Claims: Yes** MIPS CQM: No	Claims: No MIPS CQM: No
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	**MIPS CQM: N/A** eCQM: No	**MIPS CQM: N/A** eCQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		
IRIS2: Glaucoma – Intraocular Pressure Reduction (QCDR) High Priority, Outcome	Yes	No	No
IRIS39: Intraocular Pressure Reduction Following Trabeculectomy or an Aqueous Shunt Procedure (QCDR) High Priority, Outcome	**NO**	N/A	N/A

Refractive

Quality Measures	Benchmarked?	Topped Out?	7-point Cap?
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	MIPS CQM: N/A eCQM: No	MIPS CQM: N/A eCQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		

Oculofacial Plastics/Reconstructive

Quality Measures	Benchmarked?	Topped Out?	7-point Cap?
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	MIPS CQM: N/A eCQM: No	MIPS CQM: N/A eCQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		

Pediatric Ophthalmology and Strabismus

Quality Measures	**Benchmarked?**	**Topped Out?**	**7-point Cap?**
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	MIPS CQM: N/A eCQM: No	MIPS CQM: N/A eCQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		

Neuro-Ophthalmology

Quality Measures	**Benchmarked?**	**Topped Out?**	**7-point Cap?**
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	MIPS CQM: N/A eCQM: No	MIPS CQM: N/A eCQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		

Retina/Vitreous

Quality Measures	Benchmarked?	Topped Out?	7-point Cap?
Q019: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	MIPS CQM: N/A eCQM: No	MIPS CQM: N/A eCQM: No
Q384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery (MIPS CQM) High Priority, Outcome	Yes	**MIPS CQM: Yes**	**MIPS CQM: Yes**
Q385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery (MIPS CQM) High Priority, Outcome	Yes	MIPS CQM: No	MIPS CQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		
IRIS13: Diabetic Macular Edema - Loss of Visual Acuity (QCDR) High Priority, Outcome	Yes	**Yes**	No
IRIS58: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days (QCDR) High Priority, Outcome	Yes	No	No

Uveitis/Immunology

Quality Measures	Benchmarked?	Topped Out?	7-point Cap?
Q117: Diabetes: Eye Exam (eCQM, MIPS CQM)	Yes	**MIPS CQM: Yes** eCQM: No	**MIPS CQM: Yes** eCQM: No
Q238: Use of High-Risk Medications in Older Adults (eCQM, MIPS CQM) High Priority	**NO**	N/A	N/A
Q374: Closing the Referral Loop: Receipt of Specialist Report (eCQM, MIPS CQM) High Priority	**MIPS CQM: NO** eCQM: Yes	MIPS CQM: N/A eCQM: No	MIPS CQM: N/A eCQM: No
Q487: Screening for Social Drivers of Health (MIPS CQM) High Priority	**NO** Will have 5-point floor in 2024		

Quality Payment PROGRAM

MIPS Value Pathways

MVP Candidate Submission: Enhancing Optimal Care for Cataract Surgery

This MVP candidate submission was prepared jointly by the American Academy of Ophthalmology (Academy) and the American Society of Cataract and Refractive Surgery (ASCRS).

The Academy is the largest association of eye physicians and surgeons in the United States with a nationwide community of 20,000 members. The Academy protects sight and empowers lives by setting the standards for ophthalmic education and advocating for patients and the public.

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.

Table 1: MVP Descriptive Information

MVP Name	• Enhancing Optimal Care for Cataract Surgery

Primary/Alternative Contact Names	• Primary point of contact:
	  ○ Contact 1 Name: Mark Cribben
	  ○ Contact 1 Title: Director of Government Relations
	  ○ Contact 1 Org: American Society of Cataract & Refractive Surgery (ASCRS)
	  ○ Contact 1 Email: mcribben@ascrs.org
	  ○ Contact 1 Phone: 202-256-7255
	• Alternative point(s) of contact:
	  ○ Contact 2 Name: Brandy Keys, MPH
	  ○ Contact 2 Title: Director, Health Policy
	  ○ Contact 2 Org: American Academy of Ophthalmology (the Academy)
	  ○ Contact 2 Email: bkeys@aao.org
	  ○ Contact 2 Phone: 202-737-6662

Intent of Measurement	• What is the intent of the MVP?
	  ○ The Enhancing Optimal Care for Cataract Surgery MVP is intended to improve high quality cataract care, while encouraging a more patient-centered and SDOH-sensitive view of cataract surgery.
	• Is the intent of the MVP the same at the individual clinician and group level?
	  ○ Yes.
	• Are there opportunities to improve the quality of care and value in the area being measured?
	  ○ Yes. As outlined in Table 2, the chosen Quality measures focus on important areas in patient care. Many of the measures address a performance gap and most of the eCQMs or QCDR measures included are *not* topped out.
	• Why is the topic of measurement meaningful to clinicians?
	  ○ In ophthalmology, there are multiple subspecialties that have little-to-no overlap in the conditions they treat. By focusing this MVP specifically on cataract care, we allow for germane and outcomes-oriented measurement and comparison for cataract surgery and the ocular conditions cataract patients may face. This will allow identification of areas for improvement that are actionable on the practice-level and at the clinician-level.
	  ○ We chose cataract surgery as the topic for this MVP candidate because it is the topic of the only available ophthalmic Cost category measure and it is the number one surgical procedure, by volume, under Medicare.
	• Does the MVP act as a vehicle to incrementally phase clinicians into APMs? How so?
	  ○ It provides a roadmap for a future cataract-specific APM, such as the bundled payment model developed by ASCRS, to be tested and implemented by CMMI. This MVP would also provide a runway for practices to build up to the payment model developed by ASCRS.
	  ○ Any new MVPs involving ophthalmology would have to be created in consultation with the Academy and ASCRS (and any other relevant subspecialty ophthalmology society for the specific model) as there is substantial room for error in the

development of a related MVP that could jeopardize sight-saving surgery for the Medicare population.

- Due to the varied types of practice structures within the specialty, without being a part of a large health-care organization, the current structure of APMs does not create a means for cataract surgeons to incrementally phase-in. For that reason, this roadmap and implementation is even more valuable.

- Is the MVP reportable by small and rural practices? Does the MVP consider reporting burden to those small and rural practices?
  - The measures we chose are broadly reportable and offer a variety that will allow small and rural practices to report on the measures most meaningful to their patient population.
  - The vast majority of ophthalmologists in America are Academy members and the IRIS Registry provides a low-burden approach to reporting that is a free member benefit. All of the measures chosen herein can be supported by the IRIS Registry and are backed by evidence-based evaluation and clinician support.
- Which Meaningful Measure 2.0 Framework Domain(s) does the MVP address?
  - Person-Centered Care
  - Seamless Care Coordination
  - Wellness and Prevention
  - Equity
  - Affordability and Efficiency
  - Safety
    *We label the Meaningful Measure 2.0 domains in Table 2.

Measure and Activity Linkages with the MVP	• How do the measures and activities within the proposed MVP link to one another? (For example, do the measures and activities assess different dimensions of care provided by the clinician or are they assessing the same clinical actions?). Linkages between measures and activities should be considered as complementary relationships.
	  ○ Improvement activities focused on thinking about care through a health equity lens connect to the outcome quality measures by creating a means to ensure that the existing gaps underserved communities are facing are being closed.
	  ○ Quality measures included range from direct and varied cataract outcome measurements to lifestyle risk modification measures to address the broad range of patient care related to cataract surgery and to complement the chosen improvement activities.
	• Are the measures and activities related or a part of the episode of care or continuum of care offered by the clinicians?
	  ○ Yes. The entire MVP is relevant to an episode of cataract surgery. In addition, the measures included address language access, financial barriers to care, and care coordination, thus ensuring a full range of access to understandable and affordable care for each patient.
	• Why are the chosen measures and activities most meaningful to the specialty?
	  ○ The measures and activities chosen all directly measure or promote improvement in areas that impact cataract care and outcomes.
	  ○ Cataract surgery is evaluated by the only ophthalmic Cost category measure and is the number one procedure, by volume, under Medicare.

Appropriateness	• Is the MVP candidate developed for multiple specialties or is it focused to a specific specialty? If so, has the MVP been developed collaboratively across specialties?
	  ○ No, due to the significant differences between the subspecialties of ophthalmology, an MVP that accounts for these differences is not currently viable due to the limited number of cost measures available for ophthalmology and the limited range of quality measures that can be included in one MVP (as outlined in our response to the draft comprehensive eye care MVP, see attached).
	  ○ Cataract surgery is evaluated by the only ophthalmic Cost category measure and is the number one procedure, by volume, under Medicare.
	• Are the measures clinically appropriate for the clinicians being measured?
	  ○ Yes. The measures and activities chosen all directly measure or promote improvement in areas that impact cataract care and outcomes.
	• Do the measures capture a clinically definable population of clinicians and patients?
	  ○ Yes. The measures and activities chosen all directly measure or promote improvement in areas that impact cataract care and outcomes.
	• Do the care settings captured by the measures represent those most appropriate for the specialty intended by the MVP?
	  ○ Yes.
	• Prior to incorporating a measure in an MVP, is the denominator of the measure inclusive of the intended specialty or sub-specialty?
	  ○ Yes.

Comprehensibility	• Is the MVP comprehensive and understandable by the clinician or group?
	  ○ Yes. These are clinically-relevant measures that are already in use and have robust measure specifications.
	• Will the intent of the MVP be meaningful to patients?
	  ○ Yes. For patients, the core ideas behind cost measures and patient outcomes are understandable.

Incorporation of the Patient Voice	• Does the MVP take into consideration patients in rural and underserved areas?
	  ○ Yes. In addition to outcome-based quality measures, this MVP contains several Improvement Activities to drive improvements in the care of the underserved:
	  ▪ IA_AHE_7: Comprehensive Eye Exams
	  ▪ IA_AHE_8: Create and Implement an Anti-Racism Plan
	  ▪ IA_BE_24: Financial Navigation Program
	  ▪ IA_EPA_6: Create and Implement a Language Access Plan
	• Were patients involved in the MVP development process? If so, how was their voice included in development of the MVP candidate?
	  ○ Not currently.
	• To the extent feasible, does the MVP include patient-reported outcome measures, patient experience measures, and/or patient satisfaction measures?
	  ○ Yes.
	  ○ IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
	  ○ Quality measure IRIS 59: Regaining Vision After Cataract Surgery
	  ○ *There are currently no other available ophthalmology patient-reported outcome measures that are valid. QPP measures 303 and 304 have significant pushback due to validity concerns.*

Table 2A

All of the Quality Measures selected by the Academy and ASCRS for inclusion in the Enhancing Optimal Care for Cataract Surgery MVP are benchmarked with the exception of Q487 (Screening for Social Drivers of Health). Measure 487 will be in its second year in MIPS in 2024, so historical benchmark data is not available at this time. In addition, most of the eCQMs or QCDR measures included below are *not* topped out. We have selected a range of Quality measures to address prevention, SDOH, and important cataract-specific outcomes.

In the Improvement Activities section, we have complemented the issues addressed by the Quality category measures by focusing on activities that promote equity, person-centered care, safety, and affordability and efficiency.

In the Cost category section, we include the only ophthalmology-specific cost measure: Routine Cataract Removal with IOL Implantation. Prior to implementing this measure in an MVP, we ask CMS to address the concerns and recommendations we have submitted about this measure in our comments on the MUC list and the Comprehensive Ocular Care MVP Candidate (attached).

Table 2A: Quality Measures, Improvement Activities, and Cost Measures

QUALITY MEASURES	IMPROVEMENT ACTIVITIES	COST MEASURES
Q012: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation CBE#: 0086e Collection Type(s): eCQM *Rationale for Inclusion:* Glaucoma has no symptoms in its early stages and its damage is permanent. Patients with cataracts may also be at risk for developing primary open-angle glaucoma; therefore, it is important for these patients to receive optic nerve evaluations. *Meaningful Measures 2.0 Domain*: Wellness and Prevention	**IA_AHE_7: Comprehensive Eye Exams** *Rationale for Inclusion:* This improvement activity addresses potential gaps in care access by encouraging ophthalmologists to participate in programs that provide free comprehensive eye exams to patients who may not receive care otherwise. *Meaningful Measures 2.0 Domain*: Equity	**COST_IOL_1: Routine Cataract Removal with IOL Implantation** *Rationale for Inclusion:* This cost measure specifically evaluates the cost of care for routine cataract surgeries. It is the only cost measure that applies to any ophthalmic specialty. This measure is designed to allow the cataract surgeon to review and understand whether attributed episode costs for routine cataract surgery are lower or higher than expected.
Q117: Diabetes: Eye Exam CBE#: 0055 Collection Type(s): eCQM, MIPS CQM *Rationale for Inclusion:* 30 million people in the U.S. have diabetes, and diabetic retinopathy affects nearly 30 percent of	**IA_AHE_8: Create and Implement an Anti-Racism Plan** *Rationale for Inclusion:* This improvement activity addresses an important	

QUALITY MEASURES	IMPROVEMENT ACTIVITIES	COST MEASURES
diabetic patients. Diabetic retinopathy and diabetic macular edema are complications of diabetes and the most frequent causes of blindness in adults. Since these conditions do not have symptoms at first, early detection is critical to preserving vision. For this reason, both the American Diabetes Association (ADA) and the American Academy of Ophthalmology (AAO) recommend annual eye exams and prompt referral to a specialist if signs of diabetic retinopathy are detected. *Meaningful Measures 2.0 Domain:* Wellness and Prevention	facet of removing barriers to health equity. *Meaningful Measures 2.0 Domain*: Equity	
Q130: Documentation of Current Medications in the Medical Record CBE#: 0565e, 0565 Collection Type(s): eCQM, MIPS CQM High Priority *Rationale for Inclusion:* Reviewing a patient's current medications is a critical step in ensuring patient safety and optimal outcomes for cataract surgery. Though topped out, it is a high priority and clinically relevant measure that is available via two collection types. *Meaningful Measures 2.0 Domain:* Seamless Care Coordination	**IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings** *Rationale for Inclusion:* This improvement activity incorporates the patient voice within this MVP. *Meaningful Measures 2.0 Domain*: Person-Centered Care	
Q191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract CBE#: 0565e, 0565 Collection Type(s): eCQM, MIPS CQM High Priority, Outcome *Rationale for Inclusion:* This high priority measure assesses the outcome of cataract surgery by evaluating best-corrected visual acuity of patients post-surgery. This measure is closely tied to patient satisfaction and directly measures quality of clinical care.	**IA_BE_24: Financial Navigation Program** *Rationale for Inclusion:* This improvement activity addresses a potential barrier to accessing and/or continuing care. By providing financial counseling, ophthalmologists may be able to identify patients who may be at risk of not following treatment plans and take steps to mitigate	

QUALITY MEASURES	IMPROVEMENT ACTIVITIES	COST MEASURES
	the issue. This measure also aligns with the agency's push to improve transparency in beneficiary costs. *Meaningful Measures 2.0 Domain*: Equity; Affordability and Efficiency	
Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation CBE#: 0028 Collection Type(s): eCQM, MIPS CQM, Part B Claims *Rationale for Inclusion:* Studies show that tobacco use can increase the risk of vision loss and blindness; therefore, it is important for ophthalmologists to screen their patients for tobacco use and provide cessation counseling when needed. *Meaningful Measures 2.0 Domain:* Wellness and Prevention	**IA_BMH_12: Promoting Clinician Well-Being** *Rationale for Inclusion:* Reducing burnout is critical to high-quality and safe patient care. This improvement activity helps ophthalmologists identify those at risk for burnout, provide resources to address the issue, and set up a system or workflow that supports the well-being of clinicians. *Meaningful Measures 2.0 Domain*: Safety	
Q374: Closing the Referral Loop: Receipt of Specialist Report CBE#: N/A Collection Type(s): eCQM, MIPS CQM High Priority *Rationale for Inclusion:* In a 2006 report to Congress, the Medicare Payment Advisory Commission found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines. This also promotes the meaningful use of CEHRT functionalities. *Meaningful Measures 2.0 Domain:* Seamless Care Coordination	**IA_CC_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close the Referral Loop** *Rationale for Inclusion:* This improvement activity is important for ensuring communication between clinicians, preventing delayed or inappropriate treatment, increasing both patient satisfaction and their adherence to treatments. This also promotes the meaningful use of CEHRT functionalities.	

QUALITY MEASURES	IMPROVEMENT ACTIVITIES	COST MEASURES
	Meaningful Measures 2.0 Domain: Seamless Care Coordination	
Q389: Cataract Surgery: Difference Between Planned and Final Refraction CBE#: N/A Collection Type(s): MIPS CQM High Priority, Outcome *Rationale for Inclusion:* This high priority outcome measure evaluates the outcome of cataract surgery. It indicates whether patients are achieving a final refraction within +/- 1.0 diopters of their planned (target) refraction as a result of surgery. This measure is closely tied to patient satisfaction.	**IA_EPA_1: Provide Patients 24/7 Access** *Rationale for Inclusion:* This improvement activity helps to ensure access to high quality care in urgent medical situations. *Meaningful Measures 2.0 Domain*: Person-Centered Care	
Q487: Screening for Social Drivers of Health CBE#: N/A Collection Type(s): MIPS CQM High Priority *Rationale for Inclusion:* This measure addresses health equity, an important topic that is not otherwise addressed within MIPS' quality measure inventory. This measure assesses the rate at which providers screen their adult patients for certain social drivers of health (DOHs); specifically, food insecurity, housing instability, transportation needs, utility help needs, and interpersonal safety. Nearly all physicians within a recent survey indicated that their patients' health outcomes are affected by one or more DOH.[1] In addition, this measure addresses a significant performance gap. A cross-sectional study found that screening for all five social needs was reported by 15.6 percent of practices, whereas 33.3 percent of practices reported no screening, suggesting that few US physician practices screen patients for all	**IA_EPA_6: Create and Implement a Language Access Plan** *Rationale for Inclusion:* This improvement activity mitigates language barriers between ophthalmologists and their patients. Clear patient understanding of treatment plans and follow-up care is critical to achieving the best outcomes. *Meaningful Measures 2.0 Domain*: Person-Centered Care; Equity	

QUALITY MEASURES	IMPROVEMENT ACTIVITIES	COST MEASURES
five key social needs associated with health outcomes.[2] [1] Sullivan, T. (2022). New Report on Social Drivers of Health and Physician Practice. Policy & Medicine. https://www.policymed.com/2022/04/new-report-on-social-drivers-of-health-and-physician-practice.html. [2]Bowe, B., Xie, Y., Li, T., Mokdad, A. H., Xian, H., Yan, Y., Maddukuri, G., & Al-Aly, Z. (2018). Changes in the US Burden of Chronic Kidney Disease From 2002 to 2016: An Analysis of the Global Burden of Disease Study. *JAMA Network Open*, *1*(7), e184412. https://doi.org/10.1001/jamanetworkopen.2018.4412. *Meaningful Measures 2.0 Domain:* Equity		
IRIS 54: Complications After Cataract Surgery CBE#: N/A Collection Type(s): QCDR High Priority, Outcome *Rationale for Inclusion:* IRIS 54 evaluates effective clinical care by measuring the percentage of patients with the following complications after cataract surgery: prolonged inflammation, incision complications, iris complications, retinal detachment, cystoid macular edema, corneal complications or return to the operating room. *Meaningful Measures 2.0 Domain*: Safety	**IA_PSPA_7: Use of QCDR for Practice Assessment and Improvements** *Rationale for Inclusion:* This activity promotes the use of the QCDR data for improving quality – such as comparing specific patient populations for adverse outcomes after cataract surgery. The IRIS Registry, which utilizes CEHRT, provides additional QCDR measures to evaluate complications after cataract surgery, and to evaluate visual function outcomes in different patient populations receiving cataract surgery. This also promotes the meaningful use of CEHRT functionalities.	

QUALITY MEASURES	IMPROVEMENT ACTIVITIES	COST MEASURES
IRIS 61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery CBE#: N/A Collection Type(s): QCDR High Priority, Outcome *Rationale for Inclusion:* This measure addresses a gap in measurement and a performance gap. IRIS 61 is directed at patients who are candidates for cataract surgery but also have glaucoma. Although cataract surgery is highly effective with respect to increased visual acuity postoperatively, there remains room for improvement in patients with cataract and concomitant glaucoma surgery. The 2023 benchmarks file shows an average performance rate of 39.13%. Measurement will be critical to focus the continued improvement of visual acuity for optimal functional activity of patients that undergo surgery. Not only is this outcome measure meaningful to both the patient and the physician, but it also shows room for continued improvement.	**IA_PSPA_16: Use of Decision Support and Standardized Treatment Protocols** *Rationale for Inclusion:* With frequent innovations in ophthalmology, it is imperative that surgeons are practicing the most current evidence-based medicine. This improvement activity protects patients by ensuring clinicians are using standardized treatment protocols to make decisions. This also promotes the meaningful use of CEHRT functionalities. *Meaningful Measures 2.0 Domain*: Safety	
IRIS 62: Regaining Vision After Cataract Surgery CBE#: N/A Collection Type(s): QCDR High Priority, Outcome *Rationale for Inclusion:* This measure addresses a performance gap. IRIS 62 evaluates the effectiveness of cataract surgery and reflects the outcome to the patient. The 2023 benchmarks file shows that the average performance rate on this measure is 39.66%. Not only is this outcome measure meaningful to both the patient and the physician, but it also shows room for continued improvement.	**IA_MVP: Practice-Wide Quality Improvement in MIPS Value Pathways** *Rationale for Inclusion:* This improvement activity was specifically formulated for practice-wide improvement on multiple aspects while participating in an MVP.	

Table 2B: Foundational Layer – Population Health Measures

QUALITY #	MEASURE TITLE AND DESCRIPTION	COLLECTION TYPE	MEASURE TYPE / HIGH PRIORITY	NQS DOMAIN	HEALTH CARE PRIORITY	MEASURE STEWARD
479	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups	Administrative Claims	Outcome	Communication and Care Coordination	Promote Effective Communication & Coordination of Care	CMS
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	Outcome	Effective Clinical Care	Promote Effective Prevention and Treatment of Chronic Disease	CMS

Table 2C: Foundational Layer – Promoting Interoperability Measures

OBJECTIVE	MEASURE ID, TITLE, AND DESCRIPTION	REQUIRED FOR PROMOTING INTEROPERABILITY	EXCLUSION AVAILABLE	ADDITIONAL INFORMATION
Protect Patient Health Information	**PI_PPHI_1: Security Risk Analysis:** Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.	Yes	No	Annual requirement for Promoting Interoperability submission but not scored.
Protect Patient Health Information	PI_PPHI_2: High Priority Practices Safety Assurance Factors for EHR Resilience Guide (SAFER Guide): Conduct an annual self-assessment using the High Priority Practices Guide at any point during the calendar year in which the performance period occurs.	Yes	No	Annual requirement for Promoting Interoperability submission but not scored.

OBJECTIVE	MEASURE ID, TITLE, AND DESCRIPTION	REQUIRED FOR PROMOTING INTEROPERABILITY	EXCLUSION AVAILABLE	ADDITIONAL INFORMATION
Attestation	PI_ONCDIR_1: ONC Direct Review Attestation: I attest that I - (1) Acknowledge the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and (2) If requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.	Yes	No	Annual requirement for Promoting Interoperability submission but not scored.
Attestation	PI_INFBLO_2: Actions to Limit or Restrict Compatibility or Interoperability of CEHRT: I attest to CMS that I did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.	Yes	No	Annual requirement for Promoting Interoperability submission but not scored.
e-Prescribing	PI_EP_1: e-Prescribing: At least one permissible prescription written by the MIPS eligible clinician is transmitted electronically using CEHRT.	Yes	Yes	

OBJECTIVE	MEASURE ID, TITLE, AND DESCRIPTION	REQUIRED FOR PROMOTING INTEROPERABILITY	EXCLUSION AVAILABLE	ADDITIONAL INFORMATION
e-Prescribing	PI_EP_2: Query of Prescription Drug Monitoring Program (PDMP): For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history.	Yes	Yes	
Provider to Patient Exchange	PI_PEA_1: Provide Patients Electronic Access to Their Health Information: For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's certified electronic health record technology (CEHRT).	Yes	No	

OBJECTIVE	MEASURE ID, TITLE, AND DESCRIPTION	REQUIRED FOR PROMOTING INTEROPERABILITY	EXCLUSION AVAILABLE	ADDITIONAL INFORMATION
Health Information Exchange	PI_HIE_1: Support Electronic Referral Loops by Sending Health Information: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider — (1) creates a summary of care record using certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.	Yes	Yes	The optional PI_HIE_5 or PI_HIE_6 Health Information Exchange measure may be reported as an alternative reporting option to PI_HIE_1 and PI_HIE_4.
Health Information Exchange	**PI_HIE_4: Support Electronic Referral Loops by Receiving and Reconciling Health Information:** For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.	Yes	Yes	The optional PI_HIE_5 or PI_HIE_6 Health Information Exchange measure may be reported as an alternative reporting option to PI_HIE_1 and PI_HIE_4.

OBJECTIVE	MEASURE ID, TITLE, AND DESCRIPTION	REQUIRED FOR PROMOTING INTEROPERABILITY	EXCLUSION AVAILABLE	ADDITIONAL INFORMATION
Health Information Exchange	**PI_HIE_5: Health Information Exchange (HIE) Bi-Directional Exchange:** The MIPS eligible clinician or group must attest that they engage in bidirectional exchange with an HIE to support transitions of care.	Yes	No	This measure is an optional alternative Health Information Exchange measure and may be reported as an alternative reporting option in place of PI_HIE_1 and PI_HIE_4 OR PI_HIE_6.

OBJECTIVE	MEASURE ID, TITLE, AND DESCRIPTION	REQUIRED FOR PROMOTING INTEROPERABILITY	EXCLUSION AVAILABLE	ADDITIONAL INFORMATION
Health Information Exchange	**PI_HIE_6: Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA):** The MIPS eligible clinician or group must attest to the following: • Participating as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on ONC's website) in good standing (that is, not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy. • Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement.	Yes	No	This measure is an optional alternative Health Information Exchange measure and may be reported as an alternative reporting option in place of PI_HIE_1 and PI_HIE_4 OR PI_HIE_5.

OBJECTIVE	MEASURE ID, TITLE, AND DESCRIPTION	REQUIRED FOR PROMOTING INTEROPERABILITY	EXCLUSION AVAILABLE	ADDITIONAL INFORMATION
Public Health and Clinical Data Exchange	**PI_PHCDRR_1: Immunization Registry Reporting**: The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry /immunization information system (IIS).	Yes	Yes	
Public Health and Clinical Data Exchange	**PI_PHCDRR_2: Syndromic Surveillance Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.	No	No	Bonus Promoting Interoperability measure at this time.
Public Health and Clinical Data Exchange	**PI_PHCDRR_3: Electronic Case Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.	Yes	Yes	
Public Health and Clinical Data Exchange	**PI_PHCDRR_4: Public Health Registry Reporting:** The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.	No	No	Bonus Promoting Interoperability measure at this time.
Public Health and Clinical Data Exchange	**PI_PHCDRR_5: Clinical Data Registry Reporting:** The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.	No	No	Bonus Promoting Interoperability measure at this time.

APPENDIX B

AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

April 24, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
200 Independence Avenue, SW
Washington, DC 20201

Re: Existing and 2025 Candidate Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to reiterate and highlight our ongoing concerns with the existing and 2025 candidate Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), as well as recommend an alternative framework for MVPs that addresses many of the pitfalls of the current approach. We are hopeful the Centers for Medicare & Medicaid Services (CMS) will address our concerns and recommendations in the 2025 Quality Payment Program (QPP) proposed rule.

The AMA appreciates the ongoing dialogue with CMS on MVPs, but the AMA and medical specialty societies continue to believe that the best way to address the problems with CMS' existing MVP approach is to create separate MVPs for individual health conditions, episodes of care, and major procedures, specifically for areas that are high volume conditions and procedures—similar to the current MVP for Lower Extremity Joint Repair. **However, based on ongoing conversations and meetings we have had with CMS, as well as CMS stating that it does not want a large portfolio of MVPs, we have developed an alternative MVP framework.** This alternative framework categorizes quality and cost measures into condition-specific subdivisions within a broader MVP. Physicians who specialize in treating a particular condition would be able to clearly identify the available measures for that condition and register to be held accountable for those condition-specific quality and cost measures within the MVP. By creating MVPs through the proposed framework, CMS and physicians could also more easily identify and remedy gaps in measurement and scoring challenges, such as no or limited condition specific measures or measures without a benchmark. **We believe this framework helps address many of the problems with the current MVPs for many specialists, is feasible for CMS to implement, and helps inform patient decision-making.** We encourage CMS to obtain feedback on the framework in the proposed rule.

While we believe this approach holds significant promise to deliver more value to physicians who participate in MVPs and their patients, we do not believe it will resolve all the problems with the *Surgical Care MVP Candidate*. As discussed in previous correspondence, we believe this draft MVP inappropriately lumps multiple specialties (e.g., general surgery, colorectal surgery, neurosurgery, and

thoracic surgery, etc.) into a single MVP without a basis in how care is delivered to patients. **We recommend CMS not move forward with the Surgical Care MVP Candidate as currently drafted. At a minimum, CMS should work with the national medical specialty societies to develop one MVP for each specialty using the alternative framework outlined below that groups measures by the major conditions that specialty treats.** With the exception of the surgical care MVP Candidate, the AMA believes that CMS and the specialties can work together to modify the other existing or proposed MVPs within this framework. AMA's goal is to have MVPs that work for patients, physicians, and CMS.

Condition-Stratified Framework for Aligning Quality and Cost in Specialty MVPs

While there is no one-size-fits-all approach to MVPs that will work for every medical specialty, we believe that an MVP Framework that prioritizes alignment of quality and cost measures will alleviate many of the concerns with the existing MVP approach that ignores the variation in care provided by subspecialists and to different patient populations. The framework also takes into consideration independent and small physician practices, as it is premised on maintaining the finalized flexibilities for small practice scoring.

Instead of the current approach of having a long list of quality measures in the MVP ordered by Measure ID, we suggest that CMS organize the quality measures into categories, each of which is relevant to a particular patient condition or an episode of a particular type of treatment. If applicable, cross-cutting quality measures, such as depression screening and advance care planning, would be in a separate category. The available cost measures, and the relevant improvement activities, would then be placed into the same condition or procedure categories, i.e., an episode-based cost measure specific to a particular condition or procedure would be shown in the same category as the quality measures for that condition/procedure.

For example:

- In the *Advancing Care for Heart Disease MVP*, the quality measures would be grouped based on whether they applied to coronary artery disease, heart failure, atrial fibrillation, or other heart conditions. The measures could be further subdivided based on whether they relate to medical management of the condition or an interventional procedure (e.g., percutaneous coronary intervention (PCI) or ablation). The heart failure cost measure would be placed in the same category as the quality measures applicable to heart failure, and the PCI cost measures would be placed in the category for intervention related to coronary artery disease. This is shown in the attached table.
- In the proposed candidate MVP for *Comprehensive Ocular Care MVP Candidate*, we recommend CMS restructure it into subcategories of measures related to cataract, glaucoma, retina and vitreous conditions, or other eye conditions. The cataract episode-based cost measure would be grouped with the cataract quality measures. Please see attached table.

We also would like to see CMS **develop MVPs that involve multiple specialists who coordinate care for patients with a particular condition, during an episode of care, or for a procedure.** For example, as discussed at the February 26, 2024 MVP Round Table with CMS, the AMA supports the proposal submitted by the American Association of Neurological Surgeons and Congress of Neurological Surgeons that would add spine surgeons to the Musculoskeletal Care MVP. This would be more reflective of real-world, multi-disciplinary, and team-based musculoskeletal care than grouping them into an overly broad surgery MVP.

Quality Measure Scoring

This approach would also enable modifications to the scoring rules for MVPs to achieve more appropriate quality scores for MVP participants, including:

Few relevant measures:

If there are fewer than four quality measures in the MVP category for the specific type of condition that a physician manages or the specific procedure the physician performs (subcategory), then the physician would only be required to report those measures, rather than being forced to use generic measures in the MVP that are not relevant to their care or to not participate in the MVP at all.

Topped out measures:

To ensure equitable scoring rules and incentivize participation in MVPs, topped-out measures would not be capped.

New or existing measures or measures without a benchmark:

If there are few or no benchmarked outcome measures or high priority measures relevant to the condition(s)/procedures the physician manages/delivers, then the physician could be given maximum credit for submitting the unbenchmarked measures for a longer period in order to encourage submission of enough cases to develop a benchmark.

Measures with substantive changes:

The current approach to truncate the performance period to nine months may not yield sufficient data to establish reliable measure scores and/or benchmarks. Alternatively, if CMS cannot calculate a benchmark from truncated performance data, CMS creates a performance period benchmark. The scoring rule would lead to uncertainty and potential inequities with achieving the performance threshold. To encourage reporting on measures with substantive changes that need a new benchmark, physicians should be given maximum credit for submitting the measures to encourage submission of enough cases to allow CMS to develop a benchmark for future years, just as with the new or existing measure recommendation discussed previously. The current approach to truncate the performance period to nine months may not yield sufficient data to establish reliable measure scores and/or benchmarks.

Cost Measures

The AMA remains extremely concerned about the MIPS cost measures. We have long opposed inclusion of the Total Per Capita Cost (TPCC) in MIPS as it holds physicians accountable for costs over which they have no control because the services are ordered, provided, and priced by others, and for which they receive no data that might allow them to understand and influence their performance on the measure. We have also opposed the inclusion of TPCC in any MVPs that include other episode-based cost measures. If CMS continues to use TPCC in MVPs, we recommend that it be modified in several ways:

- Eliminate inappropriate attribution to specialists due to qualified health care professional (QHP) billing by (a) incorporating patient relationship codes/modifiers, (b) using place of service codes, and/or (c) identifying TINs that should otherwise be excluded if not for billing by QHPs.

- Exclude the cost of all preventive services from the measure in order to avoid penalizing physicians, including those who provide primary care, for delivering this high-value care, especially since any savings from preventive services are highly unlikely to be realized during the same performance year that the preventive services are provided.
- Disaggregate the total costs into subsets that are related to the conditions managed by different types of specialists, since it is those costs that each specialist can actually control. The disaggregated amounts would provide more meaningful and reliable measures of differences in practice than the current specialty adjustment and avoid holding specialists accountable for costs they cannot reasonably influence or control.

Finally, we are concerned about the Cost Performance Category resulting in MIPS scores that are inequitable for physicians and misleading for patients because of the limited portfolio of specialty-specific cost measures. For example, since only a subset of ophthalmologists is scored on the cataract surgery episode-based cost measure, other ophthalmologists will have more weight assigned to the Quality and Promoting Interoperability Performance Categories, which means that the MIPS scores for different ophthalmologists will reflect different components of value-based care. **CMS must prioritize development of additional episode-based cost measures.**

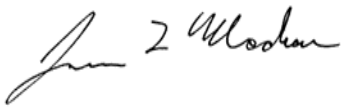
Additionally, while it is difficult to make a concrete recommendation to address this problem prior to the release of the 2022 QPP Experience Report and accompanying public use file, we continue to believe that CMS should consider alternative cost measure benchmarking approaches that will lessen the unpredictability and unfairness of the current Cost Performance Category. We also remain concerned that the cost measure benchmarks may be exacerbating the inequities in the program because they rely on a 10-decile methodology. For instance, given there is very little variation in costs in cataract surgery episodes and a low reliability threshold, we remain concerned that the decile scoring approach may be penalizing physicians for outlier episodes of care or for marginal differences in care. There is no requirement under the Medicare Access and CHIP Reauthorization Act (MACRA) to use a 10-decile approach to scoring, and we urge CMS to explore alternatives.

Population Health Measures

While measuring improvement in population health is important, introducing additional, one-size-fits-all requirements rather than considering the measures for potential use into existing criteria and tailoring them to each MVP adds unnecessary complexity and is less effective at improving patient outcomes. For example, the population health measures are focused on hospital care that is not clinically relevant to ophthalmologists. While ophthalmologists and other specialists, including primary care, may be exempt from some of the measures, inclusion of these measures as a foundational layer would result in confusion and concern about the applicability of those measures and MVP. It also adds an additional category into the program with burdensome and uneven scoring rules that were never intended or required by Congress in the MACRA statute. Maintaining the foundational requirement just adds additional quality measure requirements and standards into the program and increases administrative burden. Because CMS has added this new foundational category, we believe it is not accurate to say that MVPs reduce the number of quality measures that a physician or group must report. In addition, given the measures are based solely on administrative claims, CMS is potentially introducing the same flaws we have repeatedly highlighted with the global cost measures into this new category. **Therefore, we urge CMS to remove the flawed population health measures and category as a foundational requirement as it fails to accurately capture quality.**

Thank you for considering our recommendations to improve the design of MVP and overall QPP. Please do not hesitate to contact Margaret Garikes, Vice President of Federal Affairs with any questions or to discuss further at margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

Attachment

QUALITY & COST MEASURES IN CONDITION-STRATIFIED 2024 MVP FOR HEART DISEASE

SYSTEM	CONDITION	SERVICE	QUALITY Measures**	Outcome	Priority	Bench-mark	Topped Out or 7-Point Cap	COST
Heart Disease	Coronary Artery Disease	Medical Management	Q006: CAD: Antiplatelet Therapy				Topped	No Condition-Specific Measure
			Q007: CAD: Beta Blocker Therapy for Prior MI or LVSD				Topped	
			Q118: CAD: ACE or ARB Therapy					
			Q243: Cardiac Rehabilitation Referral from Outpatient Setting		Y			
			Q441: Ischemic Vascular Disease Optimal Control	Y				
		Intervention	Q243: Cardiac Rehabilitation Referral from Outpatient Setting		Y			Elective PCI
			Q441: Ischemic Vascular Disease Optimal Control	Y				STEMI with PCI
	Heart Failure	Medical Management	Q005: HF: ACE or ARB or ARNI Therapy for LVSD				Capped	Heart Failure
			Q008: HF: Beta-Blocker for LVSD				Capped	
			Q377: Functional Status Assessment for Heart Failure		Y	No		
			Q492: CV-Related Admission Rates for Heart Failure Patients	Y		?		
	Atrial Fibrillation	Medical Management	Q326: A-Fib: Chronic Anticoagulation Therapy			No		No Condition-Specific Measure
		Intervention	Q392: Cardiac Tamponade/Pericardiocentesis Following Ablation	Y		No		No Condition-Specific Measure
	Other (AMI, SVT, etc.)	Intervention	Q393: Infection After Cardiac Implantable Device	Y		No		No Condition-Specific Measure
Broad or Focused Services			Q238: Use of High-Risk Medications in Older Adults		Y	No		
Continuous or Broad Services for Patient*	Screening and Followup		Q134: Depression Screening and Follow-Up				Capped	Total Per Capita Cost Medicare Spending Per Beneficiary
			Q128: BMI Screening and Follow-Up				Capped	
			Q487: Screening for Social Drivers of Health		Y	No		
	Other		Q047: Advance Care Plan		Y		Topped	
			Q503: Gains in Patient Activation Measure Scores	Y		No		

* Not intended to be mandatory. The measures would only be used by physicians providing continuous or broad services to a patient, using the definitions in the Patient Relationship Categories adopted by CMS.
** Not an endorsement of measures. Broken down to demonstrate how the framework can be conceptualized based primarily on existing or proposed MVPs.

QUALITY & COST MEASURES IN 2024 MVP FOR OCULAR CARE: Our Prelimary Suggestions

SYSTEM	CONDITION	SERVICE	QUALITY: Measures	Outcome	Priority	Bench-mark	Topped Out or 7-Point Cap	COST
	Cataract and Anterior Segment*		Q191: Visual Acuity After Cataract Surgery	Y	Y		CQM Topped	Routine Cataract Removal with IOL Implantation Cost Measure
			Q389: Planned vs Final Refraction After Cataract Surgery	Y	Y			
			IRIS54: Complications After Cataract Surgery	Y	Y			
			IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery	Y	Y	No (new, 7-pt floor)		
			IRIS62: Regaining Vision After Cataract Surgery	Y	Y	No (new, 7-pt floor)		
	Glaucoma	Medical Management	Q012: Optic Nerve Evaluation in Glaucoma				Topped	No Condition-Specific Measure
			Q141: Reduction of Intraocular Pressure or Plan of Care	Y	Y			
			IRIS2: Reduction of Intraocular Pressure	Y	Y			
			IRIS39: Intraocular Pressure Reduction After Procedure	Y	Y	No		
			IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery	Y	Y	No (new, 7-pt floor)		
	Retina	Medical & Surgical	Q019: Communication About Retinopathy with Diabetes Mgt Phys.		Y		CQM Capped	No Condition-Specific Measure
			Q117: Diabetes Eye Exam				CQM Capped	
			Q384: No OR Return After Retinal Detachment Surgery	Y	Y		Capped	
			Q385: Visual Acuity Improvement After Retinal Detachment Surgery	Y	Y			
			Q499: Appropriate screening and plan of care for elevated intraocular pressure following intravitreal or periocular steroid therapy			No (new, 7-pt floor)		
			Q500: Acute posterior vitreous detachment appropriate examination and follow-up			No (new, 7-pt floor)		
			Q501: Acute posterior vitreous detachment and acute vitreous hemorrhage appropriate examination and follow-up			No (new, 7-pt floor)		
			IRIS13: Loss of Visual Acuity in Diabetic Macular Edema	Y	Y		Topped	
			IRIS35: Improvement of Macular Edema in Patients with Uveitis	Y	Y	No		
			IRIS38: Endothelial Keratoplasty, Dislocation Requiring Surgical Intervention	Y	Y	No		
			IRIS58: Improved Visual Acuity After Vitrectomy	Y	Y			
	Cornea		IRIS1: Endothelial Keratoplasty - Post-operative improvement in best corrected visual acuity to 20/40 or better	Y	Y	No		No Condition-Specific Measure
			IRIS38: Endothelial Keratoplasty, Dislocation Requiring Surgical Intervention	Y	Y	No		
	Other (Reconstructive, Pediatric, Neuro, Immunology)		We can add a section for pediatric ophtho with 117, IRIS17, IRIS50, IRIS54, IRIS61, IRIS62 Uveitis-Immunology: 499, IRIS17, IRIS35 Oculoplastics: 137, 357, 397 Neuro: 318, 419					No Condition-Specific Measure
	Refractive		IRIS23: Refractive Surgery: Patients with a postoperative uncorrected visual acuity (UCVA) of 20/20 or better within 30 days	Y	Y			No Condition-Specific Measure
			IRIS24: Refractive Surgery: Patients with a postoperative correction within + or - 0.5 Diopter (D) of the intended correction	Y	Y	No		
			IRIS38: Endothelial Keratoplasty, Dislocation Requiring Surgical Intervention	Y	Y	No		
General**	Preventive Care and Screening***		Q012: Optic Nerve Evaluation in Glaucoma				Topped	
			Q117: Diabetes Eye Exam				CQM Capped	
			Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention					
			Q487: Screening for Social Drivers of Health		Y	No (new, 5-pt floor)		
	Other***		Q238: Use of High-Risk Medications in Older Adults		Y	No		
			Q130: Documentation of Current Medications in the Medical Record		Y		Capped	
			Q374: Receipt of Specialist Report		Y	No (MIPS CQM) Yes (eCQM)		

* Measures 303 and 304 were developed for PQRS and are not appropriate for MIPS, per the measure steward.
** Not intended to be mandatory. The measures would only be used by physicians providing continuous or broad services to a patient, using the definitions in the Patient Relationship Categories adopted by CMS.
*** Not an endorsement of measures. Broken down to demonstrate how the framework can be conceptualized based primarily on existing or proposed MVPs.