June 27, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Mr. Slavitt:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 10,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care.

We appreciate the opportunity to comment on the MIPS and APM proposed rule. Due to the fact that all eligible providers will be participating in MIPS for the first performance year, and it is likely there will be no advanced APMs ophthalmologists can participate in for the foreseeable future, we will focus our comments mainly on MIPS and provide general comments on advanced APMs.

QUALITY PAYMENT PROGRAM

ASCRS has advocated for changes to the existing quality reporting programs for several years. We appreciate that CMS has made many changes to these programs as they are transitioned into the components of MIPS and that CMS is engaged with the medical community and willing to modify the program as needed. We believe there is still significant work that needs to be done in order to make this new program work for all medical specialties, and ophthalmology in particular.

Overall, ASCRS has a major concern that the implementation timeline is too short and physicians will not be ready to participate in the new program on January 1, 2017. During this transition period to a new payment system, physicians and their practice administrators must have time to be educated on and understand the new program. Our primary recommendation is to urge CMS to move back the first performance period to begin July 1, 2017, so that physicians and practices have ample time to transition from the existing reporting programs (PQRS, Value-Based Payment Modifier, and EHR/meaningful Use) and be successful in the new payment program, which also incorporates a new component – Clinical Practice Improvement Activities.

During the first transition year, we recommend CMS provide physicians with flexibility to choose a performance period that best fits his or her practice. Physicians should have the option to report for a full year, or choose a shorter performance and reporting period. In addition, physicians should have an optional
look-back to January 1, 2017, which would allow them to report on quality measures specified around a 12-month reporting period or surgical measures needing time to determine outcomes. Finally, we recommend CMS hold any provider harmless from penalties in the first transition year of the program if they are negatively impacted by the timing of the performance period.

There are also specific issues in the proposed rule we will outline in detail below. These include:

- The lack of an option to report quality measures as part of the Quality component through the current existing Measures Groups, such as Cataract and Diabetic Retinopathy.

- Thresholds under the Quality reporting category are too high. CMS proposes to raise the reporting requirement to 90% of all patients reporting via registry or 80% of Part B patients via claim. Achieving these thresholds would be overly burdensome to physicians and disincentivize reporting through a registry.

- The Resource Use category attribution methodology is based on the existing Value Based Payment Modifier, which potentially holds physicians responsible for care they did not provide. Further, the cost measures included in the category are primary care-focused and do not apply to specialists, particularly ophthalmologists. We also recommend lowering the percentage weight for this category to 0% of the MIPS Composite Score to limit penalties for specialists.

- The Advancing Care Information category retains measures from Stage 3 of Meaningful Use that physicians—in particular, specialists such as ophthalmologists—cannot meet because they rely on actions of patients and other providers, which are out of the physician’s control.

Performance Period Timing

- **ASCRS recommends the first year’s performance period be adjusted to become a transition period beginning later in the year**, to ensure adequate time for physicians and practices to become familiar with the new program and implement it. The implementation of the Quality Payment Program represents the single biggest change to Medicare physician payment in decades, since the implementation of RBRVS. Even if CMS finalizes the rule in the fall as planned, that leaves fewer than four months for physician practices to absorb the complex program laid out in this proposed rule. **While we are pleased that CMS has listened to physician feedback and provided some flexibility in the program, that means practices will be required to evaluate several different options to determine how best they can participate, and put into operation any changes to clinical work-flows or administrative processes in a very short amount of time. This would represent a serious burden to small practices, which make up the majority of our membership. A transitional period, beginning later in 2017 will help ensure physicians will be successful in the new program.**

- Physicians should also have the option of incorporating data from as early as January 1, 2017 for the Quality Performance component to accommodate certain measures with specifications based on year-long reporting and allow adequate time to determine outcomes for certain surgical measures.
- We believe CMS has the ability to adjust the performance period for the first year since the MACRA statute requires payment adjustments beginning in 2019, but does not require the performance period to begin at any specific date.

- In future years, physicians should also have the option to report for a shorter performance period, or a full calendar year, depending on what is most appropriate for their individual practices.

- We recommend CMS provide additional training materials to eligible providers and ensure help desk staff are adequately trained on the details of the new program.

**Provider Input**

- ASCRS asks that as CMS moves forward in developing different aspects of MIPS and Advanced APM programs, the agency prioritizes getting feedback from the provider community, in particular, specialists such as ophthalmologists, who are often in solo or small practices. ASCRS has previously encouraged and continues to urge CMS to work with medical specialty societies as the Quality Payment Program is developed. On issues such as the development of episode groupers, patient relationship codes, or risk adjustment models, CMS cannot effectively establish a successful program and understand the consequences of their rulemaking without involving medical specialty groups. We appreciate CMS’ willingness to involve the medical community in its efforts so far, and encourage the agency to continue to seek feedback. **ASCRS has already participated in several meetings and is eager to participate fully to provide input as development of the programs continues.**

**Impact on Small Practices**

- ASCRS recommends the size of a small practice be consistent across all performance categories of MIPS. A uniform standard for the size of a small practice will help to ensure providers have a clear idea of goals and requirements as they begin to evaluate how they will participate in the program.

- We appreciate the proposals to provide accommodations for small practices in the scoring of the Quality and the reporting for Clinical Practice Improvement Activities (CPIAs) categories and request a similar set of criteria for small practices in the other performance categories. However, for Quality scoring, a small practice is defined as 10 or fewer providers, while under the CPIA category, it is 15 or fewer as required by MACRA.

- ASCRS is worried that requirements of the new program will disproportionally affect small practices. The majority of our members are in practices with five or fewer practitioners. In the regulatory impact analysis section of this proposed rule, CMS estimates that 87% of solo practitioners will receive a negative payment adjustment and 67% of practices with 2-9 providers will receive a penalty. **Given these estimates, it is imperative that CMS adjust the first year’s performance period and work to assist smaller practices with how to be successful in the MIPS program.** While we understand the estimates may be based on older data, it is unlikely more timely data will indicate a significant change in the impact on small practices who already struggle to comply with the current programs.
MIPS PROGRAM STRUCTURE

- ASCRS supports CMS’ proposal to allow participation in the MIPS program at either the individual or group level. The current quality reporting programs are based on a combination of group and individual performance and do not provide a holistic or comparable view of performance.

- We also support the proposal to reweight categories that do not apply to particular specialties. We continue to contend that many measures, particularly in Resource Use, are primary care-based and not applicable to specialists. We appreciate CMS’ proposal to reweight categories where it is determined there are no applicable measures, rather than penalize physicians for a circumstance beyond their control.

Prospective Performance Information

- CMS needs to be proactive in helping providers understand the basis for the individual or group’s score. For instance, if there are no resource use measures that apply to a particular provider or group, then CMS must inform participants in advance how their category weights would be affected. Furthermore, lack of prospective information is a disincentive to participate in advanced APMs or MIPS APMs, which may have different performance criteria, since an eligible provider will not be reasonably sure he or she can meet the required thresholds, or if not, meet MIPS criteria.

- ASCRS supports frequent feedback to providers on how they are doing in each of the MIPS categories. We support CMS’ efforts to release annual feedback reports but believe that biannual or quarterly reports would provide more accurate, current information on a provider’s status in the MIPS program.

- ASCRS recommends CMS adopt a straightforward process for practices to determine whether a category applies to their specialty. For example, the Measures Applicability Validation (MAV) process that CMS used to determine how many PQRS measures providers were required to report was confusing and unwieldy. Under this process, providers did not know whether they were required to report certain measures until after the reporting period when it was too late to make reporting adjustments. CMS should adopt a process that is clear and prospective when making determinations as to whether each MIPS category applies to particular specialties and subspecialties.

Submission Methods

- ASCRS opposes requiring in future years that eligible providers submit data for multiple performance categories through a single submission method. If CMS’ intention is to provide flexibility, it is counterintuitive to lock physicians into a single submission method, which may not reflect the needs or composition of the individual or group.

- We do appreciate the flexibility that the program allows, however, for providers to submit data for a particular category via one or multiple submission methods and use the highest performance score toward the component score.
**Risk Adjustment**

- CMS should work with medical specialty societies to determine how to develop an effective risk adjustment method.

- **Risk adjustment methods in the proposed rule do not provide sufficient protection for physicians.** ASCRS believes that CMS has yet to develop a risk adjustment method that adequately accounts for patient comorbidities and compliance, as well as patient demographic and socioeconomic factors. Developing an effective risk adjustment method that has been successfully tested is a key factor in ensuring that these programs do not adversely affect providers treating specific patient groups, such as low-income or elderly patients.

- **It is important to consider how several chronic conditions, such as glaucoma and age-related macular degeneration, are treated by ophthalmologists.** Treatment for those conditions is limited to managing the progression of the disease to ensure patients do not lose their eyesight completely. For instance, glaucoma patients will never recover fully, but preventing further progression of the disease depends on them using prescribed drops and coming into the ophthalmologist’s office for regular pressure checks. Physicians should not be held responsible for unrealistic outcomes or outcomes entirely dependent on patient compliance.

**MIPS COMPONENT CATEGORIES**

**QUALITY PERFORMANCE CATEGORY**

**Oppose Elimination of Measures Group Reporting Options**

- **ASCRS opposes CMS eliminating the Measures Group reporting options and urges they be reinstated.** Many of our members used the Cataracts Measures Group or the Diabetic Retinopathy Measures Group, which required the reporting of 8 measures on 20 patients, 50% of whom must be Medicare Part B patients, to successfully meet the PQRS reporting requirement. By doing away with this Measures Group quality reporting option, CMS has actually made this category more difficult for many providers to meet, particularly those in small practices.

- **We believe the elimination of the option is counterintuitive to CMS’ stated goals for overall quality improvement and specific condition and/or episode-based performance and measurement.** At CMS’ encouragement, the ophthalmic community invested significant time and resources developing the Cataract and Diabetic Retinopathy Measure Groups to satisfy that stated goal. The Cataracts Measures Group features six outcomes measures that focus on surgical complication rates, clinical outcomes, patient-reported outcomes, and patient satisfaction. We believe these highly relevant measures are more in line with CMS’ stated goals than other measures not grouped to address particular conditions or procedures.

- **While we recognize CMS has proposed a list of specialty measures lists in the proposed rule (Table E) the sets are merely a re-ordering of the numerical list of available measures (Table A) by specialty and are not analogous to the Measures Groups. Under the proposal, a physician would be able to choose any**
of the measures available without any relationship between them and not specific to a particular procedure or condition.

- By focusing on a particular condition or episode, as in the Measures Groups, a physician could focus on a procedure or condition that represents the majority of his or her particular practice.

- Physicians reporting through the Measures Groups were already participating at a more advanced level, since the Cataracts Measures Group included six outcomes measures and two cross-cutting measures, and the Diabetic Retinopathy Group included one outcome measure and two cross-cutting measures, which CMS deems to be “high priority.” Therefore, under CMS’ proposals, physicians would not be required to submit as many clinically-relevant measures that center around a particular condition or procedure. Given the much higher reporting thresholds for registry reporting (discussed below), there is a further disincentive for physicians to report on these measures since several, such as Measure #191, Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery and Measure #192, Cataracts: Complications within 30 Days Following Surgery Requiring Additional Surgical Procedures, are only reportable through registry. If physicians opt to report via claims, they will not be able to select several of the outcome measures included in the Measure Groups.

- In the CY 2012 Medicare Physician Fee Schedule Final Rule, CMS finalized lowering the patient threshold to 20 patients from the previously finalized threshold of 30 for the Measures Group, with the rationale that it would reduce provider burden. The measures included in the Measures Groups are work-intensive, and so require a lower number of patients for providers, particularly those in small practices, to achieve. For larger groups reporting through the CMS Web Interface, CMS proposes to base the Quality score on a sample of 248 Medicare patients, which is significantly lower than the reporting requirement for individual physicians. Similarly, individual physicians should retain the option of reporting on 20 patients through the Measures Group. We urge CMS to continue to work toward the goal stated in this proposed rule of reducing provider burden by maintaining its previously set standards toward that goal of reduced burden.

- We urge the Measures Group option be reinstated to continue to build on the work already achieved by physicians.

**Reporting Requirement**

- ASCRS also opposes the increased threshold requirements for the percentages of patients that must be reported for quality measures and urges CMS to retain the current reporting threshold under PQRS of 50% of Medicare Part B patients. Under PQRS, providers had to report their quality measures for 50% of all Medicare Part B patients via registry, claims, EHR or the Group Practice Reporting Option, which CMS has previously stated was statistically significant. CMS’ proposal would require providers who report via registry to report measures for 90% of all their patients and providers who report via claims to report measures for 80% of all Medicare Part B patients. This is a significant increase that will make quality reporting much more difficult for many providers. Given the high number of patients required, physicians will be required to begin reporting on patients in January 2017, to meet the threshold. Not only does this leave very little room for error, but as we have stated above, the implementation time following the final rule and the beginning of reporting will be too short for physicians and practices to implement new workflows and administrative processes.
• We urge CMS to remove the requirement to report all patients when reporting via registry. MIPS is specific to Medicare Part B, and therefore, requiring data submissions for all patients from all payers is outside the scope of the program.

• Again, this proposal seems to be going back on CMS’ previously stated explanations that prior reporting thresholds were statistically significant. This proposal also penalizes those providers who are using a registry to report PQRS, which is counter to CMS’ stated goal of encouraging more providers to report via registry.

Global and Population Measures Attribution

• ASCRS opposes using the same attribution method as was originally used for ACOs and is currently used for the VBPM for CMS’ proposal to score providers on 2 or 3 (depending on practice size) additional ‘global’ or ‘population based’ quality measures to be gathered from administrative claims data. As we have stated before, and will again in our comments on Resource Use, these measures potentially hold providers, especially specialists such as ophthalmologists, responsible for care they did not provide. The measures—acute and chronic care composites and all-cause hospital readmission—focus on the delivery of primary care, which does not apply to ophthalmology.

• The attribution process is problematic since CMS will first assign beneficiaries who have had a plurality of primary care services rendered by primary care physician, and secondly, for beneficiaries who remain unassigned, will assign beneficiaries who have received a plurality of primary care services rendered by non-primary care physicians in the TIN. CMS changed this attribution model for ACOs and at the time noted the possible negative effects it could have on specialists. These same issues arise with the VBPM—and will likely with the global and population measures—and may have the effect of holding specialists, such as ophthalmologists, accountable for the cost and quality of care they did not actually provide.

• Therefore, specialists such as ophthalmologists, should be exempt from these additional measures and evaluated only on the 6 measures they choose to report.

Quality Performance Scoring

• ASCRS is very concerned with how CMS proposes to measure and score quality improvement in the years following the first performance period. We understand the intent of quality improvement is to measure improvement over time and that MACRA requires the MIPS score eventually to be based on a provider’s improvement over time. We appreciate that the first year’s category score will not be contingent on delivering improved care. However, if CMS finalizes the proposal to determine the 2017 performance baseline benchmark on 2015 performance, we request that specific examples of how each measure will be scored be included in the final rule.

• Since the improved performance is a new aspect of quality reporting, physicians will need to have as much information as possible to prepare for the performance year.

• Specifically, we request CMS to provide information regarding how it intends to score process measures versus outcome measures. Will process measures be given full credit based solely on being reported, or will there be a patient threshold? In Table 19, the sample score includes process and
outcome measures. Some measures received full credit, while others did not. We request that the final rule include an explanation of how each measure will be scored. The information should include performance data from previous years and how that will be used to set the benchmarks. Providers participating in PQRS in previous years have only had to report measures and not had specific benchmarks that must be met. They have not had the advantage of tracking their performance in previous years to have an idea of what measures they should be reporting on and how they will likely fare.

- **Scoring for Measures with High Success Rates**

When developing a scoring standard, we request that CMS take into account that some procedures, such as cataract surgery, are already overwhelmingly successful. Numerous studies have found there is very little differential in outcomes and cost for cataract surgery nationwide. When setting a benchmark, we urge CMS not set it so narrowly that many surgeons providing exemplary care are penalized just to satisfy budget neutrality concerns. In addition, since cataract surgery is the number one Medicare-reimbursed procedure, we urge CMS not remove cataract measures from the Quality component, just because of the high success rate.

- **Risk Adjustment for Scoring Benchmarks**

Once again, we reiterate our earlier concerns about risk adjustment. When dealing with chronic conditions, such as age-related macular degeneration or glaucoma, the goal of treatment is to reduce additional sight loss, and success is dependent upon patient compliance—and thus out of the physician’s direct control. Scoring benchmarks should be set with those considerations in mind that patients will never improve and that a successful outcome is managing the disease to prevent further sight loss and contingent upon patient compliance.

- **Scoring Small Practices**

  - **Global and Population Measures:** While we appreciate that CMS is proposing to adjust the scoring mechanism to account for small practices with 10 or fewer providers by not counting the hospital readmission measure, we would still recommend ophthalmologists, regardless of practice size, not be scored on these measures.

  - **Reporting Thresholds:** We recommend small practices have lower reporting thresholds and adjusted scoring mechanisms throughout the MIPS program.

  - **Practice Size:** We recommend the small practice size be increased to 15 or fewer providers to align with the statutory requirement under CPIA.

  - **Small practice size should also be consistent across all categories.** For instance, the Quality score is based on practices with 10 or fewer eligible providers, while the CPIA requirement is for practices 15 or fewer, as set forth in MACRA. This inconsistency further adds to the complexity practices—and in particular small practices—must work through to determine how they will participate and be successful in the MIPS program.
RESOURCE USE (COST)

Cost Measures Do Not Apply to Our Specialty

- ASCRS continues to have major concerns with the Resource Use performance category of MIPS. As we have stated previously, the current Value Based Payment Modifier (VBPM) cost measures are primary care-focused and do not apply to our specialty. CMS has proposed the continuation of two measures from the VBPM: total costs per capita for all attributed beneficiaries and Medicare Spending per Beneficiary. These measures would potentially attribute high costs of treatment for non-ophthalmic conditions to ophthalmologists, simply due to the flawed attribution process based on E/M billing (discussed below). We continue to assert that it is impossible for CMS to evaluate specialists based on their cost data using these measures since none of the measures apply to specialty providers, such as ophthalmologists.

- In addition, we oppose the proposal to lower the patient threshold to 20 patients from the current level of 125 patients for the Medicare Spending per Beneficiary measure, since it would likely attribute more patients to a provider or group.

- ASCRS urges CMS to reweight the proposed overall composite score weight for Resource Use from 10% to 0% for the first performance year. The current cost measures still do not reflect specialty practices and the episode-based cost measures need further refinement before being incorporated into the program.

Flawed Attribution Methodology

- CMS should adopt the same exclusions for the resource use category attribution process as currently used for ACOs, so that specialists, such as ophthalmologists, are not being penalized for costs they cannot control. Many ophthalmologists bill E/M codes when they treat patients. Therefore, we have many members, who under the current attribution method in the Value Based Payment Modifier, have patients with medical care unrelated to ophthalmology attributed to them. This current attribution method is flawed and needs to be reworked. A similar attribution method was used to assign beneficiaries to Accountable Care Organizations (ACOs). ASCRS and other medical specialty groups pointed out the same issues with the ACO attribution method to CMS, and as a result, CMS changed the method to exclude specialties, such as ophthalmology from the attribution process.

Episode Groupers

- ASCRS opposes the proposal to measure ophthalmologists’ resource use through episode groupers. While we appreciate CMS’ efforts to develop cost measures that are more meaningful to specialists, we do not believe the current proposals adequately measure cost or adjust for risk. ASCRS provided detailed feedback on the Method B episode groupers that CMS released and will do the same for Method A episode groupers.

- As we noted in our comments above on the Quality category, complications after cataract surgery are extremely rare. There is very little differentiation among cataract surgeons both for resource use and in outcomes. When rare complications, but also variations in outcome occur, it is often due to patient
comorbidities, such as diabetes, glaucoma, macular degeneration or retinal disorders, or other significant pre-existing health issues.

- In order to provide more useful feedback, CMS should release additional information on how it plans to use these episode groupers to measure resource use. ASCRS believes that provider input is essential to getting episodes right, and that CMS failed to adequately include providers in each stage of the episode grouper development process.

- In 2013, ASCRS was initially consulted by Brandeis when it first started developing the cataract episode group. However, the model our physician representative helped develop looked significantly different from the proposed cataract episode group in Method B. ASCRS was contacted again a few years later, but there was insufficient follow-up from Brandeis to our physician representative, and consequently, ASCRS was not part of the subsequent episode development process over the past three years. Furthermore, it was never clearly communicated to ASCRS that the episode groups being developed by Brandeis would be turned into the episode groups CMS would develop under MIPS.

- ASCRS continues to believe CMS has not yet found a good way to adjust for risk. Until CMS has a risk adjustment method that can accurately account for various patient factors and has been sufficiently tested, CMS should not move forward with measuring provider cost.

**ADVANCING CARE INFORMATION**

ASCRS thanks CMS for listening to our previous feedback regarding the existing Meaningful Use/EHR Incentive Program and supports some of the proposed changes that CMS has built into the Advancing Care Information category that offer more flexibility for providers. However, there are still issues with patient engagement, health information exchange and public health and clinical data registry reporting requirements.

- **ASCRS appreciates that providers will have the ability to customize the program to better suit their needs, but contends that the proposal does not actually remove “all-or-nothing” scoring, since providers must satisfy all of the objectives and measures under the base score in order to receive any points for the category at all.**

- However, we do appreciate that if a provider is unable to meet any increased thresholds for the performance score measures, he or she may still receive 50 points from the base score merely for reporting.

- **We also applaud CMS for getting rid of the quality component of Meaningful Use, which was redundant and created a burden for providers required to report quality under both PQRS and Meaningful Use.**

- **We appreciate the exception for providers not administering immunizations under the public health and clinical data registry reporting objective, since the current public health registries are primary care-focused, this entire objective limits ophthalmologists.** We appreciate that ophthalmologists participating in the IRIS registry will be able to achieve a bonus point.
Measures Outside the Provider’s Control

- ASCRS opposes the measures included in the Advancing Care Information category that hold providers responsible for information over which they have no control and recommends they be removed. While we agree that patient engagement, care coordination and health information exchange are important goals, we continue to believe that the requirements for Patient Electronic Access and Health Information Exchange hold providers responsible for the actions of patients and other physicians outside of their control. ASCRS and others in the medical community have continually recommended CMS remove measures that hold providers accountable for the action of patients and other providers.

- Physicians have no control over whether a patient or other provider has the ability to receive information or take any particular action. Under the initial requirements for Stage 2 of Meaningful Use, many ASCRS members had difficulty reaching the measure thresholds, and we supported the changes CMS finalized as part of Modified Stage 2. The proposals CMS is now making for the performance score are similar to Stage 3, which ASCRS and medical community opposed. As we indicated in our comments on Stage 3, many of the required measures are not appropriate for our specialty, as our patient population tends to be older Medicare patients. These patients do not typically have access to or knowledge of a computer, which has a direct impact on our members’ ability to meet the requirements of several of these measures. Our members located in rural areas have difficulty meeting these measures as well, as many of their patients do not have access to a computer. Similar to our comments above regarding quality improvement, physicians should not be measured based on patient action.

- Specifically, ASCRS is certain our members will continue to struggle meeting the Patient Electronic Access to Health Information and the Coordination of Care through Patient Engagement objectives. ASCRS, along with other medical organizations, has worked to educate CMS regarding the difficulties our members have had with these two patient engagement measures in Stage 2 of Meaningful Use. When the Meaningful Use Flexibility proposed rule was issued, ASCRS was very supportive of CMS’ reduction of the patient electronic access requirement from 5% to one patient and the secure electronic access requirement from 5% to being functionally able to allow patients to send secure electronic messages. These changes made it significantly more likely that ASCRS members would be able to successfully attest to Modified Stage 2. We appreciate that to achieve the base score, physicians must only provide a numerator and a denominator, but for the performance score, they must achieve a certain, yet-to-be-determined, threshold of patients accessing and using the technology. Given the characteristics of our members’ patient base, which have not changed, it is unlikely they will be able to achieve at significantly higher levels than previously.

- In addition, we continue to oppose the measures included in the Health Information Exchange objective requiring the action of other providers and recommend that thresholds under the performance score not be set at levels unattainable by our members. Under the Health Information Exchange Objective, providers are still required to exchange information with other providers by creating a summary of care and electronically exchanging the summary of care record. While CMS has clarified with ASCRS that providers were able to meet this measure for Stage 2 by sending an email, many EHR systems are only able to meet this measure by exchanging information with other providers who have an EHR system that will accept a Consolidated-Clinical Document Architecture (CCDA) formatted document. This is problematic, as many of our providers are located in areas where the doctors they refer patients to and receive patients from do not have an EHR. Therefore, our providers are often penalized for the decision by surrounding providers not to adopt EHR systems.
• **The Health Information Exchange Objective does not adequately reflect EHR interoperability.** Not only is success for this objective based on actions of other providers out of control of the individual physician, it is a poor metric for interoperability, by being too focused on the quantity of information moved and not the relevance of these exchanges. EHR vendors often design their systems to make them just interoperable enough to meet existing Meaningful Use requirements, but not to facilitate true interoperability. We urge CMS to re-focus the ACI category on interoperability by developing on specialty-specific interoperability use cases rather than the quantity of data exchanged.

**Hardship Exemptions**

• ASCRS still believes that there should be hardship exemptions available for providers in this category who are unable to report due to hardships, such as unforeseen circumstances or vendor issues, as there have been in the Meaningful Use program. If a provider receives a hardship exemption in this category, the weight of the ACI performance category should be reweighted among the other three performance categories so the provider is not penalized.

**EHR Certification and Modified Stage 2**

• We appreciate the proposal to allow providers to continue with Modified Stage 2 of Meaningful Use, particularly when using 2014-certified technology for the first year, as many of our members do not yet have 2015 technology. For the first performance period, providers have the alternate option of reporting on objectives and measures previously finalized as part of Stage 3 or Modified Stage 2 of Meaningful Use, based on the certification year of their Certified Electronic Health Records Technology (CEHRT). Providers with 2015, or a combination of 2015 and 2014, technology can report on the objectives and measures specified under the Advancing Care Information category or objectives and measures that correlate to Stage 3 or Modified Stage 2. Providers with only 2014 CEHRT would not be able to report on measures and objectives that correlate to Stage 3 requiring 2015 CEHRT, and thus would be required to report on Modified Stage 2. **We appreciate the flexibility offered in the proposed rule, which will mean more of our members can be successful by reporting on to Modified Stage 2.**

**Advancing Care Information Score**

• We urge CMS to set the performance score benchmarks at levels that can reasonably be achieved by all providers, particularly in the first performance period. When developing scoring benchmarks for the performance component of the Advancing Care Information category, we reiterate our previous concerns about timing and not holding providers responsible for actions outside their control.

• **Given the relatively short lead time providers will have to implement the MIPS program, we again suggest the performance period be pushed back for the first year and measure thresholds not be set beyond a reasonable achievement level.** As we have mentioned above, and in previous comments, specialists, and ophthalmologists, in particular, have struggled to meet measure thresholds in previous iterations of the Meaningful Use program.

• **We oppose setting benchmarks similar to those in Stage 3, since they will be out of reach for many providers.** ASCRS has joined with the medical community to oppose and seek a delay of Stage 3 since the measure thresholds are far too high. For example, under Stage 3, providers would be held
accountable for 10% of their patients to either view, download, or transmit their health information. Most of our members were not able to reach the previous goal of 5% under the original proposal for Stage 2. It is highly unlikely physicians will be able to meet the thresholds set under Stage 3.

**CLINICAL PRACTICE IMPROVEMENT ACTIVITIES**

*Activities*

- **We recommend additional activities, such as participating in continuing medical education or fellowships, be included in the list of available CPIAs.** ASCRS has continuously urged CMS to ensure the Clinical Improvement Activities category is as flexible and simplistic as possible. While we appreciate that some of the CPIAs listed are activities our members are already doing in their practices, we do not feel there are currently enough CPIAs for providers to choose from. Specialty practices are extremely varied, and CIPAs will need to be as well. The proposed list of CPIAs is heavily tilted toward primary care practices and does not provide many options for specialists. Several peer-reviewed articles have demonstrated significant positive impacts on patient care and safety due to these activities, while there has been no demonstrated impact due to other activities, such as the use of EHR.

- **We applaud CMS’ plan to develop a process for future years of MIPS where stakeholders can recommend activities for potential inclusion in the CPIA inventory. We urge CMS to be flexible and allow as many proposed CPIAs onto the final list as possible.**

*Descriptions and Details Needed.*

- **We recommend CMS provide more detail in the final rule regarding descriptions for individual CPIAs.** We find many of the descriptions for individual CPIAs to be lacking in clear detail as to what constitutes successfully completing a CPIA. Once again, the implementation of the MIPS program poses a significant challenge to providers, especially in regard to the new CPIA category, and so we urge CMS to provide as much information to providers so they can be sure they are doing all that is necessary to be successful.

*Performance Period*

- **We support CMS’ proposed 90-day performance period for the CPIA category.**

*CPIA Scoring*

- **ASCRS appreciates and supports CMS’ proposal to re-weight individual activities to 30 points and require practices with fewer than 15 providers to report on only two CPIAs for full credit, as required by MACRA.**

- **In addition, we recommend all categories include lower thresholds for small practices and the number of providers be consistent across all categories.**

- **ASCRS opposes CMS’ proposal to measure performance on CPIAs to determine the provider’s category score in the future.** The MACRA statute does not provide for scoring based on improved performance under CPIA, and we urge CMS maintain the proposed attestation method for the first year in the following years. To reiterate the point above, several of the CPIA descriptions are quite short and broad;
therefore, it would be very difficult for a provider to determine what would first constitute successfully performing an activity, and what would be an acceptable level of improvement for future years.

- Finally, if a provider can only achieve full credit in future years, it may disincentive the provider from performing worthy activities for future years if he or she cannot receive credit for them under this category.

**PHYSICIAN COMPARE**

ASCRS urges CMS to ensure that all data regarding eligible providers’ performance and MIPS composite score be accurate, statistically significant, and presented in a way that patients and the general public can accurately interpret the score. While we support transparency, ASCRS believes there are significant problems with CMS’ proposal to publish additional MIPS data on the Physician Compare website. As we have commented before and stated earlier in this comment letter, ASCRS opposes the attribution method employed currently under the VBPM and proposed methodology going forward under the Resource Use category. This attribution methodology holds physicians responsible for care they may not have provided, and thus is an inaccurate indicator of a physician’s overall quality performance. Patients using Physician Compare to research physicians are unlikely to understand the nuances of how data is collected and reported on the site, and thus are not being shown an accurate summary of the physician they are researching, particularly if that physician is a specialist such as an ophthalmologist. In addition, there have been many errors with the data that has previously been posted on Physician Compare, and CMS must perfect its data collection process and fix the current data issues before releasing more data to the public via the Physician Compare website.

**ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)**

Generally, ASCRS has very few members who will be able to meet the thresholds required to significantly participate in an Advanced APM as a qualifying participant. CMS has itself stated that very few specialists will qualify for APMs in the first few years. We encourage CMS to develop and approve more APM options so that specialists have the opportunity to participate in these models if they so desire. Currently, the majority of APMs are focused on primary care. As specialists who are generally in small or solo practices and provide care in an office setting and in either an outpatient facility or an ASC, very few models exist for ophthalmologists. We urge CMS to foster development of models that accurately reflect specialty practices.

In addition, ASCRS requests more information on how CMS plans to use the episode groupers in the future to develop APMs. We understand there is the possibility of a ‘bundle of bundles’ for some specialties and we request CMS to work closely with us and all the ophthalmology specialty societies in the development of any ophthalmology episode groupers or bundles going forward.

**MIPS APMs and Partially Qualifying Participants**

- As we noted above, we encourage CMS to provide clear, prospective information to providers about their eligibility for credit under MIPS or full participation in an advanced APM. As proposed, providers will not know until after the reporting period is over if they qualified for the APM based on number of patients or payments. ASCRS appreciates CMS’ proposal to provide credit in MIPS for participation in some non-advanced APMS and allow for partial qualification for advanced APMS. While many current
models are primary care focused, we do have members participating in Track 1 ACOs and appreciate the opportunity for those providers to get credit. However, CMS’ proposal for APM qualifications is very complicated, making it nearly impossible for providers to determine whether they will qualify, and to what extent.

- We do not believe the proposal provides adequate protection for providers who intend to participate in an advanced APM and fall short of the patient or payment thresholds. To be certain they are not penalized, providers will have to report for MIPS, in case they do not meet the APM threshold. This is a disincentive for providers to participate in APMs, which seems counter to CMS’ stated goals.

- In addition, ASCRS supports a flexible approach that allows providers to move seamlessly between the MIPS and Advanced APM payment models.

CONCLUSION

In summary, ASCRS urges CMS to consider our comments closely and, of foremost importance, move back the first year’s performance period to allow providers time to receive education on the new program and implement new clinical work flows and administrative processes as required under MIPS. In addition, we also urge CMS to reinstate the Measures Groups, such as Cataract and Diabetic Retinopathy, in the Quality component to ensure providers can continue to report on measures that reflect a certain procedure or condition. We also urge CMS to lower the reporting thresholds for the Quality category.

We appreciate that CMS has made changes to the Advancing Care Information category that reflect our earlier comments, and urge the agency also to remove measures that hold physicians responsible for actions beyond their control. **We reiterate our long-standing opposition to the attribution methodology used in the Resource Use category.** Finally, we urge CMS to prioritize new advanced APMs that are workable for specialists.

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Thank you for providing our organization with the opportunity to present our comments on the proposed rule. Should you have any questions regarding our comments, please do not hesitate to contact Allison Madson, Manager of Regulatory Affairs, at amadson@ascrs.org or 703-591-2220.

Sincerely,

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