ASRS American Society of Retina Specialists

August 21, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services Department
of Health and Human Services Hubert H. Humphrey
Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program; Proposed Rule (CMS-5522-P)

Dear Administrator Verma:

The American Society of Retina Specialists (ASRS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule (CMS-5522-P), published on June 30, 2017 in the Federal Register, regarding the Quality Payment Program (QPP) implementing the MIPS Program (Program) and APMs under the Medicare Access and Chip Reauthorization Act (MACRA). ASRS is the largest retinal organization in the world, representing more than 3000 members in every state, the District of Columbia, Puerto Rico, and 59 countries.

We appreciate the administration's continued outreach to the physician community before and during the comment period on this proposed rule, including its briefings, webinars, and meetings with the AMA and national medical specialty societies, as it continues the transition to the QPP. We applaud CMS for proposing continued flexibility in the second year of the transition period as well as offering new opportunities for bonus points. As we noted in previous comments, extending transition year policies to ensure a smooth implementation of the new Program is both valued and appreciated by our members.

Overall, ASRS supports many of the recommendations that the American Medical Association (AMA) submitted in its comment letter regarding the MIPS Program given that APMs do not currently exist for retina specialists. In particular we support the following recommendations:

- Opposing inclusion of items or services beyond the physician fee schedule, especially Part B drugs, when determining MIPS eligibility, applying the MIPS payment adjustment, and in cost score calculations.

- Seeking more feedback and analysis of data before adopting an approach to measure and score improvement.

- Maintaining the cost category weight at zero for the 2018 performance period.

- Taking additional time to develop, test, and refine new episode-based cost measures prior to

including them in the MIPS Program in future years.

- Postponing the proposed ABC benchmarking methodology for Physician Compare star ratings.

We offer our detailed comments on the MIPS Program below. In addition to the points above, we also recommend the following:

- Maintaining the minimum 90-day reporting period with one year optional for quality for the second year performance period
- Maintaining flexibility to report only relevant measures by permanently eliminating requirement to report cross-cutting measures and global and population based measures
- Delaying phase out of topped out measures; at a minimum, increase the timeline for removal of topped out measures and do not cap points
- Improving risk adjustment and attribution methods in the cost category or reweight to another category
- Postponing improvement scoring for cost indefinitely until CMS develops a mechanism to account for changes in standard of care and cost effectiveness
- Delaying assignment of Part B drugs to physicians until CMS can track costs to all who prescribe drugs (Part B and D)

APPLICATION OF PAYMENT ADJUSTMENT TO PART B DRUGS

ASRS strongly opposes application of the MIPS payment adjustment to the cost of Part B drugs administered to patients during the payment year as these costs reimbursed to physicians serve as a pass-through mechanism to cover acquisition costs, and should not be impacted by payment adjustments. While payments to physicians for administering Part B drugs should be included in the payment adjustment along with other services, the cost of the drug itself should not be included. Applying the payment adjustment to a physicians' reimbursement for purchasing and administering the drug would penalize certain specialties and subspecialties and create a potential windfall for others.

Under the "buy and bill" payment methodology CMS reimburses physicians the average sales price (ASP) of the drug plus 6% or 106% (104.3% after sequestration adjustment). This extra 4.3% is not meant to be profit for physicians, but rather is intended to reimburse physicians for the acquisition and overhead costs of the drug. These costs can be significant, particularly for biologics, and include costs for shipping and handling, taxes, storage space, monitored refrigeration, maintenance, inventory tracking, disposal, loss, general staff time and other indirect costs. Given the paucity of cost data, in 2016 ASRS commissioned Quorum Consulting to conduct a study of 8 practices that could provide detailed cost accounting data for calendar year 2015 in the short time allotted in the comment period for the Medicare Program Part B Drug Payment Model [CMS-1670-P]. The study found that drug acquisition and overhead expenses for injectable drugs that have their own unique HCPCS J codes was, on average, 98.9% (range 96.5% to 103.2%) of total payments across the 8 practices. It is worth noting that given the limited time available to collect these data, only high-volume practices with capable financial staffs were able to

respond to the survey within the short window provided. Even under these circumstances, not all high volume practices generated net revenue from office administered drugs. In fact, our belief is that lower-volume practices, which provide the majority of patient care in retina around the country, would have less purchasing power and higher overhead costs compared to the practices in the study from which we were able to collect data.

Even in the first year of the Program, a physician subject to MIPS' maximum 4% penalty would almost totally negate the reimbursement meant to cover the direct cost of the drug. Once the Program penalties reach 9%, payment for the drug would be well below its actual cost to the physician.

In sum, if reimbursement for Part B drugs is reduced further as a result of application of a negative adjustment under MIPS, ASRS is concerned that many retina practices will cease purchasing such Part B drugs as the payment will not cover the cost. In these cases, patients with limited eyesight will be forced to travel further to hospital outpatient departments (HOPD) for their treatments where the cost of Part B drugs in this setting is not attributed to the physician. We do not believe that Congress intended this effect and CMS should seek clarification before it proceeds with its proposal. ASRS believes the payment adjustment that excluded Part B drugs should continue to be applied to as it has for the legacy (PQRS, VM and Meaningful Use) programs.

QUALITY PERFORMANCE CATEGORY

Overall, ASRS appreciates the CMS proposals to retain the 60% weight in the 2020 payment year for quality metrics, maintain the data completeness threshold of 50% for the 2018 performance year, and allow reporting through multiple mechanisms. However, CMS should not require physicians to explore alternative submission mechanisms to meet reporting requirements if they do not have enough measures to report under their chosen mechanism. CMS should only review the measures available to a physician given their chosen submission mechanism – claims, registry, EHR or QCDR – to determine if a physician could have reported on additional measures.

<u>Quality Performance Period Recommendation: Maintain the minimum reporting period of 90 days with the 1-year reporting period as optional</u>

We understand the desire to move to a 12-month performance period for quality, however, we request that there be a more gradual increase from a minimum 3-month reporting period to a 1-year reporting period for quality data submission. We ask that the one-year reporting period continue to be optional to better align with the other MIPS categories**.** This would permit reporting on a full calendar year for those physicians who believe it is more appropriate for their practice while providing the flexibility to select a 90-day reporting period to harmonize MIPS reporting or a 6-month reporting period to ramp up to a longer reporting period in coming years.

ASRS believes this flexibility could resolve problems that may occur if a physician updates or switches their EHR during the performance year. Moreover, a shortened reporting period would give physicians the opportunity to review quality data submitted on their behalf by a registry. ASRS has received several comments from members that they would like to ensure that the data that is submitted on their behalf via a registry is accurate and correctly mapped from their EHRs to QCDRs. While ASRS has confirmed that registry vendors plan to provide physicians with real-time snapshots of their quality data so that they can confirm its accuracy before it's submitted on their behalf, this is still a work in progress. In fact, many of our members did not receive feedback for the first two quarters of 2017 until mid-July and found that

their data was incorrect due to unresolved mapping issues. A 90-day or 6-month performance period would allow time for these dashboard improvements to be implemented, allow corrections to be made in data mapping, and promote continuous quality improvement.

Cross-Cutting Measures Recommendation: Permanently eliminate requirement to report

We appreciate that CMS eliminated the requirement to report on cross-cutting measures and take this opportunity to provide feedback regarding a potential requirement to report cross-cutting measures in the future. We believe that these measures should continue to be available for clinicians who are looking for additional measures to report outside of their specialty, but they should not be a requirement, particularly for subspecialists. Our members voiced concerns that cross-cutting measures such as the Preventive Care and Screening measures for high blood pressure, body mass index and tobacco cessation, are not appropriate for certain subspecialists to report. For subspecialists who are seeing patients based on particular episodes of care, it simply may not be appropriate to address all of a patient's co-morbid diseases and behavioral risk factors.

In addition, given the emphasis that CMS places on the merits of quality measures and improvement scoring, retina specialists should be relieved of the administrative burden of reporting on measures that are not relevant to their specialty or that relate to outcomes they cannot influence as it would be unrealistic to expect improvement from specialists on such measures. We continue to seek granularity in quality measure groups and ask that physicians continue to be allowed flexibility in reporting a lower number of quality measures and not be required to report cross-cutting measures.

Global and Population Based Measures Recommendation: Keep as optional

The ASRS previously urged CMS to allow global and population-based measures to be optional under MIPS because they potentially hold physicians, especially certain specialists, responsible for care they did not provide. Although CMS retained the all-cause hospital readmission (ACR) measure, which focuses on the delivery of primary care and does not apply to ophthalmology, we appreciate that CMS will not apply this measure to small practices. ASRS requests that CMS make these measures optional in the future or, at a minimum, maintain this policy to exempt small practices.

Eliminate the all-payer data requirement and make it optional

We agree with the AMA that the requirement to report all-payer data is counter to its goal to incentivize electronic reporting. As reporting measures through the claims option is only based on Medicare Part B patients, CMS is placing the highest burden on physicians who choose to report via methods it should be incentivizing— EHR, qualified registry, or QCDR. Therefore, physicians may be deterred from adopting electronic reporting mechanisms.

In addition, the all-payer data requirement is especially burdensome for small practices that do not have the resources to hire a full-time or part-time employee to collect and document quality information. Even if a practice has an EHR, much of the information that supports outcome and high priority measures is not captured within the EHR system, but instead is collected through manual key entry. **Therefore, we urge CMS to eliminate the all-payer data requirement and make it optional.**

Topped Out Measures Recommendation: Postpone the proposal or increase timeline for removal of topped out measures

We acknowledge, as CMS points out in the proposed rule, that when a large majority of clinicians

submitting topped out measures perform at or very near the top of the distribution, there is little or no room for the majority to improve. CMS believes asking clinicians to submit measures identified as topped out and for which they already excel is an unnecessary burden that does not add value or improve beneficiary outcomes. We disagree with the CMS assessment, as some of these topped out quality measures remain very relevant.

As stated previously, ASRS supports the long-term goals of reducing the reporting burden on physicians and improving quality by moving towards reporting meaningful measures that improve patient outcomes. **Yet we urge CMS to take a step back and reconsider its proposal to phase out these measures before implementing such a policy**. ASRS believes there is a value to reporting many of the measures that are topped out or coming close to that designation. While we agree that not all measures are useful over time, some of the topped out measures should be kept in perpetuity. Examples include: Class C infection (sepsis); complications of cataract surgery; post-operative infection after abdominal surgery; and central line infections. These measures are extremely important indicators as changes in quality on these fronts are strong gauges of quality care.

Moreover, **we believe CMS should not consider a measure "topped out" until the measure is topped out for every reporting mechanism**. As CMS notes **approximately 70% of claims measures are topped out**, while only 10% of EHR measures are topped out and 45% of registry/QCDR measures are topped out. Many physicians still report quality measures via claims, particularly those in small practices. Eliminating these measures will have a significant impact on the Program given the very high percentage of topped out measures reported via this reporting mechanism. We understand the desire to encourage reporting via mechanism other than claims, however, the ongoing issues and obstacles surrounding reporting via EHRs and registries, including interoperability, connectivity and timely performance feedback, must first be resolved to ensure that more physicians can switch to those mechanisms. This will take more time.

Further, we believe the timeline for removal should be adjusted to allow for the development of new measures to replace topped out measures. Measures development is a lengthy, complex, costly and time consuming process. Depending on the measure, it can take a minimum of one to three years after stakeholder internal development for a measure to go through field testing, refinement, obtain endorsement and CMS approval. Thereafter, working with EHRs and registries to enable electronic reporting can add additional years to the process.[1] For example, of the seven retina measures that American Academy of Ophthalmology (AAO) started developing with input from the retina societies in 2009, four have been approved as QCDR measures, but none have not yet completed field testing and refinement. Moreover, these four measures are only available for manual reporting. **If topped out measures are being removed faster than new measures are being developed there will not be enough measures for some specialists to report. CMS should either maintain topped out measures or lengthen the timeline for removal until more measures can be developed and approved.**

Finally, for some specialties such as retina, there are very few outcomes measures available to report and QCDR measures are still being tested or are only available for manual reporting. In some cases, the only existing outcomes measures are topped out. If CMS finalizes such a proposal, it is critical that it not penalize physicians or specialties with a low number of measures to report and ensure that the determination of which measures are "relevant" (under the Eligible Measure Applicability (EMA) policy or otherwise) is made with input from the applicable specialty.

[1] New measures must be submitted to CMS to be considered through a pre-rulemaking process (MUC and MAP), and are then proposed, finalized, or removed through the federal rulemaking process. Measures submitted to the MUC in 2017 would not be considered for implementation until 2019.

In sum, CMS should not implement a proposal to phase out topped out measures at this point in the Program. It should not proceed with such a policy until the Program progresses and additional new measures are developed. If CMS decides to implement its proposal, ASRS urges CMS to increase the timeline for removal of topped out measures, change the definition of topped out measure to include only those topped out in all available reporting mechanisms, consider each measure on a case-by-case basis, seek input from relevant specialty societies regarding which measures should be phased out and prior to eliminating a measure, and lengthen the phase out period to ensure more time to develop and field-test measures. Further, CMS should not cap topped out measures during the phase out period.

Scoring Quality Performance

Expand protections for reporting on new measures

To encourage reporting on new measures, CMS should institute protections to ensure that physicians are not penalized for reporting on new measures. Under the current scoring criteria, CMS does not create a benchmark or provide associated achievement points on a measure until after receiving first year data. If CMS cannot create a benchmark because less than 20 physicians report on the measure the maximum amount of points a physician can earn for reporting on the measure is three achievement points. Physicians will be discouraged from reporting on new measures if they can only earn a maximum of three points. **To encourage reporting on new measures, we recommend that CMS automatically award the maximum achievement points for reporting on new measures as long as the physician meets data integrity requirements.**

COST PERFORMANCE CATEGORY

ASRS appreciates that CMS again proposes to weight performance in the cost category at 0% for the 2018 reporting year. However the jump to a weight of 30% for the 2019 reporting year is concerning. Even though this percentage is required by the MACRA statute, ASRS opposes weighting this category until appropriate cost measurement is possible for all physicians. We agree with the AMA that CMS has recently taken a number of important steps to improve its ability to fairly and accurately measure and compare physician resource use. We appreciate its efforts to increase clinical input into the development of new measurement tools such as patient relationship categories and episode-based measures. **Recognizing that more time is needed to complete this very important work, we also believe that the weight of this category should remain at very low levels for several years beyond 2018 as it will take several years to develop a set of new episode-based measures that would cover a large percentage of physicians. We support the AMA and other physician organizations in pursuing legislation that would extend MACRA's two-year cost transition period to five years.**

In the interim, ASRS continues to have major concerns with the measures carried over from the Value-Based Payment Modifier (VM) to assess performance in the cost performance category. Despite acknowledging problems, CMS has continued use of the total per capita costs for all attributed beneficiaries (total per capita costs measure) and Medicare Spending per Beneficiary (MSPB) while episode grouper are under development. ASRS has repeatedly urged CMS to address weaknesses in its methods of adjusting for differences in physician specialty and subspecialty as well as patient risk, and to improve feedback to physicians to avoid inappropriate attribution of hospitalization costs to our members unrelated to their outpatient care for a particular patient.

Without refinements to VM attribution methodologies to distinguish between specialists and

subspecialists in the same field, many subspecialists, like retina specialists, may be inappropriately labeled as high-cost utilizers due to inaccurate attribution methodologies. For example, subspecialists that treat patients that require high-cost drugs or procedures would not be distinguished from physicians in the same specialty who do not provide similar treatment to similar patients, resulting in inaccurate "comparisons" and misleading information provided to patients. The typical patient population cared for by retina specialists is comprised of patients who are generally sicker, older, and have more comorbidities than the average ophthalmology patient. The conditions most commonly treated by retinal specialists include diabetic retinopathy, artery/vein occlusions, and wet age-related macular degeneration. While these conditions have effective pharmacologic treatments, there is no permanent cure necessitating continual monitoring and ongoing care. If not adjusted for, discrepancies in these patient populations, disease processes, and treatments would lead to inaccurate "comparisons".

As one step towards ensuring appropriate refinements, ASRS urges CMS to increase granularity when making peer-to-peer comparisons within provider specialties and sub-specialties to more accurately and appropriately capture the quality of care being delivered to Medicare patients. Under current program structure, CMS uses the Composite Performance Score to make broad comparisons regardless of provider specialty and sub-specialty for the purpose of applying adjustments to provider payments. We urge CMS to use taxonomy codes within this and other subspecialties to track physician performance and ensure relevant comparisons are being made between providers in MIPS. For example, NUCC recently approved new, voluntary healthcare provider taxonomy codes for ophthalmology subspecialties in retina, oculoplastics, uveitis, and glaucoma subspecialties. ASRS encourages CMS to further define "peer" groups of providers, as in the case of ophthalmology, throughout the QPP and as more specialty specific taxonomy codes become available.

That said, we appreciate that CMS indicates in the proposed rule that if it does not finalize a weight of zero percent to the cost performance category for the 2018 reporting year, it will use its statutory authority to redistribute weights under Section 1848(q)(5)(F). CMS proposes to assign a scoring weight of zero percent to the cost category in the 2020 payment year for those clinicians for whom it cannot reliably calculate a score for the cost measures that adequately captures and reflects the performance of a clinician and proposes to redistribute the weight of the cost performance category. For most clinicians, the weight of the cost performance category would be redistributed to the quality performance category. **ASRS appreciates this policy as it believes a clinician that is not attributed a sufficient number of cases or if errors in attribution are noted such that a measure cannot be scored reliably then the measure should not be scored for that clinician.**

So far, ASRS has received some limited feedback from its members on their 2016 QRUR reports. While some reported errors in attribution, other retina specialists indicated that they have not had many patients attributed to them. We will continue to monitor this. We support this policy since many retina specialists may not have cases attributed to them under the methodology applied to these cost measures.

For specialists, such as retina specialists who do have patients attributed to them under these cost measures, we urge CMS to ensure a transparent and fair review process to confirm attribution is appropriate. CMS should allow clinicians to object to the attribution and if they demonstrate that CMS cannot reliably calculate a score for the cost measures that adequately captures and reflects their performance, CMS should redistribute the cost score to another performance category.

Inclusion of Part B Drugs

CMS proposes to include the cost of Part B drugs in assessing the cost performance of physicians only when the cost can be tracked at an NPI level. ASRS strongly opposes this policy as the Medicare payment is merely a pass-through that covers physicians' acquisition costs. Moreover, as CMS acknowledges, it

cannot track costs to all who prescribe and administer such drugs equally. Retina specialists and other physicians that practice in academic medical centers and hospitals that do the purchasing and billing of prescription drugs on their behalf will not be assigned the cost of the drug because they did not bill for reimbursement. If this policy is adopted, then many physicians who provide these critically important drugs will have little choice but to refer their patients to hospital outpatient departments where Medicare and its beneficiaries will face higher costs. We, therefore, believe it is inappropriate and arbitrary to apply such a policy and urge CMS to limit MIPS cost calculation to the physician fee schedule.

Episode-Based Measures

ASRS appreciates that CMS has acknowledged difficulties with attribution under the current measures and will transition to episode-based measures. CMS proposes to add new episode-based measures that are still being developed and refined for the 2018 reporting year. Although ASRS does not have any episode-based measures under development that will apply to retina specialists, we do participate on the MACRA Episode-Based Cost Measures Clinical Subcommittee on Ophthalmologic Disease Management that is developing ophthalmology episode groupers. We urge CMS to account for differences among and within specialties and improve attribution with these measures.

In the interim, we fear CMS will continue to use the flawed cost measures utilized in the VM, which will perpetuate inaccurate and inequitable comparisons of costs among physician practices. Until CMS develops a risk adjustment method that can accurately account for various patient factors, distinguish among subspecialty physicians, and that has been sufficiently tested, CMS should not continue to use these measures or it should apply a flexible policy to review attribution and redistribute the weight of the performance category as discussed above.

IMPROVEMENT SCORING FOR COST AND QUALITY

MACRA requires CMS to implement improvement scoring in second year of MIPS for cost and quality if data "sufficient to measure improvement" are available.

Quality Improvement Scoring

We appreciate that CMS is attempting to implement this requirement for the quality category such that a quality improvement score may be available to a broad number of clinicians by measuring improvement at the performance category level. CMS notes, however, that by measuring improvement in quality based only on the overall quality performance category achievement percent score, some clinicians and groups may generate an improvement simply by switching to measures on which they perform more highly, rather than actually improving at the same measures. Additionally, while ASRS believes physicians should report measures that are meaningful to their practice, this type of measurement would mean that physicians are being judged on different quality measures which are not necessarily comparable.

If CMS proceeds with its proposal to phase out topped out measures, any clinicians previously reporting the topped out measures would have difficulty achieving improvement as they cap the score in those phase out years, and potentially even more difficulty in the phase out year. CMS should consider a mechanism that would not penalize physicians for changes in quality reporting that are out of their control such as elimination of measures, or the learning curve for reporting new measures.

While ASRS supports the goal of striving to improve patient outcomes, we are not confident that this proposed mechanism for quality improvement scoring will help physicians achieve that goal. In fact, we

concur with the AMA in its belief that adding improvement scoring at this time for both quality and cost is premature. **We recommend that CMS continue to seek feedback and experience regarding improvement methodologies at least through the MIPS transitional period before adopting an approach that, once put into motion, may be difficult to change.**

Cost Improvement Scoring

Although we acknowledge that improvement scoring is required by the MACRA statute if sufficient data are available, ASRS has strong concerns about the concept of rewarding clinicians for simply reducing costs regardless of the quality of care delivered.

One of the stated goals of the QPP is to improve beneficiary outcomes. ASRS is concerned, however, that the cost improvement score methodology may discourage physicians from using new technology and treatments that in some cases are arguably the most cost effective but not the least costly alternative. If physicians are incentivized to avoid such treatments it could lead to poorer beneficiary outcomes. In many cases lower cost may not equal higher quality.

Improvement scoring on costs does little to encourage the adoption of new technologies and drugs, such as FDA-approved technologies and drugs. For instance, physicians would be incentivized not to choose better therapies in an effort to maintain or improve the score. If Part B drugs are included in the cost calculations, physician prescribing practices could be negatively incentivized. Retina specialists in particular would be incentivized to switch to a less expensive drug that is not FDA approved for use in the eye, such as Avastin, to achieve cost improvements, even though the more expensive FDA approved drug, Eylea®, may in fact be a more effective treatment for the patient. For example, Diabetic Retinopathy Clinical Research Network (DRCRnet) Protocol T, which was funded by the National Eye Institute, found that the relative benefit of Eylea® was clinically and statistically significant for the subset of eyes that were 20/50 or worse at baseline. Moreover, according to the 2016 ASRS Preferences and Trends survey, 80 percent of respondents indicated that if Avastin, Lucentis and Eylea cost the same, they would use Eylea® for new-onset wet AMD. Many retina specialists start with Avastin in an effort to reduce costs and switch to a more expensive branded drug if Avastin fails to achieve results. We fear under this model, there would be a penalty for providing the patient the best treatment option. If there is an incentive to prescribe the lower cost alternative, patient outcomes may be negatively impacted.

Because the cost and quality performance categories are evaluated separately and quality measurement has not reached the point of consistently evaluating meaningful quality improvement, it is not possible to know if a physician that is high cost is actually delivering high quality and the most appropriate care to patients or whether he or she is just delivering costly but average care. The best care may require increasing costs from year to year. For example, there is currently no treatment for dry age-related macular degeneration (AMD) but some potential treatments are in the pipeline. Should those new treatments become available, they will no doubt be costly but may stabilize visual acuity and prevent further loss of vision. Under the current proposal, physicians would be penalized for providing more costly treatments that preserve the independence and quality of life for these elderly patients. **Improvement scoring in this category should be postponed until CMS can develop a mechanism to account for standard of care or cost effectiveness of the treatments provided.**

ADVANCING CARE INFORMATION (ACI) PERFORMANCE CATEGORY – Recommendation: Exclude measures out of physicians' control

ASRS appreciates and supports many of the changes that CMS proposes for the Advancing Care Information category as they continue to allow physicians to customize the program to better suit their needs. We appreciate that CMS allows physicians to receive 50 points from the base score by reporting a numerator of at least one for the numerator/denominator measure, or a "yes" response for the yes/no measure. ASRS also appreciates the flexibility that CMS offers in the proposed rule to allow physicians to continue to use 2014 CEHRTs, that CMS proposes a one-time bonus for those physicians who have switched to 2015 CEHRTs, and that CMS recognizes that certain areas may not have immunization registries, and modifies scoring for the clinical data registry reporting to allow retina specialists and other ophthalmologists the option to earn 5% for each public health or clinical data registry that they use. In addition, we appreciate that those who report to one or more public health agencies or clinical data registries, different from the registry used for the performance score, will earn a bonus score of 5 percentage points.

While we agree that patient engagement, care coordination and health information exchange are important goals, we continue to strongly oppose the requirements for Patient Electronic Access and Health Information Exchange measures that effectively hold providers responsible for the actions of patients and other physicians outside of their control. We ask that these measures be removed as requirements for fulfilling the base score.

The vast majority of retina specialists' patients are Medicare age. The top two retinal diseases that affect a large proportion of the Medicare population are age-related macular degeneration (AMD) and diabetic retinopathy and both diseases limit patients' sight. Many of the elderly patients are not likely to use a computer, thereby limiting our members' ability to meet the requirements of several patient-focused measures. For example, physicians would be held accountable for 10% of their patients to 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. Furthermore, retina specialists in rural areas have even more difficulty meeting these measures, as some of their patients do not have Internet access. Accordingly, retina specialists will continue to struggle to meet the Patient Electronic Access to Health Information and the Coordination of Care through Patient Engagement objectives.

We also continue to oppose the Health Information Exchange objectives that require the action of other providers. As we have commented previously, the Health Information Exchange objectives do not take into consideration EHR interoperability, rather their focus is on the quantity of information exchanged. Such metrics are poor indicators of interoperability as the focus is on the number of records exchanged and not the relevance of the information shared. EHR vendors often design their systems to make them just interoperable enough to meet existing Meaningful Use requirements, but not to facilitate true interoperability. CMS needs to focus on making the EHR vendors provide improved interoperability before penalizing physicians for not using features that don't exist on our specialty-specific EHRs. Again we urge CMS to re-focus the ACI category on specialty-specific interoperability use, rather than on the number of cases exchanged.

<u>Maintain Hardship Exemptions</u>

We appreciate that CMS is extending exemptions for small practices, practices with insufficient internet connectivity, practices facing extreme and uncontrollable circumstances, clinicians who lack of control over EHR decision-making, and practices with decertified EHRs. Given our membership, we continue to be concerned that many small and solo practices will not have the technical resources during a switch to ensure usability, interoperability, and security while continuing to focus on reporting. Nor will these small practices have the time needed to develop the internal guidance, principles and practices to ensure that these systems improve patient care. We acknowledge that CMS recognizes transitioning to CEHRT systems may take up to several years to resolve and appreciate that CMS has removed the limitations on

requesting such exemptions.

IMPROVEMENT ACTIVITIES (IA) PERFORMANCE CATEGORY - Recommendation: Continue flexibility and a broad inclusion of activities.

We appreciate that CMS is continuing its special consideration to the circumstances of small practices and practices located in rural and geographic health professional shortage areas by allowing them to report on one high-weighted or two medium-weighted activities. We also appreciate that simple attestation continues and that CMS is maintaining the required period of time for performing improvement activities to 90 days, allowing clinicians to continue to become more familiar with reporting the new measures.

ASRS applauds CMS for proposing to formalize a process for an Annual Call for Activities that will allow stakeholders the opportunity to recommend activities for potential inclusion in the Improvement Activities inventory. We urge CMS to continue to be flexible and include as many proposed IAs on the final list as possible.

NEW COMPLEX PATIENT BONUS

CMS is required under MACRA to consider risk factors and assess appropriate adjustments in scoring methodology under MIPS. As it waits for data from further studies to finalize a longer term approach, CMS proposes a one-time bonus payment for physicians who treat complex patients by using a proxy for patient complexity. Of the two options suggested, ASRS believes the Hierarchical Condition Category (HCC) could be an appropriate proxy to capture various indicators of medical complexity. HCC is based on age and sex; Medicaid eligibility, first qualified for Medicare on the basis of disability, or lives in an institution (usually a nursing home); diagnoses from the previous year. Although this may not include diagnoses in the current year, HCC scoring begins to account for a majority of complex patients that retina specialists treat. The typical patient population cared for by retina specialists is comprised of patients with diabetic retinopathy and elderly patients with wet-AMD and many of these patients have multiple medical problems. HCC does not completely address barriers to care such as patient compliance, logistical issues specific to patients with limited sight, and scheduling conflicts often related to the patient's dependence on sighted family and friends.

Overall, HCC is preferred by ASRS as an interim proxy for patient complexity and we encourage CMS to continue to consult with specialty groups as it develops a better methodology to appropriately adjust for complex patients in the long run.

PHYSICIAN COMPARE

<u>Concerns about the 30-day preview period – Recommendation: Extend the time period to a minimum of 90 days.</u>

We understand that CMS finalized the 30-day preview period in the CY 2017 Quality Payment Program Final Rule (81 FR 77392). However, in the past, there have been many errors with data posted on Physician Compare. CMS must improve its data collection process and fix the current data issues before releasing more data to the public via the Physician Compare website. Our members are concerned that 30

days is not enough time to adequately review information on Physician Compare, return feedback and ensure that the information will be published accurately. We ask that CMS revisit the preview period and recommend that the timeframe be extended to a minimum of 90 days.

Concerns about Accuracy and Validity of Information on Physician Compare- Recommendation: Seek specialty input prior to publicly releasing any new data.

MACRA requires CMS to publicly report information regarding the clinician or group's performance in the MIPS program. While it is laudable to provide as much actionable and pertinent information as possible on this website, ASRS notes that information provided on the site lacks the proper financial and socioeconomic contexts. Specifically, the ASRS is concerned that publishing data without social risk-adjustments could lead patients and consumers to misinterpret low quality scores for subspecialists who care for complex and socially vulnerable elderly patients.

Additionally, the site lacks an explanation for how Part B drugs are included in the total reimbursement. Retina specialists who buy and bill CMS for expensive injectable medications appear to spend more than retina specialists in academic settings where the reimbursement for drugs is returned to the hospital that purchased the drug even though these physicians may prescribe and administer the same amount as those in private practice. Therefore, meaningful costs comparisons among retina specialists cannot be made. Moreover, Physician Compare does not provide granularity at the subspecialist level to distinguish retina specialists from other ophthalmologists. Again we urge CMS to use the NUCC established taxonomy codes to enable more appropriate peer comparisons of services provided and billed, to assess individual provider quality and cost prior to publishing such comparisons for patients. Absent apples-to-apples comparisons, the data is not truly meaningful to patients and in fact, may be harmful, not only for the physicians, but also for patients who are forced to make decisions that are based on inaccurate or misleading data.

CMS proposes to use the ABC methodology to calculate benchmarks for MIPS quality data that will be published on the Physician Compare website. Our members reviewed the ABC comparison methodology and we strongly oppose using the methodology for subspecialists. Given the limited number of outcome based quality measures, compounded with relatively small numbers of subspecialists caring for complex patients, the ABC comparison methodology forces a star rating distribution that will not be accurately understood. We recommend that CMS continue to seek specialty society input prior to releasing more data to the public on Physician Compare.

Overall, we agree with the AMA that due to the lack of access to data it is difficult to analyze how its methodology for creating the MIPS benchmarks and calculating achievement points might conflict with the ABC methodology used to determine Physician Compare star ratings, and how these two methodologies would affect physician scores. The AMA has identified several concerns with the development of the ABC methodology, particularly that there has not been adequate time or sufficient detail for stakeholders to provide useful feedback. We share the AMA concerns **that physicians may be rated in 2017 under a new program using a new methodology that has not yet been publicly shared with stakeholders. We join the AMA in urging CMS to further explore this issue after more thoroughly briefing the AMA and specialties and providing additional time for feedback.**

SMALL PRACTICES

Small Practice Accommodations

In previous comments regarding the Program, ASRS urged CMS to assist physicians in small practices to ensure a successful implementation of the Program. As the majority of our members are in practices with five or fewer physicians, we expressed concern that the Program would disproportionally affect our members. We appreciate the continued flexibility and additional accommodations CMS has proposed for small practices in the proposal

Small Practice Bonus

ASRS applauds CMS for its proposal to add a 5 point bonus to the final score for physicians in a small practice who participate in at least one MIPS performance category. This should help many physicians achieve the performance threshold of 15 points and in general encourage participation in the Program. CMS requests comments regarding whether it should also apply such a bonus to clinicians practicing in rural areas. ASRS would support a similar bonus for such clinicians.

Determination of Small Practice Size

CMS proposes to assess practice size by utilizing Medicare administrative claims data to determine whether a group meets the small practice definition as opposed to attestation by the practice. The proposed data collection period would be for 12 months starting September 1st two years before the performance period through August 31st in the year prior to the reporting period. ASRS supports this proposal.

CMS defined the term "small practices" as practices consisting of "15 or fewer clinicians and solo practitioners." Practice size is determined by the number of National Provider Identifiers (NPIs) associated with a TIN, which includes clinicians who may be excluded from MIPS such as clinicians newly enrolled in Medicare or falling below the low volume threshold. While CMS may be constrained by statutory definitions, the potential for confusion and misinterpretation caused by this determination could unduly penalize physician practices. If a practice believes it is "small" because it has 15 or fewer MIPS eligible professionals, but actually has more than 15 NPIs within its TIN, it may incorrectly rely on beneficial scoring for small practices or on the small practice bonus when calculating the data it needs to report. **We join the AMA in urging CMS to only include MIPS-eligible professionals in defining small practices -- as those practices with "15 or fewer MIPS-eligible professionals."** Alternatively, if CMS is not able to define small practices this way, it should provide significant education to physicians regarding who will be included in the definition of small practices on the QPP website and in educational materials CMS distributes to physicians.

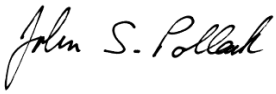
CONCLUSION

We appreciate CMS's willingness to involve the medical community in its efforts to develop the QPP and we urge CMS to continue to work with medical specialty societies as the QPP is refined, particularly on issues such as the development of episode-based measures, patient relationship codes, and risk adjustment models.

Thank you for the opportunity to present our comments on the proposed rule. If we may provide any additional information, please contact Jill Blim, ASRS Executive Vice President at jill.blim@asrs.org.

Sincerely,

Mark S. Humayun, MD, PhD
President



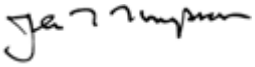
John Pollack, MD
President-Elect

Timothy G. Murray, MD, MBA
Vice President Governance

Carl Awh, MD
Treasurer

Philip J. Ferrone, MD
Secretary

Jeffrey S. Heier, MD
Vice President Education



John Thompson
Chair, Health Policy Council

Tarek Hassan, MD
Immediate Past President