ASRS American Society of Retina Specialists

September 12, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
7500 Security Blvd
Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

Re: File Code CMS-1832-P; Medicare Program; 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2025)

Dear Administrator Oz,

The American Society of Retina Specialists (ASRS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule.

ASRS is the largest retina organization in the world, representing over 3,500 board certified ophthalmologists who have completed fellowship training in the medical and surgical treatment of retinal diseases. The mission of the ASRS is to provide a collegial open forum for education, to advance the understanding and treatment of vitreoretinal diseases, and to enhance the ability of its members to provide the highest quality of patient care.

Please find a summary of our comments on the proposed rule as well as our full comments below.

For the Physician Fee Schedule (PFS) sections of the proposed rule, ASRS:

- Opposes CMS' proposed site of service differential to cut indirect PE values for facility-based services.
    - Continues to support the American Medical Association's (AMA) Physician Practice Information Survey (PPI) as the most accurate measure of the practice costs to provide care.
- Opposes the arbitrary and across-the-board "efficiency" adjustment that inappropriately assumes all time values in current code values are inflated.
    - Recommends CMS institute a complexity modifier to provide additional reimbursement when individual cases require more time and resources to treat.

- Disagrees with CMS' proposed value for dark adaptation and recommends implementing the RUC-recommended value.

- Responds to CMS' request for information (RFI) on global surgical codes and continues to recommend against across-the-board code modifications.

- Responds to CMS' RFI on the prevention and management of chronic disease.

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For the Quality Payment Program (QPP) sections of the proposed rule, ASRS:

- Supports CMS' proposed MIPS performance threshold of 75 points for 2026-2028.

- Supports CMS' effort to stratify MVPs by disease state or sub-specialty, but continues to question the utility of MVPs in general.
    - Recommends MVPs remain voluntary.
    - Responds to CMS' RFI on potential "core" elements for MVPs with concern it will return to initial stages of the QPP and force specialists to report on clinically irrelevant measures again.

- Thanks CMS for proposing to implement ASRS-proposed updates to our stewarded measures to improve clarity for physicians reporting them and encourages CMS to maintain a robust set of available quality measures in the program.

- Responds to the RFI on advancing digital measurement.

- Supports CMS' proposal to phase-in scoring for new measures in the Cost category.

- Continues to request CMS prioritize development of specialty-specific advanced alternative payment models (APMs).

CONVERSION FACTOR AND BUDGET NEUTRALITY

Retina specialists and other physicians have experienced cuts to the fee schedule conversion factor for the last five years, coinciding with record inflation in the economy. As the only Medicare providers who do not receive inflation-based updates, physician reimbursements have failed to keep up with the cost of providing care for many years. For retina specifically, average reimbursements in real dollars for the most commonly performed procedures fell 8.2% between 2011 and 2020, or 20.7% adjusted for inflation.[1]

We appreciate the relief Congress provided for 2026, but this one-time update does not provide sustainable levels of reimbursement for physician practices long-term. We continue to call on CMS to join with the physician community in advocating that Congress institute a permanent inflation-based update. In the meantime, we ask that CMS forgo policies that necessitate major budget neutrality adjustments and work with the physician community to address inadequate reimbursement that is within its current authority.

PRACTICE EXPENSE METHODOLOGY UPDATE

A key way CMS can ensure baseline reimbursement for physician services are adequate is through ensuring that PE values are accurate and evidence-based. **ASRS continues to support using the AMA's**

[1] DeRuyter NP, Patel S, Chen Q, Leder H, Leung E, Reddy R, Blim J, Awh CC, Hahn P; Health Economics Committee, American Society of Retina Specialists. Trends in Medicare Reimbursement for Common Vitreoretinal Procedures: 2011 to 2020. Ophthalmology. 2022 Jul;129(7):829-831. doi: 10.1016/j.ophtha.2022.01.019. Epub 2022 Jan 24. PMID: 35085660.

Physician Practice Information (PPI) survey results as the basis for CMS' practice expense methodology. CMS should work with the AMA to address its concerns rather than dismissing the survey results entirely. We strongly believe using real-world physician data is critical to ensuring accurate rate setting. We urge CMS to delay consideration of any modifications to the indirect expense methodology until the PPI data are implemented. Regular updates to this data are also crucial to ensure the long-term viability of physician practices.

Site of Service Differential Proposal

ASRS strongly opposes CMS' proposal to modify the allocation of indirect practice expense (PE) relative value units (RVU) in this rule. In making this proposal, CMS seeks to reduce duplicative payments for overhead and other indirect costs when procedures are performed in a facility. CMS points to the growing percentage of employed physicians and indicates it is reimbursing physicians for the cost of offices they no longer maintain.

We disagree with CMS' rationale that there has been a large reduction in private practices. Retina specialists, and other ophthalmologists, remain largely in private practice maintaining their own offices. ASRS' recent 2025 *Preferences and Trends (PAT) Survey* found that more than 76% of domestic retina specialists are currently in private practice.[2] This is in line with the AMA's recent physician benchmark survey that found ophthalmology was the specialty with the highest percentage of private practice by far at 70.4%.[3] The overwhelming majority of retina specialists would lose reimbursement for the indirect costs of running their practices, such as overhead and coding and billing, that are still incurred whether they are providing services in a facility or clinic.

In fact, it is the indirect costs of maintaining an office that have squeezed retina specialists the most in recent years. Rent, benefits, EHR subscriptions, and other regular expenses have grown along with overall inflation, but some key cost centers—such as staff salaries—have skyrocketed. The increased patient load and competition from other providers like hospitals make it difficult for retina specialists to hire and retain good clinical and administrative staff. A large practice in Tennessee notes that comparing 2019 to 2024, staff costs were up 63% and in the last twelve-month period had a 31% labor turnover rate. A mid-size practice in Pennsylvania reports a similar turnover rate in 2024 of 32.9% and a 26% increase in benefits costs between 2019 and 2024. To keep up with demand, this practice has also increased its average entry level wage by 13% over that same time period. A solo practice in Florida notes they cannot keep pace with local wages even offering 5% raises every year.

These cost pressures continue to mount, even as demand has grown. Office-based medical interventions with anti-neovascular growth factor (anti-VEGF) drugs have become the dominant treatment for prevalent chronic retinal diseases such as age-related macular degeneration (AMD) and diabetic retinopathy. This means retina specialists have to devote more of their time caring for patients in the clinic, rather than the OR. Compounding this, recent reimbursement reductions for surgical care make it financially challenging for retina specialists to leave clinic to perform surgery, such as retinal

[2] American Society of Retina Specialists, 27th Annual Preferences and Trends Survey, July 2025, https://www.asrs.org/clinical/pat-survey
[3] American Medical Association, Physician Practice Benchmark Survey, June 2025, https://www.ama-assn.org/about/ama-research/physician-practice-benchmark-survey

detachment repair.[4] Cutting the indirect practice expense to surgical reimbursement means retina specialists will lose money every time they leave the clinic, making it difficult to justify performing sight-saving surgeries when their practice will be at risk of insolvency.

Retina specialists who are employees of hospitals or health systems—typically academic medical centers—also carry some indirect costs. Contracts can vary by institution, but some may require employed physicians to contribute to the cost of overhead as well. Reducing the indirect practice expense, regardless of employment model, will endanger retina specialists' ability to provide the care patients require.

EFFICIENCY ADJUSTMENT

ASRS also strongly opposes CMS' arbitrary and across-the-board "efficiency" adjustment, which would further reduce access to care. Paired with the above site of service differential, it will drastically reduce physician reimbursement without any evidence to support it. Basing these reductions on accumulated productivity adjustments to the Medicare Economic Index (MEI) is also unfair since physicians do not receive MEI-based inflationary adjustments like other Medicare providers. Physicians should not be subject to this productivity adjustment without also being able to realize the gains from the MEI itself.

ASRS continues to strongly support the AMA RUC process. Like the PPI mentioned above, it represents a good-faith effort by physicians to categorize and value the relative effort it takes to furnish each of the thousands of procedures included in the physician fee schedule. Every code is carefully evaluated so specialists across medicine have the opportunity to provide input and ensure that time and intensity are accurately and fairly accounted for. The process can seem cumbersome, but its precision is vastly preferable to the proposed across-the-board cut that erroneously assumes all procedures realize efficiency gains at exactly the same rate.

ASRS members are concerned that CMS is over-simplifying how retina specialists and surgeons across medicine improve their skills over time. Retina specialists first coming out of fellowship may take longer to perform procedures and they typically do become quicker as they become more experienced, but that time improvement tends to level out at about five years. The RUC process accounts for this differential between surgeons of varying experience by surveying practitioners at different career stages and often recommends work values at the 25th percentile of the survey, rather than the median. This means most surgeons are already not being compensated for the time it takes them to provide the service. True reduction in procedure times come system-wide when new treatments or technology are developed and introduced. RUC also incorporates these gains by requiring re-valuation at shorter intervals for new technology. Again, these refinements are applied service-by-service rather than arbitrarily to every service.

Becoming efficient does not necessarily translate to cost savings. The combination of novel treatments and a rapidly expanding patient population of older Americans over the last few decades has exponentially increased the demand for retina specialists' services. To see the number of patients

[4] Leung EH, Patel S, Reddy R, Boucher N, Sharma C, Blim J, Ferrone PJ, Hahn P; American Society of Retina Specialists Health Economics Committee. Opportunity Cost of Vitreoretinal Surgeries. J Vitreoretin Dis. 2023 Jun 17;7(4):275-280. doi: 10.1177/24741264231178590. PMID: 37927325; PMCID: PMC10621695.

requiring treatment, retina specialists and their practice staffs have been forced to innovate in care delivery, making significant investments in both human and physical capital. Retina specialty practices now routinely employ a much higher percentage of both clinical and administrative staff to physicians than they did the past. The same Tennessee practice mentioned above now has 15.28 employees per physician, versus the 12-13 per physician they had in 2019. Techs help physicians run the clinic smoothly by anticipating physician needs and preventing long patient waits. Scribes allow the physician to focus on the patient rather than a computer screen, while billers spend countless hours behind the scenes working with payers to obtain authorizations and ensure patients will have access to the care they need. Patients appreciate this ease of access, but it does not come without a cost.

Despite the RUC's built-in safeguards to ensure time accuracy, retina specialists report that factors such as patient complexity can make cases take longer. For example, complex retinal detachment repair (CPT code 67113) requires the surgeon to select from several different surgical techniques, such as scleral buckling, draining subretinal fluid and/or removing the lens, which can vary the surgical time significantly. A recent study found the time variation across cases to be 20 to 30 minutes.[5] This aligns with a trend observed across medicine and surgery showing that surgical times are increasing due to patient complexity.[6] CMS does not take these factors into account and provides no evidence to show that overall times are decreasing. Furthermore, by reducing reimbursement, retina specialists may not be able to take on the more complex cases that require significantly more time.

Retina procedures can have unpredictable procedure lengths, and are often performed on an emergent basis, so many surgery centers across the country have reduced or eliminated access for these surgeries because they cannot cover their costs. Approximately 70% of US retina specialists reported challenges accessing OR time in the 2025 *ASRS Preferences and Trends* survey. Adding a new pressure from CMS' proposed efficiency adjustment could exacerbate these existing challenges and lead to patient harm. While patient outcomes benefit from experienced surgeons who can perform procedures within a reasonable time, efforts to reduce the time too much could be dangerous and lead to costly complications. It is unlikely surgeons will be able to decrease their operating times further. By making these reductions, Medicare would be moving away from evidence-based values and not compensating surgeons for the time it actually takes to complete the procedure.

Instead of penalizing physicians for unfounded efficiency gains, we recommend that CMS implement a modifier that provides additional reimbursement for complex cases that require extra time and resources to furnish. ASRS recommends CMS implement a new modifier to adequately compensate surgeons for the additional work they do to care for complex patients . This modifier could be applied in cases when a patient does not fit the definition of a "typical" case, such as having relevant co-morbidities or other recent surgery. Other situations that have been documented to increase time, such as instructing a trainee, could also quality for this modifier. To address the ongoing challenges retina

[5] Angermann R, Huber AL, Hofer M, et al. Efficiency benchmarks in the surgical management of primary rhegmatogenous retinal detachment: a monocentric register cohort study of operating room time metrics and influential factors. BMJ Open 2021;11:e052513. doi:10.1136/bmjopen-2021-052513

[6] Childers, Christopher P MD, PhDa,b; Foe, Lauren M MPHc; Mujumdar, Vinita JDc; Mabry, Charles D. MD, FACSd; Selzer, Don J MD, MS, FACSe; Senkowski, Christopher K MD, FACSf; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRSg,h,i; Tsai, Thomas C MD, MPH, FACSc,j,k. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. Journal of the American College of Surgeons ():10.1097/XCS.0000000000001588, August 13, 2025. | DOI: 10.1097/XCS.0000000000001588

specialists are facing to schedule OR time, a similar modifier or adjustment should be considered for the facility fee when patients are particularly complex or need emergency surgery.

CUMULATIVE IMPACTS OF CMS' RVU PROPOSALS

ASRS strongly opposes the proposals to modify both practice expense and work RVUs. Taken together, they would have a profound impact across the healthcare system. By drastically and arbitrarily modifying RVUs in the fee schedule, CMS also risks destabilizing access to care and the cost of care for all patients. If they cannot sustain the costs of running an independent practice, physicians will be forced to move away from community-based practice into the larger systems CMS seeks to prevent.

Furthermore, CMS risks creating workforce shortages. The additional two-year fellowship and long-term administrative hassles associated with the Part B drugs retina specialists administer has already made retina a less-desirable sub-specialty for physicians-in-training resulting in un-filled fellowship slots each year. The additional pressures CMS introduces in this proposed rule will only worsen that trend and potentially leave an aging population without sufficient retina specialists to meet their needs.

ASRS strongly urges CMS to reverse course and not finalize these proposals.

SPECIFIC CODE VALUATIONS: DARK ADAPTATION, 92284

ASRS urges CMS to accept the RUC-recommended work RVU of 0.32 for CPT code 92284. CPT code 92284 describes diagnostic testing for symptomatic visual loss and requires that a physician interprets the validity of the test for each eye. There is increased intensity/complexity of work involved with the diagnostic test due to a greater amount of data and more diagnostic possibilities to consider than the screening test. For patients with nyctalopia or other complaints of poor night vision, a dark adaptation plot of each eye with multiple points of sensitivity vs. time after beginning of the dark adaptation for each eye is interpreted by correlating to age-adjusted norms, physical findings, comorbidities known to affect night vision (e.g., retinal degenerations such as retinitis pigmentosa, cone dystrophies and Stargardt's disease, as well as acquired conditions such as vitamin deficiencies, age-related macular degeneration and diabetic retinopathy), and, if available, compared with prior test results.

The RUC-recommended intra-service work time and work RVU of 0.32 is commensurate with the overall time and intensity required for the physician who administers the test, reviews results for each eye to determine reliability and interocular consistency, analyzes the validity of the test by evaluating fixation losses, correlates both the dark adaptation rod and cone plots and the rod/cone breakpoint with age-adjusted norms, physical findings, and prior test results, interprets the plots of retinal sensitivity over time for the two eyes, determines the diagnosis or formulates a differential diagnosis and need for subsequent testing, and prepares a report and enter it into the medical record.

The RUC time and work value recommendations are based on a valid survey of 35 clinicians who performed the procedure and completed the survey. CMS states that the RUC-recommended intra-service time and work RVU, both of which are supported by a direct crosswalk to CPT Code 92228, *Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral* (work RVU = 0.32, 7 minutes intra-service time, 9 minutes total time), are overstated relative to the current intra-service time and value.

CMS offers no evidence or data to support its claim that "the RUC-recommended intra-service work time and work RVU are overstated." **ASRS strongly recommends that CMS only finalize code values that are based on rationale consistent with the established methodology RUC uses.**

Additionally, CMS overlooked three codes in stating that "the recommended work RVU of 0.32 fell near the top" of the range of codes with the same intra-service time and similar pre- and post-service times. Since 2015, the following codes have been valued with identical intra-, pre-, and post-service times: MPC 71111, CPT 92228, and CPT 72083. Two of these three are valued at 0.32 RVU. The third (CPT 72083) has a work value of 0.35 RVU. The recommended value of 0.32 RVU is at the lower end of the range for codes with identical times. We found only two eligible crosswalk codes valued in this same recent time frame with work values of 0.29 RVU: CPT 71110 and 92132. Both have shorter intra-service times (6 minutes) than CPT 92284 (7 minutes). CPT 92568, on the MPC list, is also valued at 0.29 work RVU, but carries a different intra-service time of 8 minutes and has not been revalued in the past 10 years.

CMS' chosen crosswalks of 92132 and 71110 have intra-service times of 6 minutes, 1 minute less than the median survey time of 7 minutes. Using them to value CPT 92284 will lead to distortion of relativity in the database rather than maintaining it as CMS claims. Using a crosswalk to CPT 92228, with identical times as the survey medians, will maintain relativity between services in the database. Moreover, there are only two eligible crosswalk codes valued in this same period with a work RVU of 0.29, specifically CPT code 71110 and CPT code 92132, both of which CMS used as reference codes in their proposed recommendation. ASRS believes that this crosswalk supports the most valid time estimate when compared to the time proposed from physician experts familiar with the latest technology and potential range of eye diseases. Further, the RUC recommendation more appropriately maintains rank order and relativity within the payment schedule.

GLOBAL PAYMENTS – REQUEST FOR INFORMATION (RFI)

ASRS appreciates CMS' interest in assuring that the shares of pre-operative and intraservice work relative to post-operative work for global surgery codes are accurate. However, we continue to oppose any across-the-board valuation reductions to global codes, whether it be to address the percentage split of post-op care discussed in the rule, or in general. ASRS and our colleagues across the surgical community continue to refute CMS' arbitrary assumptions that post-operative care is not being provided and urge any revaluations be done through the established RUC process that takes an individual and relativity-based approach to assigning value.

In this RFI, CMS asks whether data collected through the ongoing requirement for targeted practices could be used to help determine how payment should be split when a practitioner other than the operating surgeon provides post-operative care. We reiterate our comments from the 2025 proposed rule that this situation does not typically apply to retina specialists because other than in the immediate days following emergency surgery where another surgeon in the same practice may see the patient once due to scheduling conflicts, retina specialists typically see their surgical patients for all follow-ups. Regardless, we have long-standing concerns with the validity of the data gathered through the ongoing process and strongly recommend against using it to make any sort of valuation decisions.

The HHS Office of Inspector General (OIG) agrees with our concerns related to this data collection. In two reports issued this summer, OIG faults CMS for an ill-managed and not well-publicized process that

has left surgeons, other providers, and contractors confused about its requirements and intentions.[7],[8] ASRS and our coalition partners have raised these concerns in the past and recommend CMS discontinue this program. If CMS has concerns that it is paying for visits that are not being performed, it should flag those codes for RUC revaluation instead.

PREVENTION AND MANAGEMENT OF CHRONIC DISEASE RFI

As providers of care for millions of seniors who suffer from potentially-blinding chronic disease, retina specialists are strongly supportive of this administration's focus on the prevention and management of chronic disease. In particular we applaud the focus on how Medicare can support and improve quality of life for chronic disease patients. Numerous studies link visual impairment and poor ocular health with worse mental health outcomes, including depression. [9],[10],[11] Retina specialists strive to tailor medical and surgical treatments to the individual needs of their patients, helping them to maintain independence, and preventing other issues, such as falls. Not only does this care benefit the patient's overall health, it also has a positive impact on economic activity.[12]

With the exception of some diabetic eye disease, chronic retinal disease is not entirely preventable and largely develops as an expected part of aging. Early intervention, however, can make a significant difference in patient outcomes and ASRS supports efforts to ensure at-risk patients are screened early and regularly to monitor and potentially slow disease progression. Retina treatments, particularly physician-administered Part B drugs, can be costly, and therefore, treating at an earlier stage could mean less intensive and costly treatments over time. To ensure older patients are receiving these early exams, CMS could consider adding a dilated eye exam as part of the "Welcome to Medicare" visit covered for beneficiaries aging into the program.

Early intervention to stop or slow progression, paired with ongoing treatment leads to the best outcomes and helps maintain patients' quality of life. The treatment burden associated with chronic retinal disease can be high, so retina specialists are researching ways to cut down on visits, imaging, and injections. Recent breakthroughs have focused on addressing this, and so the newer generation of treatments such as Vabysmo (faricimab) and Eylea HD (aflibercept), are longer-lasting and/or more powerful doses of older therapies.

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[7] "CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries." HHS Office of Inspector General, June 26, 2025. https://oig.hhs.gov/reports/all/2025/cms-should-improve-its-methodology-for-collecting-medicare-postoperative-visit-data-on-global-surgeries/

[8] "CMS Should Confirm when it is Receiving Medicare Postoperative Visit Data on Global Surgeries when Reporting is Required." HHS Office of Inspector General, August 27, 2025. https://oig.hhs.gov/reports/all/2025/cms-should-confirm-it-is-receiving-medicare-postoperative-visit-data-on-global-surgeries-when-reporting-is-required/

[9] Fonteh, C.N., Mathias, M.T., Mandava, N. *et al.* Mental health and visual acuity in patients with age-related macular degeneration. *BMC Ophthalmol* 22, 391 (2022). https://doi.org/10.1186/s12886-022-02602-9

[10] Demmin, D. L., & Silverstein, S. M. (2020). Visual Impairment and Mental Health: Unmet Needs and Treatment Options. *Clinical Ophthalmology*, *14*, 4229–4251. https://doi.org/10.2147/OPTH.S258783

[11] Virgili G, Parravano M, Petri D, Maurutto E, Menchini F, Lanzetta P, Varano M, Mariotti SP, Cherubini A, Lucenteforte E. The Association between Vision Impairment and Depression: A Systematic Review of Population-Based Studies. *Journal of Clinical Medicine*. 2022; 11(9):2412. https://doi.org/10.3390/jcm11092412

[12] Karen Mulligan, Jaehong Kim, Bryan Tysinger, Jill Blim, Geoffrey Emerson, Philip J. Ferrone, Judy E. Kim, Seth Seabury, Paul Hahn; The Broader Economic Value of Treatment for Diabetic Macular Edema. *Diabetes Care* 1 June 2023; 46 (6): 1196–1203. https://doi.org/10.2337/dc22-2527

Yet outside of traditional Medicare, patients may not be able to realize those benefits and be forced to receive more doses of less-effective therapies because of insurer demands. Medicare Advantage (MA) and commercial payers routinely implement onerous prior authorization and step therapy requirements for most anti-VEGF drugs. Patients are generally required to fail first with off-label Avastin (bevacizumab) that must be repackaged for ocular use before the insurer will cover FDA-approved drugs. These newer generation therapies have come on to the market at the same time as biosimilar versions of the first-generation drugs, which can frequently mean insurers make patients fail through several steps before they are granted access to the newest and likely most effective treatments. With every additional step an insurer imposes, it lengthens the time from the patients' initial diagnosis—sometimes by months—and potentially worsens their disease. **ASRS continues to recommend that CMS revoke MA plans' ability to impose step therapy so that all Medicare beneficiaries have equal access to newer, longer-lasting treatments.**

QUALITY PAYMENT PROGRAM

MIPS Performance Threshold

ASRS joins with our colleagues across medicine **and supports CMS' proposed 2025 MIPS performance threshold of 75 points for 2026 through 2028**. Participating in the MIPS program is costly and time-consuming for retina practices. We thank CMS for recognizing that maintaining consistency from year-to-year helps make participation in the program more predictable and enables practices to make relevant adjustments in response to feedback from prior years.

MVPs

ASRS thanks CMS for listening to medical community feedback and supports the proposal in this rule to stratify the MVPs broadly by condition or sub-specialty. We believe this change will simplify reporting for clinicians who choose the MVP option and help patients make relevant comparisons between providers. **We continue to have concerns about the MVP concept in general, however, and strongly recommend that it remain a <u>voluntary</u> option.** We appreciate that CMS has not set a definitive date to sunset traditional MIPS and urge that it remain a participation model indefinitely.

Transitioning all clinicians to MVPs would introduce additional complexity into the program without remedying the long-standing drawbacks and administrative hassles of MIPS. MVPs, while well-intentioned, maintain the same confusing and disparate scoring methodologies for each of the four categories and offer only a modicum of burden reduction by reducing the number of required quality measures from six to four. MVPs also include population-based administrative claims measures. Counterintuitively, these measures, which CMS sees as reducing burden, actually increase it because physicians do not know what patients are being measured and how the actions of other clinicians will impact them. This adds a financial risk they have little ability to control.

Finally, the group-level and sub-group-level reporting options are confusing and complicated. While retina specialists are generally in single-specialty practices and would likely report the ophthalmologic MVP across the entire TIN, we oppose any automatic measure or MVP assignment by CMS. Keeping with our call to maintain MVPs as a voluntary option, physicians should have the sole ability to choose the participation option, measures, and activities that most reflect their clinical practice.

MVP "Core Elements"

ASRS also opposes and questions the usefulness of a new "Core Elements" requirement for MVPs. Not only should a physician have the ability to select measures, but this concept would seemingly reinstate the original cross-cutting measure requirement that was removed from the Quality category several years ago. If CMS determined at that point cross-cutting measures were not necessary, it does not provide rationale for why they should be returned to the program.

ASRS has long-opposed these types of requirements because they force retina specialists to report on primary care-based measures irrelevant to their clinical practice. We appreciate CMS' clarification at a recent AMA-hosted briefing that the required core elements would be tailored to each MVP. This is preferable to across-the-board requirements; however, it exacerbates the difficulty comparing sub-specialties within an MVP. Retina specialists as ophthalmic sub-specialists are grouped with all other ophthalmologists in the Complete Ophthalmologic Care MVP even though they treat different diseases and provide different care than, for example, cataract surgeons or glaucoma specialists. Even identifying one common ophthalmic measure that all participants could report would be difficult—and comparing their performance irrelevant. We urge CMS not to move forward with the core element concept.

ASRS-Stewarded Measure Updates

ASRS thanks CMS for proposing updates to two of the quality measures we have developed and stewarded:

- #500 - Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up
- #501 - Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up

As registries implemented these measures after they were approved for 2024, we determined that the wording for the expected frequency of reporting these measures was not clear. We recommend CMS finalize the proposed changes to clarify that they should be reported once per performance period.

We appreciate the assistance and input CMS provided throughout the multi-year process ASRS has undertaken to develop these measures. They ensure our members can continue to participate in the MIPS program and provide information to patients suffering from retinal disease. This has been an expensive and labor-intensive endeavor for a small organization like ASRS, but we continue to believe it is worthwhile to improve the quality of care and differentiate the care retina specialists provide. We strongly recommend that CMS maintain a robust set of quality measures that provide all specialists and sub-specialists with relevant reporting options.

In its rulemaking, briefings with the medical community, and one-on-one conversations, CMS has time and again stressed its desire to reduce or limit the number of available measures, activities, and MVPs as a means of reducing burden. We join with our colleagues across medicine to push back on that notion. Specialists and sub-specialists, like retina specialists, have devoted decades to their education to become experts in their subjects. As medical doctors they must consider the overall health of the patient. A few, generalized measures targeting things like medication reconciliation or advanced care planning do not represent the core of what they do and provide no help in guiding a patient needing specialized care for a specific medical issue. It is more burdensome for specialists to report generalized

measures because they have to add administrative processes and use valuable time with the patient on issues that are not the focus of the visit. We strongly encourage CMS to maintain a wide range of measure options and continue to work with specialties who are identifying real gaps in care and striving to close them by developing measures.

Promoting Interoperability (PI) - Security Risk Analysis Attestation

CMS proposes to require an additional attestation in the PI category affirming that the clinician or group has taken steps to implement security risk management. While well-intentioned, we do not believe this requirement should be added to the category. These requirements are already part of the HIPAA Security Rule and including them in MIPS is redundant and burdensome. Over the past few years, retina practices nationwide have been the victim of cybercrimes and ASRS members have taken significant action to prevent these attacks that jeopardize patient personal data, clinical operations, and the financial health of their practices. We recognize CMS is seeking to protect those same things, but do not believe this duplicative requirement is necessary.

We do, however, encourage CMS to consider ways to incentivize these protections across the healthcare system. Last year, retina specialists and providers across the system were paralyzed by an attack on the Change Healthcare clearinghouse—through no fault of their own. This massive attack demonstrated the interconnectedness of the healthcare system, showing that one seemingly isolated incident where basic security protocols were not followed had major repercussions for all patients and providers. We urge CMS to identify ways to hold insurers, vendors, and other intermediaries in the healthcare system with access to electronic patient data accountable for cybersecurity risks.

Advancing Digital Measurement RFI

As noted above, ASRS is committed to quality reporting that is clinically-relevant and not overly-burdensome. We join with our colleagues in the AMA and across medicine to commend the administration's focus on transitioning to digital quality measures (dQMs) that will accomplish both those goals. We also agree that the transition must be handled in a way that avoids disruption and unnecessary, expensive additional steps. We encourage CMS to move directly toward Fast Healthcare Interoperability Resources-based (FHIR) standards for dQMs and provide the infrastructure to assist measure stewards in developing and transitioning their existing measures to those standards.

For a small medical society like ASRS, developing our three clinical quality measures (CQMs) cost more than $300,000 and countless un-paid hours of labor from our physician members. Adding an interim step of requiring specifications for a FHIR-based electronic quality measure (eCQM) version would be time-consuming and costly. It is also difficult to guarantee that we or other developers could accomplish that step before it is outdated and the dQM standard is required.

If CMS elects to move toward the dQM option directly, we request that sufficient time and assistance is available to stewards and developers to make the change. Budgeting and planning for these activities can be a multi-year prospect. Doing so to meet a new standard will require additional time, expertise and testing. We request CMS provide flexibility and a transitional period for developers to update and clinicians to implement new measure versions. Without a phased approach, CMS risks both developers and clinicians exiting the program.

Cost Measure Phase-In

ASRS supports CMS' proposal to implement a two-year informational phase-in for new cost measures. Retina specialists are not currently eligible for existing cost measures in MIPS, however, were a measure to become part of the program this educational period would be useful. Adding cost measurement would be a major change for retina specialists, so a grace period could assist them in making modifications to their practices or clinical processes without the added pressure of potential penalties. In addition, this informational period would provide the opportunity to identify and potentially remedy issues with the measure specifications. For example, CMS would not have had to recalculate and modify clinicians' scores in 2023 when ASRS and other ophthalmic societies raised concerns with retina specialists being inappropriately attributed the Diabetes cost measure. We recommend CMS finalize this proposal.

A-APMs for Specialists

ASRS and our colleagues in the Alliance of Specialty Medicine and the Surgical Coalition have long called for specialty-focused and/or specialty-specific A-APMs. We reiterate that call here and note that the need is even greater now as CMS implements the statutorily-required split conversion factor for qualifying participants (QPs) and non-QPs, and states its desire to prevent further consolidation of physician practices into hospital-based systems.

Currently, retina specialists participate in A-APMs at very low rates. Those who do are typically academic-based and have little input into their institution-wide participation. Popular models such as accountable care organizations (ACOs) are primary care-focused and do not specifically target or measure the care retina specialists provide. Because most retina specialists are in private practice, they have limited if any opportunities to join ACOs because of perceptions that the cost of care they provide will impact scores.

So far, CMS' Innovation Center has resisted implementing specialty-focused or physician-developed models, and has never even tested a model recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). However, if they maintain that stance, independent physicians like retina specialists who are under threat from CMS' indirect PE and efficiency adjustment proposals, may view the higher conversion factor for QPs as more incentive to join hospital systems that are participating in ACOs. This would not only preclude any advances in value-based retina care, but would be costlier to the system overall by adding to the ranks of facility-owned practices.

ASRS recommends CMS and the Innovation Center rethink their strategies for incorporating specialists into A-APMs. We encourage the Innovation Center to test and potentially implement proposals vetted by PTAC and work directly with specialties to identify gaps in care or actual cost inefficiencies. Retina specialists possess a true spirit of innovation, demonstrated by clinical breakthroughs that have saved the sight of millions who once had no treatment options, while revolutionizing their practice models to ensure those patients receive the care they need. They are ready and willing to make further transformations in care delivery if they have the assurances that they have a reliable partner in CMS.

CONCLUSION

Thank you again for the opportunity to provide comments on this proposed rule. If you have questions, please contact Allison Madson, vice president of health policy, at allison.madson@asrs.org.

Sincerely,

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President
American Society of Retina Specialists