September 14, 2026

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

Submitted electronically via www.regulations.gov

RE: [CMS-1832-P] Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements

Dear Administrator Oz:

On behalf of the members of the American Society of Cataract and Refractive Surgery and the Outpatient Ophthalmic Surgery Society, we are writing to provide comments on the CY27 Medicare Physician Fee Schedule (fee schedule) and Quality Payment Program (QPP) proposed rule as published in the *Federal Register* on July 14, 2026.

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 6,500 ophthalmologists in the United States and abroad who share a particular interest in and commitment to advancing the art and science of ophthalmic surgery.

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

Despite continued increases in practice costs and inflation, ophthalmologists are, once again, facing significant reductions in Medicare physician reimbursement. While the reductions to the 2027 proposed conversion factors are primarily a result of the expiration of the 1-year 2.5% Medicare physician payment increase for 2026 that was enacted by Congress, significant changes to the practice expense methodology, as well as other proposals included in this rule, exacerbate the overall impact for 2027 and beyond.

We acknowledge that CMS does not have the authority to reform the Medicare physician payment system so that physicians receive an inflation update, however CMS continues to implement payment policies that result in significant reductions to

reimbursement for specialty physicians due to budget neutrality requirements. CMS should continue to work with Congress on a long-term solution to the Medicare physician payment system challenges and prioritize payment policies that strengthen the Medicare Physician Fee Schedule for all physicians.

ASCRS and OOSS are extremely concerned with CMS' continued move to overhaul practice expense methodology with sweeping changes to indirect practice expenses that are not based on specialty-specific data and disproportionately penalize private practice physicians, like ophthalmologists. We reiterate that cataract surgeons are in private practice and provide services in facilities but continue to treat patients in their offices and practices, therefore continuing to incur substantial, uncompensated costs. The implementation of this year's **PE Site-of-Service Payment Differential Update coupled with the 2027 proposed indirect PE methodology changes result in untenable reductions in reimbursement for anterior segment surgeons.**

Therefore, we strongly urge CMS to reconsider these policies to more accurately reflect specialty-specific practice patterns utilizing data driven approaches, while maintaining access for patients to continue to receive timely quality ophthalmic care.

ASCRS and OOSS appreciate the opportunity to provide the following comments on the proposed 2027 Medicare physician payment updates and policies, including the Indirect Practice Expense Methodology Changes, Payments Using Modifier -25, Global Surgical Services, changes to the G2211 E/M Visit Complexity Add-on Code, the QPP provisions, as well as the PE Site-of-Service Payment Differential Update implemented in 2026. **Below, we provide an overview of the actions we urge CMS to take as part of this MPFS rulemaking. Context and rationale are provided in the sections that follow.**

Medicare Physician Fee Schedule Policies

ASCRS and OOSS urge the Agency to:

- *Conversion Factor and Medicare Physician Payment*
  - **Continue to work with Congress on a long-term solution to the Medicare physician payment system challenges that includes an annual physician payment update that is appropriately adjusted for inflation.**

- *2026 Updates to Practice Expense (PE) Indirect Methodology – Site-of-Service Payment Differential*
  - **Repeal the 2026 implementation of the 50% work adjustment to the indirect practice expense methodology for January 1, 2027, as it fails to consider: 1) ophthalmologists have a high percentage of physicians (70.4%) still practicing in private practice where they see patients for pre- and postoperative care and other ophthalmic conditions such as glaucoma, dry eye, and comprehensive eye exams, and 2) the majority of global ophthalmic surgery packages include in-office visits for pre- and postoperative care that**

continue to require indirect practice expenses such as rent, utilities, additional overhead expenses, and a dedicated medical, billing, and administrative staff.

- **Utilize data driven approaches to address CMS concerns regarding potential duplication of indirect expense payment between the Medicare Physician Fee Schedule and hospital payment system. CMS should also work closely with stakeholders to ensure that independently practicing physicians, such as ophthalmologists, are not unintentionally harmed.**

- *Proposed 2027 Indirect Practice Expense Changes*
  - **Withdraw the proposed 2027 indirect practice expense proposals, including the removal of the indirect practice cost index (IPCI), and maintain the current methodology while CMS identifies an appropriate source of current specialty-level practice cost data and more fully evaluates the individual and cumulative impacts of the proposed changes.**

- *Payments Using Modifier -25*
  - **Withdraw the CMS proposal on payments using modifier -25**

- *Global Surgery Packages/Data Collection Efforts*
  - **Not expand the CPT code 99024 reporting requirement to all physicians.**

- *Payment Equity for Postoperative E/M Visits – the full increase of work and physician time for E/M office visits should be incorporated into surgical global periods for all 10- and 90- day codes.*
  - **Follow the precedent set in 1997, 2007, and 2011 (in accordance with the statute) and apply the increased E/M values as finalized in the CY 2021 PFS to the postoperative E/M visits in 10- and 90-day global surgical procedure codes.**

- *G2211 E/M Complexity Add-on Changes – Flawed Budget Neutrality Assumptions*
  - **Use actual claims experience to recalibrate the utilization assumptions so that future budget neutrality adjustments accurately reflect physician billing patterns.**

Quality Payment Program

MIPS Performance Threshold

- **ASCRS and OOSS support the maintenance of the performance threshold at 75 points for the 2027–2028 performance years.**

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

- **ASCRS and OOSS continue to offer our strongest opposition to making MIPS Value Pathways (MVPs) mandatory. Forcing specialty physicians, like ophthalmologists, to report on mandatory MVPs would subject them to problematic population-health measures, which we reiterate have nothing to do with the specialty of ophthalmology or the care that is provided.**
- **The feedback from medical societies has not been adequately incorporated and the currently available MVPs are unable to truly assess clinician performance.**
    - **ASCRS worked collaboratively on a cataract surgery-specific MVP and submitted it to CMS in January 2024.** Eyecare is a diverse field with subspecialties with little patient or condition overlap. **In response to CMS' stated desire to limit the number of MVPs, ASCRS, in conjunction with the ophthalmic community, compromised and submitted to CMS recommended subspecialty grouping within a single ophthalmic MVP.** While CMS made some improvements since the Comprehensive Ocular Care MVP Candidate was released in late 2023, **we were disappointed to see that our efforts at improving the coverage of this MVP and to create a workable model through compromise with CMS were largely ignored.** We urge CMS to work collaboratively and in good faith to develop workable MVPs for *voluntary reporting,* rather than MVPs that leave entire subspecialties with insufficient measures.
    - **While CMS states that 98% of specialties will be covered by an MVP, that *does not account for subspecialties, as shown in our analysis in the MVP section of this comment letter.***

MVP Proposals

- **Complete Ophthalmologic Care MVP:** This MVP continues to provide inadequate subspecialty coverage under the Quality performance category. We are particularly concerned with the removal of a cataract outcome measure as the chosen core measure for cataract surgeons.
    - We would also like to emphasize that a quality and cost comparison between subspecialists that have no overlap in treated conditions is impossible. For example, retina and anterior segment subspecialists should *not* be scored against each other.

- **ASCRS and OOSS are deeply concerned with the structure of MVPs.** CMS continues to combine many subspecialties into a single MVP. Patients looking for a cataract surgeon do not care how that surgeon compares to an ophthalmologist that solely treats retinal disease or glaucoma. **Patients want to know how their clinician rates compared to other clinicians providing that same service.**

- **Core Measure Reporting:** We strongly support the small practice exemption and the attestation for those without available core measures. We also strongly support the proposals to both exempt core measures from the 7-point cap and to

score them using flat benchmarks if they are topped out for 2 or more consecutive years.

MIPS Quality Category Proposals

- **Outcome/High-Priority Measures and Core Measures Designations:** We ask CMS to maintain the outcome/high-priority measure designations alongside the core measure designations and to allow reporting of either a Core Measure or an Outcome/High-Priority Measure in order to provide the flexibility needed for subspecialists to report on measures germane to their practice.

RFI: Transition Toward Digital Quality Measurement

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

MIPS Cost Category Proposals

- **Cost Measure Feedback Reports:** We remain concerned that more clarity is required in the cost measure feedback reports. ASCRS submitted a letter to CMS in April of this year with detailed recommendations on improvements that must be made to cost measure feedback reports to provide clinicians with actionable information.
- **Cataract Surgery Episode-Based Cost Measure: ASCRS and OOSS are concerned with the Cataract Cost Measure specification.** In particular, we outline concerns regarding risk adjustment, standardized cost, and service assignment.
- **Measure Development Transparency: ASCRS and OOSS remain concerned with the lack of post-field test transparency in pre-rulemaking cost measure development**. For some cost measures, significant changes (including changes that would put additional specialties at risk for measure attribution) are made after field testing.

MIPS Promoting Interoperability Proposals

- **2027 Electronic Prior Authorization (ePA) Measure: ASCRS and OOSS support the proposal to make this an optional bonus measure in 2027.**
- **2028 Electronic Prior Authorization (ePA) Measure: ASCRS and OOSS *strongly oppose* CMS' proposal to make this a mandatory measure beginning in 2028** as the functionality and availability are not sufficient at this time.

ePA for Prescription Drugs: ASCRS and OOSS oppose the adoption of this measure as mandatory in 2028 as the technological capability for this measure is not widely available or accessible. If this measure is adopted, we ask that it be an optional

bonus measure until such time as the technology necessary is widely and functionally available to all clinicians.

RFI: Electronic Prior Authorization (ePA) Measures Transition to Performance Rate-Based

- **ASCRS and OOSS are opposed to any transition of these measures from attestation-based to performance rate-based as they are not ready for full implementation *and* the proposed removal of the CEHRT measure calculation criteria creates the potential for a substantial reporting burden.**

Extreme and Uncontrollable Circumstances (EUC)

- **Automatic EUC Eligibility Determination: ASCRS and OOSS support the use of alternative data sources *in addition to PECOS data* for the determination of EUC eligibility.**
- **Third-Party Intermediary EUC Application: ASCRS and OOSS strongly support CMS' proposal to extend the application deadline for this EUC.**

Advanced Alternative Payment Models (APMs)

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

Ambulatory Specialty Model (ASM)

While we appreciate CMS' decision to look into models that could be more applicable to specialists, **ASCRS and OOSS remain deeply concerned with and oppose any mandatory ASM participation.**

Full comments on these issues are below:

MEDICARE PHYSICIAN FEE SCHEDULE

Update to the CY 2027 Medicare PFS Conversion Factor

As required by law, the CY27 proposed rule establishes two conversion factors—one for those qualifying participants (QP) in advanced Alternative Payment Models (APMs) and another for those participating in the traditional Merit-based Incentive Payment System (MIPS) or nonqualifying participants. As proposed, the conversion factor for QPs in APMs is $33.17, a decrease of $0.40 (1.19%) from the current conversion factor of

$33.57, while the conversion factor for those in traditional MIPS (all other clinicians) is $32.84, a decrease of $0.56 (1.68%) from the current $33.40. The conversion factors reflect a 0.75% update for QPs and a 0.25% update for non-qualifying participants, the expiration of the 1-year 2.5% Medicare payment increase for 2026 that was enacted by Congress, and a 0.53% positive budget neutrality update.

As there is a lack of APMs for specialty care physicians, most ophthalmologists participate in MIPS and will be facing the lower conversion factor of $32.84.

ASCRS and OOSS remain concerned that long-term Medicare payment reform has yet to be enacted. Once again, **we urge the agency to continue to work with Congress on a long-term solution to the Medicare physician payment system challenges that include continuous reimbursement reductions coupled with increasing expenses and the lack of an inflationary update.**

Inflation Update

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

Ophthalmic practices—mostly small, solo, and two-to-four-physician offices—continue to struggle with the high cost of skilled labor, medical supplies and equipment, and rents, just like all other Medicare providers, such as hospitals, skilled nursing facilities, and hospices. However, these other Medicare providers receive positive annual payment updates that reflect their costs due to inflation. For example, hospitals, hospices, skilled nursing facilities, ambulatory surgery centers, etc., receive a market basket adjustment that increases their payments relative to a measure of inflation (e.g., Consumer Price Index (CPI)). As the agency is aware, the forecast for the Medicare Economic Index (MEI)—a measure of inflation faced by physicians with respect to their practice costs and general wage levels—is 2.5% in 2027.

The lack of a meaningful rate increase that accounts for rising practice costs, such as the MEI, has made running a practice increasingly costly. The increased costs, coupled with significant administrative burdens, and significant reimbursement cuts have made it more challenging to continue to deliver timely quality care to Medicare patients at current and proposed payment levels**.** As a result, many ophthalmic practices have decided to sell to private equity groups to help with key practice functions (e.g. prior authorizations, coding and billing, insurance verifications, quality reporting and electronic health record maintenance, compliance reviews, contract negotiations, and provider credentialing) that have become increasingly costly and administratively burdensome and difficult to manage.

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

As we highlighted last year, these concerns have also been raised by the Medicare Payment Advisory Commission (MedPAC). In its June 2025 *Report to Congress*, MedPAC issued a report on physician services.[2] Their report stated the following:

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

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

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

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

Repeal of 2026 Updates to Practice Expense (PE) Indirect Methodology – Site-of-Service Payment Differential for January 2027

Effective January 1, 2026, CMS significantly revised PE indirect methodology and implemented a sweeping methodological overhaul that disproportionately penalizes private practice physicians delivering surgical services in ambulatory surgery centers (ASCs) and hospital outpatient departments. The prior PE methodology correctly accounted for the reality that roughly 41% of physicians who are in private practice and provide services in facilities, such as ophthalmologists, continue to incur substantial, uncompensated costs in maintaining their offices and practices. Once again, we remind CMS that ophthalmologists do more than perform surgery all day. In addition to pre- and postop visits associated with cataract and other ophthalmic surgical procedures, they also see patients for other ophthalmic conditions in their offices, including glaucoma, dry eye and general eye exams. The changes that were implemented in 2026 overreach by imposing a one-size-fits-all adjustment without differentiation for independent physicians' versus those employed by facilities. This broad reduction does not adequately account for the wide variation in physician-facility arrangements and inappropriately undervalues services provided by the majority of ophthalmologists.

As a reminder, in its 2025 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) emphasized that distinguishing between employed physicians and those in independent practice is essential to fully understand the redistributive effects of any policy change. **Implementing across-the-board reductions without**

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

this differentiation unintentionally penalizes independent practices and undermines physician autonomy and patient access that CMS aims to preserve.

The impact of this policy on ophthalmology is particularly severe and overlooks the fact that ophthalmologists continue to maintain offices and incur substantial practice expenses when providing services in an ASC, hospital outpatient department, and in their office. These expenses include staffing, clinical documentation, regulatory compliance, scheduling, and billing infrastructure and do not diminish because the physician is also providing services in a facility.

In the rationale to enact these changes, CMS stated that there has been a significant shift in healthcare delivery and practice patterns from physicians practicing in private (fully or partially owned) practices to physicians practicing in hospital-owned practices and physicians employed directly by a hospital. Rather than use the AMA's updated Physician Practice Information (PPI) survey data, CMS changed the methodology in determining indirect expenses for each service valued in the facility setting under the PFS, and reduced the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. CMS cited the June 2025 MedPAC report to Congress in its rationale for changing the practice expense methodology. However, CMS failed to note that MedPAC asserted that "**indirect PE RVUs for facility services should be targeted toward clinicians who do not pay indirect PE costs because they do not maintain or finance a separate practice."**[3]

The policy that was implemented on January 1, 2026, is an arbitrary approach to address the differential in site-of-service payments without consideration of specialty practice profiles or global surgery packages. In its recommendations, MedPAC stated that, "Medicare claims data could be used to determine whether a given clinician primarily practices in a facility or a service is furnished primarily in a facility, or a combination of both."[4] CMS failed to account for specialties that have a high percentage of privately owned practices, such as ophthalmology. **ASCRS and OOSS continue to strongly oppose this practice expense methodology change.**

CMS' assertions of a shift in healthcare delivery are grossly overstated and fail to consider specialty-specific practice patterns. While other specialties may have a larger portion of physicians practicing in hospital-owned practices or physician-employed directly by a hospital, ophthalmologists continue to have the highest percentage of private practices of all specialties. As we previously pointed out, according to the AMA's Policy Research Perspectives for 2024, 70.4% of all ophthalmologists are in private practice.[5]

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

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

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

Cataract surgery is reimbursed as a 90-day global surgery package, which typically allocates 10% of the global code to preoperative care, 70% of the global surgery time to intraservice time, and 20% of the global surgery package to postoperative care. While the intraservice time of cataract surgery is performed in an ambulatory surgery center (ASC) or a hospital outpatient department (HOPD), 30% of the global surgery fee is for pre- and postoperative visits that are conducted in a privately owned office-based setting. This is not apparent in the claims data and was not considered in CMS' CY 2026 PE methodology change. This policy negatively impacts the entire surgical global facility PE RVU without accounting for this factor. The highest volume cataract CPT code (66984) was performed 81% of the time in the ASC setting for Medicare. However, as previously indicated, ophthalmologists also perform follow-up visits in their offices. In addition, ophthalmologists are maintaining offices that are open while performing surgery at the ASC or hospital outpatient department.

Therefore, we urge CMS to repeal the 2026 implementation of the 50% work adjustment to the indirect practice expense methodology for January 1, 2027. CMS should utilize specialty-specific data driven approaches to address concerns regarding duplication of indirect expense payment between the Medicare Physician Fee Schedule and hospital and ASC payment systems. In addition, CMS should work closely with stakeholders to ensure that independently practicing physicians, like ophthalmologists, are not negatively impacted. This broad-based adjustment does not reflect actual practice costs and illustrates the need for a targeted approach. For example, CMS could differentiate between physicians who are fully employed by a hospital and those who remain in independent practice but furnish services in those settings using a modifier to identify hospital-employed physicians as CMS suggested in this proposed rule. This would enable CMS to apply the reduction in PE only to those physicians, who do not have separate administrative or clinical offices. This would allow CMS to apply the relevant indirect PE adjustment.

Withdraw Proposed 2027 Indirect Practice Expense Methodology Changes

CMS proposes several additional changes to the indirect practice expense (PE) methodology including phasing out the indirect practice cost index (IPCI) over 2 years and replacing it with a new stabilization factor that would generally limit annual changes in PE RVUs to 5% and expanding the allocation of indirect PE to utilize the sum of both work RVUs and clinical labor (rather than the greater of the two) for all services except 10- and 90-day global codes despite the fact that the multi-phase RAND practice expense studies recommended developing improved and recurring data sources rather than eliminating data-driven components of the methodology. This analysis underlying the proposed indirect allocator proposal modeled a policy **that did not include a 10- and 90-day global exclusion that CMS proposes. CMS offers no rationale for this decision.**

As a result of these proposed changes, ophthalmology overall is facing significant payment reductions once fully phased in, with cataract surgery (66984) facing a 30% reduction in PE RVUs over 5–6 years. **The cumulative effect of these changes, coupled with the 2026 changes to the PE Methodology: Site-of-Service Payment**

Differential Update result in untenable reductions to ophthalmic procedures and could potentially impact timely access to care for Medicare patients.

Despite the fact that CMS has expressed concerns with existing data, it has not identified a better source of specialty-level practice cost data. We strongly support the continued use of specialty society-derived data to ensure that the indirect costs of specialty physician practices, such as ophthalmologists, who incur proportionally higher costs, are appropriately recognized. While the stabilization factor is intended to limit year-to-year fluctuations in PE RVUs, ophthalmology would face significant reductions under this proposed methodology that phases out specialty-specific practice expense per hour (PE/HR) data. In addition, the stabilization factor does not address the need for specialty-level practice cost information that is currently reflected through the IPCI.

As indicated above, this is the second year in a row that CMS is proposing changes to indirect PE that represent a substantial shift in PE RVUs and significant reductions in reimbursement for services provided by ophthalmologists with a lack of transparency regarding their true impacts.

ASCRS and OOSS urge CMS to withdraw the proposed changes to the indirect PE methodology for CY2027 and maintain the current methodology until it identifies an appropriate source of current specialty-level practice cost data and fully evaluates the individual and cumulative impact of these changes.

Global Surgical Packages

Number of Postoperative Visits/Data Collection Efforts

Throughout its consideration of global surgery packages, CMS continues to question the number of actual postoperative visits that occur within each global surgery period. ASCRS has repeatedly responded to the agency's concerns with respect to cataract surgery. The postoperative values have been verified in multiple analyses and were reaffirmed in the CY 2022 MPFS Final Rule. We remind CMS, once again, that cataract surgery was revalued in 2019 with an effective date of January 1, 2020. CMS adopted the RUC-recommended value, which confirmed that ophthalmologists are providing three postoperative visits, rather than the previous four postoperative visits, in the 90-day global period (one level 2 visit and two level 3 visits). Furthermore, the three visits now align with the recent OIG audit.

Since July 2017, CMS has attempted to require some physicians, including ophthalmologists, to report non-covered CPT code 99024. Medicare physicians in nine states have been required to report on the postoperative visits they furnish during the global period of specified high-volume procedures, such as cataract surgery, CPT code 66984, using CPT code 99024.

In this proposed rule, CMS proposes to pause this data collection effort citing undue burden to physicians yet seeks comments on whether this reporting requirement should be expanded to all physicians or if other data sources are available to demonstrate the number of postoperative visits provided.

As indicated above, cataract surgery (CPT Codes 66984 and 66982) were reviewed for the 2020 MPFS and the postoperative visits now align with the 99024 Medicare claims data that was collected.

The absence of a reported 99024 visit is not evidence that a postoperative visit was not furnished as was included in the RAND report, OIG Audit, and RUC analysis of alternative data sources that show that CPT code 99024 reporting is burdensome, incomplete, and not reliable for revaluating global surgical packages. Expanding these data collection efforts to all physicians would create a further burden to all physicians and not resolve the limitations of the data. Rather, the RUC process provides a more targeted and less burdensome mechanism for identifying and correcting misevaluation.

Therefore, ASCRS and OOSS do not support expanding the CPT code 99024 reporting requirement to all physicians.

Payment Equity for Post Operative E/M Visits: The Full Increase of Work and Physician Time for Office Visits (99202–99215) should be Incorporated into the Global Surgical Periods for all 10- and 90-day Codes.

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

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

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

Payments Using Modifier -25

CMS should not finalize the proposal to reduce payment by 50% when a separately identifiable office or outpatient evaluation and management E/M service is furnished by the same physician, or a physician in the same group practice, on the same day as a procedure with a 0- , 10-, or 90-day global period.

In this proposed rule, CMS indicates their belief that duplicate payment is likely made when the same physician—or a physician in the same group practice—provides an E/M service for the same patient in conjunction with a global procedure code. Under this proposal Medicare would pay 100% of the total RVUs for the highest payment rate and reduce payment for all other same-day services by 50%. This will impact office-based, independent practices, which incur the costs of infrastructure, clinical staff, equipment and supplies.

CMS indicates that this is meant to address their perceived likely overlap and duplication of payment between the E/M services already paid for during the global surgical package and any additional E/M services billed for using modifier -25 as significant and separately identifiable.

However, modifier -25 already signifies that the E/M service is significant, separately identifiable and medically necessary beyond the work already included in the procedure. The RUC already accounts for duplication in pre-service physician work during the valuation process when a procedure is typically reported with the same-day E/M service more than 50% of the time.

Physicians may evaluate a new complaint, manage a chronic condition, adjust medications, review diagnostic testing or perform other necessary E/M services that are unrelated to the procedure itself. Ophthalmologists may use modifier -25 when they are doing surface optimization procedures such as punctal occlusion and clinical amniotic membranes when the patients are being evaluated for cataract surgery or other cornea disorders. For example, a patient may come in for a cataract evaluation and complain about severe dry eye. The patient has been using artificial tears on a regular basis but is not satisfied. To avoid the patient having to return for a separate visit, the decision is made to begin treatment of their dry eye with the insertion of a punctal plug or punctal gel during that same visit.

If CMS believes specific codes require review, those codes should be identified through the misvalued code and RUC process.

ASCRS and OOSS urge CMS to withdraw this proposal.

Changes to G2211 E/M Visit Complexity Add-on

CMS proposes to transition HCPCS Code G2211 to a modifier—MOD1 as a placeholder—that can be appended to the associated E/M base code. This modifier would increase the reimbursement of the associated E/M code by 16% instead of a flat fee.

Flawed Budget Neutrality Assumptions

ASCRS continues to remain concerned that CMS has not addressed the flawed budget neutrality assumptions associated with G2211. ASCRS and OOSS questioned CMS' utilization assumptions when CMS first established Medicare physician payment for this code, which asserted that it would be billed on 38% of all office and outpatient E/M services. These utilization assumptions resulted in a significant budget neutrality adjustment that reduced the conversion factor. Claims data has indicated lower utilization; however, the budget neutrality adjustment associated with the original utilization assumptions are still included in the physician fee schedule. This results in continued reductions in Medicare physician payment based on spending that never occurred.

Therefore, ASCRS and OOSS urge CMS to use actual claims experience to recalibrate the utilization assumptions underlying this policy so that future budget neutrality adjustments accurately reflect actual physician billing patterns.

QUALITY PAYMENT PROGRAM

Performance Threshold

ASCRS and OOSS strongly support CMS' decision to maintain the performance threshold to avoid a penalty at 75 points for the 2027–2028 performance years/2029–2030 payment years. We applaud CMS for considering the unintended burdens of an increase in the performance threshold on small and rural practices and subsequent unintended consequences of increasing healthcare consolidation due to inability of practices operating on small margins to avoid penalties.

This is particularly important given the significant changes to MIPS in this proposed rule. We ask CMS to be nimble in evaluating the impact of these changes in future years and to maintain stability in the program by maintaining this performance threshold in future years if significant changes to MIPS occur.

MIPS Value Pathways (MVPs)

Proposal to Sunset Traditional MIPS and Mandate MVPs

ASCRS and OOSS oppose this proposal in the strongest possible terms. MVPs *must* remain voluntary. ASCRS, OOSS, and the entire house of medicine have vocally opposed the sunset of traditional MIPS since it was first discussed years ago. In the time since MVPs were first introduced, we, along with the house of medicine, have voiced concerns about the subspecialty coverage of MVPs. We are disappointed that our feedback remains unincorporated and **the currently available MVPs are unable to truly assess clinician performance**.

ASCRS worked collaboratively on a cataract surgery specific MVP and submitted it to CMS in January 2024. Eyecare is a diverse field with subspecialties with little patient or condition overlap. **In response to CMS' stated desire to limit the number of MVPs, ASCRS, along with the ophthalmic community, compromised and**

submitted to CMS recommended subspecialty grouping within a single ophthalmic MVP. While CMS made some improvements since the Comprehensive Ocular Care MVP Candidate was released in late 2023, **we were disappointed to see that our efforts at improving the coverage of this MVP and to create a workable model through compromise with CMS were largely ignored.** We urge CMS to work collaboratively and in good faith to develop workable MVPs for *voluntary reporting,* rather than MVPs that leave entire subspecialties with insufficient measures.

It is Not Possible to Adequately Cover All Subspecialists in a Specialty MVP.

While CMS states that 98% of specialties will be covered by an MVP, that *does not account for subspecialties.*

Physicians are best suited to select the measures that are most meaningful to their practices and patients. While ophthalmology is solely focused on the diseases of the eye, there are several different subspecialties, and not all ophthalmologists of a particular specialty focus on the same population of patients. For example, the retina subspecialty focuses specifically on diseases at the back of the eye, neuro-ophthalmologists focus on visual problems related to the nervous system (not the eyes), and cataract and refractive surgeons focus on the front of the eye.

Given that diversity, it would be difficult to identify a limited set of measures and activities that would be useful to all ophthalmologists. This was quite evident when CMS developed the initial and subsequent drafts of an eyecare MVP. As was discussed in our meetings with CMS and our comment letters, not all ophthalmic subspecialties would be able to participate.

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

We have encouraged the development of MVPs around conditions and procedures. In fact, ASCRS and AAO jointly submitted a Draft Cataract MVP to CMS. The ophthalmic community has been successful in developing a focused set of measures—many of which are outcome measures—that reflect our members’ practices and patient population. CMS should allow specialty societies, if they so desire, to work with CMS on a particular clinical condition or procedure, but these efforts should be *clinician-led.* **It is inappropriate to require clinicians to take part in a program in which it is impossible for them to succeed.**

In addition to our comments and our draft Cataract MVP submission, in collaboration with the ophthalmic community, we worked with CMS 2 years ago to assemble a Comprehensive Ocular Care MVP that would more completely cover the ophthalmic scope of practice. CMS largely ignored our recommendations, and the result is an MVP that does not have a single ophthalmic quality measure for four ophthalmic subspecialties. **We are deeply concerned with CMS’ apparent unwillingness to collaborate with medical societies in good faith surrounding MVP development.** However, we continue to urge **CMS to allow physicians to select and report on the**

most clinically relevant measures and designate MVPs as voluntary participation options.

Specialty MVPs Do Not Provide a Meaningful Comparison for Physicians or Patients.

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

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

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

Complete Ophthalmologic Care MVP

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

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

There are multiple subspecialties in ophthalmology that have little to no overlap in the conditions they treat. Because of this, a *complete or comprehensive* ophthalmologic care MVP is not functionally feasible. **In response, ASCRS and the American Academy of Ophthalmology worked collaboratively to develop an MVP candidate**

specifically for cataract surgery—the most performed surgical procedure in Medicare—which we submitted in January 2024. By focusing this MVP specifically on cataract care—the only ophthalmic subspecialty with an available cost measure—we allowed for germane and outcomes-oriented measurement and comparison for cataract surgery. This allows identification of areas for improvement that are actionable on the practice level and at the clinician level.

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

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

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

We are specifically concerned about the following issues:

- The only Cost measure available to ophthalmologists is the Cataract Removal with Intraocular Lens (IOL) Implantation measure.
    - This is only applicable to a subset of ophthalmologists, and as such, if included in a *comprehensive* ocular care MVP, it would unfairly disadvantage cataract surgeons compared to other subspecialties (such as retina). This creates inequality in measurement as clinicians who are not scored on cataract cost will have more weight assigned to Quality and Promoting Interoperability—two categories that are more predictable and, in practice, more able to meaningfully evaluate value-based care. Moreover, with only cataract surgery cost being measured, it is impossible to truly compare all ophthalmic subspecialties.
    - We have seen significant issues with scoring this measure. Until those issues are resolved, there will not be a valid Cost category measure for ophthalmology or any ophthalmic MVP.
- Insufficient coverage of subspecialty quality measures:
    - Available measures are not meaningful for some subspecialties.
    - The low percentage and number of benchmarked measures that are not topped out which are available to each subspecialty.

- The burdens and high expenses of fully testing Qualified Clinical Data Registry (QCDR) measures at the clinician-level prior to inclusion in the MVP.
- Patient-Reported Outcome Measures in this MVP are excessively burdensome for survey collection, scoring, and feedback.
- Population health measures are not applicable to ophthalmology.

Insufficient Cost Measures to Evaluate Comprehensive Ophthalmologic Care

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

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

Insufficient Coverage of Subspecialty Quality Measures

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

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

In fact, under this MVP, large practices in only three subspecialties are able to achieve 40/40 points for Quality if reporting via eCQMs + QCDR measures. If reporting on MIPS CQMs + QCDR measures, only two subspecialties are able to achieve 40/40 points for the Quality category. Finally, via claims, none of the ophthalmic subspecialties are able to achieve 40/40 points. This is illustrated for

large practices in Figure 1 and for small practices in Figure 2. The figures and tables embedded in this letter are based on the 2026 benchmarks.

Even more concerning, only two subspecialties (only via eCQMs + QCDR measures) have four or more available measures that are both benchmarked and not topped out *and also include a core measure*. **Thus, it is very likely that the maximum score achievable under CMS' Ophthalmic Care MVP will continue to decline in future years.**

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

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

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

Improve MVP Adoption by Streamlining Quality Category Scoring Methodology

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

Subspecialty MVP Measure Sets

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

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

Topped Out Measure Scoring within MVPs

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

New or Existing Measures or Measures without a Benchmark

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

Figure 1. Maximum Achievable Quality Score for Large Practices in the Complete Ophthalmologic Care MVP



Figure 2. Maximum Achievable Quality Score for Small Practices in the Complete Ophthalmologic Care MVP



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

Subspecialty	Available Quality Measures	% Not Benchmarked (Number)	% Topped Out (Number)	%7-point Capped (Number)	Benchmarked & *not* 7-pt Capped	Benchmarked & *not* Topped Out
Cataract/Anterior Segment	7	0% (0)	14.3% (1)	14.3% (1)	6	6
Cornea/External Disease†^	4	0% (0)	25% (1)	25% (1)	3	3
Glaucoma	8	0% (0)	12.5% (1)	12.5% (1)	7	7
Refractive†^	4	0% (0)	25% (1)	25% (1)	3	3

Oculofacial Plastics/ Reconstructive†^	**4**	**0% (0)**	**25% (1)**	**25% (1)**	**3**	**3**
Pediatric Ophthalmology and Strabismus†^	**2**	**0% (0)**	**0% (0)**	**0% (0)**	**2**	**2**
Neuro-Ophthalmology†^	**5**	**0% (0)**	**20% (1)**	**20% (1)**	**4**	**4**
Retina/Vitreous^	**7**	**0% (0)**	**14.3% (1)**	**14.3% (1)**	**6**	**6**
Uveitis/Immunology†^	**4**	**0% (0)**	**25% (1)**	**25% (1)**	**3**	**3**

†No specialty-specific measures. (there are up to 5 general measures: Q117, Q130, Q226, Q374, Q487)
^No core measure germane to the subspecialty

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

Subspecialty	**Available Quality Measures**	**% Not Benchmarked** (Number)	**% Topped Out** (Number)	**%7-point Capped** (Number)	**Benchmarked & *not* 7-pt Capped**	**Benchmarked & *not* Topped Out**
Cataract/Anterior Segment	**9**	**33% (3)**	**55.6% (5)**	**55.6% (5)**	**1**	**1**
Cornea/External Disease^	**6**	**16.7% (1)**	**66.7% (4)**	**66.7% (4)**	**1**	**1**
Glaucoma	**9**	**11.11% (1)**	**55.6% (5)**	**44.4% (4)**	**4**	**3**
Refractive†	**4**	**0% (0)**	**100% (4)**	**100% (4)**	**0**	**0**
Oculofacial Plastics/ Reconstructive†^	**5**	**0% (0)**	**80% (4)**	**80% (4)**	**1**	**1**
Pediatric Ophthalmology and Strabismus	**6**	**50% (3)**	**33% (2)**	**33% (2)**	**1**	**1**
Neuro-Ophthalmology†^	**5**	**20% (1)**	**80% (4)**	**80% (4)**	**0**	**0**
Retina/Vitreous	**11**	**27.3% (3)**	**36.4% (4)**	**36.4% (4)**	**4**	**4**

Uveitis/Immunology^	**6**	**16.7% (1)**	**67% (4)**	**67% (4)**	**1**	**1**

†No specialty-specific measures. (there are up to 5 general measures: Q117, Q130, Q226, Q374, Q487)
^No core measure germane to the subspecialty

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

Subspecialty	**Available Quality Measures**	**% Not Benchmarked** (Number)	**% Topped Out** (Number)	**%7-point Capped** (Number)	**Benchmarked & *not* 7-pt Capped**	**Benchmarked & *not* Topped Out**
Cataract/Anterior Segment†^	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Cornea/External Disease†^	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Glaucoma	**2**	**0% (0)**	**50% (1)**	**50% (1)**	**1**	**1**
Refractive†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Oculofacial Plastics/ Reconstructive†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Pediatric Ophthalmology and Strabismus†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Neuro-Ophthalmology†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Retina/Vitreous†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**
Uveitis/Immunology†	**1**	**0% (0)**	**100% (1)**	**100% (1)**	**0**	**0**

†No specialty-specific measures. (there is up to 1 general measure: Q226);
^No core measure germane to the subspecialty

MIPS Quality Category

Data Completeness Threshold

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

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

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

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

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

A typical ophthalmologist sees about 100 patients per week. If we extrapolate that to a 52-week year, we can estimate approximately 5,200 patients. To determine statistical significance, most researchers use a 95% confidence level. This means that, 19 times out of 20, a sample of the specified size would yield a similar result. If we choose a tight margin of error (only 1%) and a 95% confidence interval, the size of the patient sample for this ophthalmologist would be 3,374 patients (65% of the patients seen by the ophthalmologist during the course of the year). For a general measure, like Documentation of Current Medications in the Medical Record, a 65% sample would be representative.

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

We agree that it is important that quality data represents a clinician's true performance, rather than a cherry-picked sample. Circumstances, like EHR switches during the

performance year, can make high data completeness thresholds not only hard to meet, but also difficult to meet *accurately.* For the reasons outlined above, we strongly urge CMS to maintain the current data completeness threshold of 75% for all future years. **If CMS wishes to increase the data completeness threshold in future years, we recommend the following options to ensure that practices are able to continue to report quality data in good faith:**

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

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

For practices unable to switch during the first or last quarter of the year (would have less than 9 consecutive months of data), allow the practice to apply for a Quality Category EUC.

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

Patient Reported Outcome Measures

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

Support for Maintaining 3-Point Scoring for Small Practices

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

Support for Maintaining 6-Point Bonus for Small Practices

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

Topped Out Measure Scoring for Measures Outside of Identified Specialty Sets

The dwindling number of available specialty-specific or germane quality measures is an issue that is exacerbated by the topped out measure lifecycle. **As we have stated previously, ASCRS and OOSS continue to oppose CMS' topped out measure methodology and recommend that CMS continue to award credit to physicians who maintain high quality, particularly on outcome measures.**

Under the topped out measure methodology, CMS determines what measures are available by an arbitrary quantitative level that does not consider the clinical relevance of the measure or the volume of Medicare services it impacts. For example, while cataract surgery is a highly successful surgery, it requires intense training and physical skill to perform. While rare, complications could include total vision loss. Coupled with the high volume of cataract surgery performed on Medicare beneficiaries, CMS risks wide gaps in the number of Medicare services that are subject to quality measurement if it removes measures related to cataract surgery. In addition, it is critical to continue to measure the outcome of highly successful surgeries, like cataract surgery, to ensure surgeons are continuing to achieve good outcomes. Therefore, CMS should maintain cataract surgery outcome measures in the program, refrain from removing any further measures, and continue to award full credit to surgeons who maintain high quality. The ophthalmic community has worked to develop a robust set of outcome measures related to cataract surgery, and surgeons continue to provide high-quality care to their patients, as evidenced in their superior performance on these measures. **We continue to urge CMS to maintain clinically relevant measures related to cataract surgery in the MIPS program and to award full credit to physicians who maintain high quality.**

Proposed Quality Measure Modifications and Removals

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

  ASCRS and OOSS support CMS' proposed modification to require a glaucoma plan of care to be documented within 7 days after the patient encounter when IOP was assessed.

- ***Measure 384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery***

  ASCRS and OOSS oppose the proposed removal of this measure. Per analysis done by the AMA, the topped out status of this measure does *not* reflect widespread high performance across the specialty. In addition, it is currently one of the limited available quality measures in the Complete Ophthalmologic Care

MVP. As such, we urge CMS to maintain this measure and continue to evaluate its performance over time.

Outcome and High-Priority Measure Designations: Proposed Removal

While ASCRS and OOSS understand CMS' rationale for proposing the removal of these designations, **we urge CMS to maintain these and allow reporting of *either a Core Measure or an Outcome/High-Priority Measure* in order to provide the flexibility needed for subspecialists to report on measures germane to their practice.**

Core Measure: Proposed Requirement

ASCRS and OOSS support the proposal to establish Core Measures under the condition that **CMS allow reporting of *either a Core Measure or an Outcome/High-Priority Measure* in order to provide the flexibility needed for subspecialists to report on measures germane to their practice.**

- ***Small Practice Exemption***
  - **ASCRS and OOSS strongly support the exemption of small practice from this requirement.**
  - We also support the proposal to only include a core measure reported by a small practice if it is among the highest scoring six (or four for an MVP) reported quality measures.

- ***Attestation for Those Without Available Core Measures***
  - We strongly support the proposal to allow practices without germane core measures to attest to that fact during MIPS submission.

- ***Topped Out Core Measures***
  - We strongly support the proposals to both exempt core measures from the 7-point cap and to score them using flat benchmarks if they are topped out for 2 or more consecutive years.

RFI: Transition Toward Digital Quality Measurement

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

CMS will significantly increase the burden of accurate reporting. This is particularly true for small and rural practices, which are lower resourced settings.

Benchmarking

We reiterate our opposition to mandatory dQM reporting. If dQMs are introduced as a collection type option, they should be treated like other collection types. Namely, each collection type available for a given measure has its own benchmark; that should apply to dQMs as well.

Data Completeness

We recommend keeping data completeness at its current level when adding dQMs as a collection type option. Much like eCQMs, the ability to reliably calculate performance on these measures will be impacted by external factors that make it difficult to aggregate data (e.g., a practice using multiple EHR vendors).

Readiness

As mentioned above, the market is not ready for fully dQM implementation.

Support

CMS requests feedback on what support would be useful in dQM implementation. We strongly recommend providing direct support to practices. Specifically, this can be both monetary and informational. Monetary support can help a practice operating on slim margins to upgrade to a system with the required functionality. Information should be provided in the form of accessible experts. Rather than reaching the QPP helpdesk with dQM questions, during any transition period, CMS should have direct contact information to experts in the field to answer practice dQM and EHR questions.

MIPS Cost Category

Cost Measure Feedback Reports

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

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

While we appreciate the increased ease in which clinicians can access their cost reports (linked on their MIPS Score Report) and the patient-level drill down appendix, the data

we now have under MIPS is extremely difficult for even seasoned MIPS professionals to interpret and to gain actionable insights from. **ASCRS submitted a letter to CMS in April of this year with detailed recommendations on improvements that must be made to cost measure feedback reports to provide clinicians with *actionable* information. This letter detailed tables and column headings necessary to achieve this goal and had sample reports attached.** The AMA also provided CMS with recommendations highlighting similar issues with similar requested information added to feedback reports.

Timing of Cost Measure Feedback

ASCRS and OOSS also request publication of more timely cost measure reports. While improving the reports themselves is necessary for the provision of actionable information, if this information is provided 6 months or more into the *next performance year*, it prevents clinicians from taking meaningful steps to address high-cost drivers in real time. Without *timely* feedback, it is difficult for clinicians to account for external factors or administrative changes that could impact their cost to Medicare.

Cost Measure Specifications

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

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

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

Cost Measure Scoring

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

Cataract Surgery Episode-Based Cost Measure

ASCRS and OOSS are concerned with the Cataract Cost Measure specification. This measure is meant to measure resource use of routine cataract surgery. We have taken every opportunity to comment during the measure's comprehensive reevaluation and during the 2025 proposed rule comment period. As the subspecialty society that

specifically represents cataract surgeons, we are very concerned that the majority of our comments and recommendations are not reflected in the current measure specification.

We summarize our recommendations below and outline additional recommendations on the inclusion of certain Part B drugs and the measure's exclusion codes.

Summary of Cataract Removal with Intraocular Lens (IOL) Implantation Cost Measure Issues:

- Risk Adjustment
    - The current geographic risk adjustment methodology does not capture all geographic variation, based on an evaluation of score reports.
    - In addition, it is unclear if RHC adjustments are being applied appropriately.
    - New versus established patient risk adjustment does not appear to fully address the cost differential for these two patient populations.
    - Subgrouping Site of Service: Performing the second cataract surgery of a bilateral episode at a different site of service (ASC, HOPD, or office) is not taken into account in subgrouping for this measure.
    - Subgrouping Unilateral vs. Bilateral: Some bilateral episodes are misclassified as unilateral. This can cause costs (other than the cost of the procedure itself) to be double counted or inappropriately counted in one of the unilateral episodes.

- Standardized Cost
    - It is unclear if year-over-year changes in payment rates are accounted for in this measure, as pre-trigger or post-trigger services can occur in a different calendar year from the triggering cataract surgery itself. Variations in service density and office closures can create varied rates of services in the last 3 months of the year. Neither the measure nor the available risk adjustment methodology on ResDAC seem to take this into account.

- Service Assignment
    - **Pre-trigger Office Visits with cataract as a non-primary diagnosis:** In the pre-trigger period, there are many office visit codes for which, if cataract is anywhere on the claim, the cost of the service is included. This creates a problem for managing costs of services not primarily related to cataract provided by non-ophthalmic providers.

Trigger Codes

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

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

Part B Drugs Included in Service Assignment

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

Dextenza

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

Pass-through Drugs Included in Service Assignment

We are also concerned about the past inclusion of pass-through drugs and the potential that CMS will include them again in the future.

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

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

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

The inclusion of pass-through drugs in *any* cost measure will also discourage continued medication innovation and improvements. Developing a new drug for FDA approval is an expensive, time-consuming, and risky endeavor for manufacturers.

A key factor in their decisions to develop drugs is a reasonable assurance that there will be a market for the drug once it is approved. Without certainty that this market will not be curbed during the drug's pass-through period by inclusion in MIPS cost measure scores, manufacturers will become more hesitant to continue innovating in impacted areas.

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

Diagnoses in List of Exclusions

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

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

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

- **Mature Cataracts**
  Cataract surgery on a severe, mature cataract is far more complex and riskier than an average cataract. Even though it is not coded at 66982, surgery on a

severe cataract has a higher chance of complications, including corneal failure or vitreous prolapse, leading to the need for additional referrals and follow up surgery during the 90-day postop period. Mature cataract is also coded H25.89. Codes include:

- H25.89 other age-related cataracts

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

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

- **Herpes Virus**
  Surgery and the local trauma to ocular tissues related to the act of uncomplicated cataract surgery can reactivate the herpetic virus (HSV) in patients with latent disease. Reactivation can lead to out-of-control inflammation in some patients after surgery, requiring referrals to corneal or uveitis specialists, as well as the PCP and/or a rheumatologist. Furthermore, patients can go to emergency rooms or urgent care offices, or need additional blood work or diagnostic testing, all of which will increase the costs, even though the initial surgery was uncomplicated. Codes include:
  - B005.0 Herpesviral ocular disease, unspecified
  - B00.51 Herpesviral iridocyclitis
  - B00.52 Herpesviral keratitis
  - B00.53 Herpesviral conjunctivitis
  - B00.59 Other Herpesviral disease of the eye

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

- B02.30 Zoster ocular disease, unspecified
- B02.31 Zoster conjunctivitis
- B02.32 Zoster iridocyclitis
- B02.33 Zoster keratitis
- B02.34 Zoster scleritis
- B02.39 Other herpes zoster eye disease

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

- **Anterior Scleritis**
  Surgery and the local trauma to ocular tissues related to the act of uncomplicated surgery can lead to anterior scleritis. Scleritis typically occurs in patients with underlying autoimmune diseases (sometimes prior to officially being diagnosed by the PCP). These patients tend to have significant inflammation and require visits to the PCP and rheumatologist (or urgent care/emergency room); additional blood work and diagnostic testing may also be needed. They are sometimes referred to a uveitis specialist to help with diagnosis and control of the underlying inflammation process. Other forms of scleritis have been placed on the exclusion list for these reasons, including posterior scleritis, brawny scleritis, and “other” scleritis. All forms of scleritis can be exacerbated at the time of uncomplicated cataract surgery, including anterior scleritis. We believe that anterior scleritis was overlooked. Codes include:
  - H15.01 Anterior Scleritis
  - H15.011 OD
  - H15.012 OS
  - H15.013 Bilateral

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

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

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

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

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

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

- H16.122 (OS)
- H16.123 (OU)

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

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

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

  - H02.23 Paralytic Lagophthalmos
  - H02.231 RUL

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

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

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

MIPS Promoting Interoperability (PI) Category

Maintenance of Automatic Small Practice PI Hardship

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

Electronic Prior Authorization (ePA) Measure Proposals

2027 Performance Year Proposals

ASCRS and OOSS support CMS' proposal to make the ePA measure an optional 10-point bonus measure for the 2027 performance year. Given that ePA has not been fully realized and will be, at best, in its infancy in 2027, this is a necessary step to avoid penalizing physicians for not adopting nonexistent or unavailable technology.

2028 Performance Year Proposals

ASCRS and OOSS strongly oppose CMS' proposal to make this a mandatory measure beginning with the 2028 performance year. We also oppose CMS' proposal to require the use of CEHRT that includes modules certified to all three ONC ePA authorization criteria. As mentioned above, ePA will be in its infancy in 2027. It will take more than 1 year to mature to full end-to-end functionality. Even when ePA does exist at that level of functionality, it will likely be limited in availability at first. As such, it is inappropriate and premature to set a time in which this measure would be mandatory. **We ask CMS to continue evaluating true functionality and listening to stakeholder feedback on ePA modules to ensure widespread availability prior to proposing a year in which the measure would be mandatory.** For these same reasons—the lack of true functionality and availability within the proposed timeline—we urge CMS not to finalize requiring all three ePA certification criteria be used.

Proposed New Measure: Electronic Prior Authorization (ePA) for Prescription Drugs

ASCRS and OOSS oppose the adoption of this measure as mandatory beginning in 2028. The technological capability for this measure is not widely offered and most physicians lack access. We ask CMS to evaluate the true availability of the functionality and its cost to practices when it is available prior to finalizing the inclusion of this measure in MIPS. It is vital to listen to feedback from the physicians who would be impacted by this new requirement before determining the measure's true feasibility.

If the measure is finalized, we ask that it be an optional bonus measure until such time as the technology is widely and functionally available to all clinicians.

RFI: Performance Rate-based Electronic Prior Authorization (ePA) Measures

ASCRS and OOSS are opposed to any transition of the ePA measures from attestation-based to performance rate-based. As noted above, these measures are not ready for full implementation. Moreover, with the proposed removal of the measure calculation criteria by ONC in HTI-5 and the proposed removal of the requirement to employ that certification by CMS in this rule, creating a new performance rate-based measure has the potential to add substantial reporting burden**.**

MIPS Improvement Activities Category

Category Weight and Performance Period

ASCRS and OOSS appreciate the consistency in category weight and reporting period for the Improvement Activities Category for performance year 2027. We also strongly support CMS' decision to continue to award small practices double points for each improvement activity (IA).

Extreme and Uncontrollable Circumstances

Proposed Change to Data Source for Automatic EUC Eligibility Determinations

ASCRS and OOSS support the use of alternative data sources *in addition to PECOS data* for the determination of automatic EUC eligibility. Automatic EUCs are applied when a disaster is significant enough to disrupt clinic operations. In light of this, it is crucial to capture all impacted clinicians so that they can focus on maintaining access to care during exceptional times without worrying about additional paperwork. Thus, we urge CMS to use all data sources to capture eligibility and to apply the automatic EUC should a clinician be found eligible in PECOS or any of the proposed alternative data sources. In this way, CMS can ensure that clinicians in these circumstances are not unintentionally burdened or penalized due to any clerical or administrative procedure that improperly shows them to be outside of an affected area.

Proposed Deadline Extension for Third-Party Intermediary Failure to Submit Data

ASCRS and OOSS strongly support CMS' proposal to extend the application deadline for this EUC from November 1 to December 31 of the year preceding the payment year. As most EUCs have a December 31 application deadline, this will minimize confusion among eligible clinicians and groups.

Advanced Alternative Payment Models (A-APMs)

Proposed Change to the QP Conversion Factor: Application at the TIN/NPI Level, Rather Than the NPI Level

ASCRS and OOSS strongly oppose this proposal as it will reduce the incentive to participate in Advanced APMs. As a reminder, physicians continue to receive annual updates below the rate of inflation. Further limiting the application of the QP Conversion Factor will diminish the benefit of Advanced APM participation for specialists, particularly those in small practices.

As CMS has detailed in prior rules, it is exceedingly difficult for many specialists to be allowed to participate in an Advanced APM due to APM Entity composition requirements. Overcoming this hurdle, in addition to any administrative requirements the APM imposes, is only beneficial if a payment incentive is sufficient to not only offset the costs and burden of participation, but also partially reduce the rate at which payment lags behind inflation.

Lack of Specialty-Specific A-APMs

ASCRS and OOSS continue to recommend that CMS prioritize implementing *voluntary* specialty-specific payment models that have already been developed by physician specialties, like the ASCRS Episode-based Cataract Surgery Proposal, rather than attempting to develop new payment models. As we have commented in the past, most A-APM models are primary care-focused. While some ophthalmologists participate in models, such as ACOs, they are generally not involved in the management of the ACO and are not always able to contribute much quality data. A more frequent situation is that ophthalmologists do not have any A-APMs nearby to join, or local A-APMs do not include specialists. While we continue to believe that CMS should preserve a viable fee-for-service option in Medicare and the continuation of MIPS, because that is the best option for most ophthalmologists who provide surgical

care on an episodic basis, **there should be some A-APM options available to any ophthalmologist who wants to participate.**

ASCRS has developed the Bundled Payment for Same-Day Bilateral Cataract Surgery (BPBCS) so that cataract surgeons can deliver same-day bilateral cataract surgery to appropriate patients at a lower cost for both patients and Medicare. Instead of each member of the Cataract Surgery Team (the surgeon, facility, and anesthesiologist) receiving separate payments for each individual service, the Team would receive a single bundled payment for all services the patient needs as part of the surgery, and the patient would have a single cost-sharing amount for those services. The bundled payment would give the Team the flexibility to redesign the way surgery is delivered to achieve the best outcomes at the lowest possible cost. The BPBCS would cover the costs of both the surgery and the complications that most commonly occur following surgery—neither Medicare nor the patient would pay more if those complications occurred. We urge CMS to test the BPBCS model and implement it for voluntary participation.

AMBULATORY SPECIALTY MODEL (ASM)

While we appreciate CMS' decision to look into models that could be more applicable to specialists, **ASCRS and OOSS remain deeply concerned with the ASM, particularly the mandatory participation in an untested model.** As noted in the Advanced APM section above, CMS has neglected to work with specialty societies and specialty physicians in the design and implementation of advanced APM models. **The ASM is evidence of this, as participants would be required to report on a subset of measures, many of which may not be clinically relevant to the participants' practices or the care they furnish.**

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

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

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

CONCLUSION

Thank you again for the opportunity to provide comments on this proposed rule. If you need additional information, please contact ASCRS Director of Government Relations, Mark Cribben at mcribben@ascrs.org or OOSS Washington Counsel, Michael Romansky at mromansky@verizon.net.

Sincerely,



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