January 28, 2018

Don Rucker, MD
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Washington, DC 20201

Re: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Dr. Rucker:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 9,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care.

We appreciate this opportunity to provide comments in response to the draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. Ophthalmologists have a high rate of adoption of Certified EHR Technology (CEHRT) and participation in MIPS. While ophthalmologists are always eager to integrate new technologies that improve patient care or practice efficiency, it has been our members' experience that federal programs aimed at increasing the use of EHRs and other HIT have been burdensome and not clinically relevant to the care they provide.

We are pleased that this draft strategy acknowledges the regulatory burden and advances solutions to reduce it. **Despite that, we are disappointed that ONC has included its policies related to E/M documentation scheduled to go into effect in 2021 as a key strategy in reducing burden. ASCRS and the entire medical community opposed these policies in the 2019 Medicare Physician Fee Schedule proposed and final rules because they were arbitrary, not resource-based, and threatened the relativity of the entire physician fee schedule. We appreciate that CMS delayed the implementation of these policies to allow time for the physician community to develop an alternative, and we recommend that ONC modify its strategy to account for potential changes in E/M documentation based on the AMA's CPT and RUC processes.**

In addition to our concerns about the E/M documentation policies, we will provide comments on the following issues addressed in the draft strategy:

- **Reduce burden in the MIPS Promoting Interoperability category by removing the "all-or-nothing" scoring methodology.** Currently, physicians must report on all required measures to earn any points in the category, regardless of whether the measures are relevant to their practices. Physicians should be able to focus on the measures that are the most relevant to the care they provide.

AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
4000 Legato Road • Suite 700 • Fairfax, Virginia 22033-4055 • (703) 591-2220 • Facsimile (703) 591-0614

- **Encourage continued use of qualified clinical data registries (QCDRs) by awarding full credit in the Promoting Interoperability category of MIPS to clinicians who integrate with QCDRs electronically.** Most ophthalmologists use the IRIS Registry to track clinical outcomes and report to MIPS. These physicians are using HIT at an advanced level to improve care and should be given full credit in the category rather than focusing on the meaningless measures currently required.

- **Improve EHR interoperability for ophthalmologists by advancing strategies to exchange clinically relevant information.** Since current certification standards do not require that ophthalmic data be included in clinical data summaries, ophthalmic practices often have no way to exchange clinical information relevant to the care they provide electronically.

- **Improve the usability of EHR systems' patient communication tools.** Patient portals may be inconvenient and difficult for patients to use, especially elderly Medicare beneficiaries under the care of ophthalmologists. Physicians need user-friendly features to communicate relevant clinical information to their patients.

- **Facilitate streamlined and electronic processes for obtaining prior authorization.** Ophthalmologists report an increasing use of prior authorization from Medicare Advantage (MA) and other private payers that contribute to administrative burden significantly because there is no standardization or electronic option for responding to the requests.

Full comments on these recommendations are below.

Clinical Documentation Strategies: E/M Documentation and Payment

ASCRS thanks ONC and CMS for recognizing the significant burden of documenting E/M services, especially since current documentation requirements contribute to including an abundance of data in electronic records that may not be clinically relevant. However, we continue to oppose the payment changes CMS has finalized for implementation in 2021 because they are arbitrary, not resource-based, and will negatively impact the relativity of the physician fee schedule. We support the reduced documentation changes that were implemented for 2019 but continue to urge CMS to modify its policies for 2021 based on the efforts of the AMA's RUC and CPT E/M workgroup. This process is resource-based and allows for physician input, including from ASCRS, and we thank CMS for delaying several provisions of the E/M policy to respond to that effort. We urge ONC to modify this draft to acknowledge the ongoing work of the medical community to update E/M coding and documentation.

- **ASCRS supports the documentation changes CMS finalized for 2019.** Specifically, we support the policy changes that will allow physicians to review, and not have to re-enter, pertinent information contained within the medical record for established patients. This will allow physicians to document relevant changes, or lack of change, since a previous visit and more effectively focus on the condition or conditions being addressed during the visit. In addition, we support allowing physicians to review and not have to re-enter information previously entered by ancillary staff. **We believe these changes will significantly reduce administrative burden, alleviate the burden of sifting through irrelevant information in the medical record, and allow physicians additional time to focus on patient care.**

- **While we appreciate efforts to reduce administrative burden through reducing documentation requirements in 2019, we continue to oppose the payment policies CMS finalized for 2021, which could pose a significant risk to Medicare physician reimbursement and the relativity of the physician fee schedule. Therefore, we recommend in our comments on the 2019 Medicare Physician Fee Schedule proposed and final rules that CMS abandon them and recommend that ONC also update its draft strategy to remove these policies.** ASCRS continues to support the resource-based valuation methodology for physician services. When a physician sees a patient with a more complex disease, or diseases, requiring greater time and intensity, then he or she should be reimbursed at a higher level than for a patient with less complex medical needs. Collapsing levels two through four E/M visits ignores that foundational principle of the physician fee schedule. In addition, arbitrarily changing the RVUs associated with a particular code without significant analysis of the overall impact on the relativity of the fee schedule risks far-reaching unintended consequences for the value of other physician services. **We continue to support RBRVS and the RUC process and recommend CMS make new proposals for the value of E/M codes after the CPT and RUC have completed their review of the codes.**

- **We support the CPT/RUC workgroup proposal because it was developed in a resource-based manner and allowed for physician input.** Prior to the release of the 2019 proposed rule, there was agreement in the medical community that the current guidelines may be requiring more information to be documented than was clinically necessary, and that there were ambiguities in the current documentation guidelines that needed to be addressed. While there was disagreement as to how those concerns should be addressed, no formal process had been established to develop a consensus. Following the release of the proposed rule, AMA convened a workgroup made up of experts from the CPT and RUC committees to begin the process. At its inception, the group established as a guiding principle that its efforts would be resource-based and not intended to redistribute value between different specialties. The process has allowed for extensive physician input, including from ASCRS, and should be encouraged to continue with the assurance that CMS will consider its product seriously. Therefore, we **recommend ONC modify its strategy to account for further resource-based changes to E/M codes proposed by the medical community.**

<u>EHR Reporting Strategies: Promoting Interoperability (PI) Category of MIPS</u>

ASCRS members primarily participate in the Quality Payment Program through MIPS, and therefore, we appreciate and thank CMS for listening to our recommendations and overhauling the PI category. The original scoring methodology was cumbersome and difficult for physicians to understand, and physician's scores depended too heavily on the actions of other physicians or patients. We believe the category overhaul will reduce burden and allow physicians to focus on measures most relevant to their practices. Despite these major improvements, there are still some issues to be modified, such as the continued "all-or-nothing" structure of the category and awarding credit to physicians who use EHR and HIT in a clinically relevant manner. <u>We recommend that physicians who use QCDRs that integrate with their EHR be awarded full credit in the PI category.</u>

- **We continue to recommend CMS award full credit in the PI category to any physician or group who participates in end-to-end electronic reporting through a QCDR and recommend it be included in the HIT burden reduction strategy.** Ophthalmologists have access to the IRIS

Registry, a QCDR that integrates seamlessly with most EHR systems and provides them with full reporting capabilities for MIPS. The use of the QCDR is a clinically relevant tool to provide a full picture of the physician's performance. PI measures are process related and generally primary care-based. They do not provide useful information to specialists, such as ophthalmologists.

- **Physicians using a QCDR are participating at a higher, and more meaningful, level in MIPS and should be given full credit in the PI category, so they can concentrate on clinically relevant measures.**

- **We continue to recommend elimination of the troublesome "all-or-nothing" scoring methodology that began under Meaningful Use and continued through the first two years of MIPS.** For any credit in the category, clinicians must report on each of the measures included in the category. Participants receive no partial credit for reporting on some, but not all, of the required measures. The other categories of MIPS provide some credit for reporting some data, and the PI category should be modified accordingly. If clinicians know they will not be able to complete all the required measures, they do not have any incentive to work toward meeting any of the others. **We recommend the burden reduction strategy explore alternative scoring methodologies to the "all-or-nothing" scoring methodology and so physicians can receive award partial credit for attempting to report on some of the PI measures.**

- **A potential alternative could be to require physicians and groups to attest a "yes" or "no" for each measure, which would indicate whether they had at least one patient in the numerator. The clinician would be awarded 10 points for each "yes," rather than be scored on each measure's performance. In addition, the clinician should only be scored at the objective level by being required to report one measure from the objective and receive bonus points for any additional measures reported.** This methodology would allow the clinician to focus on the measures that are the most relevant to his or her practice. For example, most ophthalmologists report to the IRIS Registry and would therefore want to report the clinical data registry measure but cannot report any of the other registry measures because they do not administer immunizations and syndromic surveillance, and electronic case registries do not accept ophthalmic data. By attesting to the clinical data registry measure, which is the most relevant to ophthalmology, the clinician would satisfy the Public Health/Clinical Data exchange objective. CMS has already recognized that not every physician can report to all the public health registries—or report on several of the measures in other objectives—and, therefore, must offer exclusions. An approach that allows physicians to report on the most relevant measures would eliminate the need for any exclusions in the category. In addition, we suggest CMS explore options for EHR vendors to report the functionality of CEHRT products they offer, and the physicians' use of those functions, rather than rely solely on physicians to report. **We encourage ONC to include recommendations for alternative scoring methodologies that will reduce burden, increase flexibility, and allow clinicians to report on the measures that are most relevant to their specialty and practice.**

Health IT Usability Strategies

Interoperability

- **Ophthalmologists continue to struggle to exchange relevant clinical information about their patients electronically because EHR certification standards do not require any ocular data to be included in clinical summaries.** Ophthalmologists do not typically coordinate care with other physicians who are not focused on the eye. However, ophthalmologists frequently refer to or coordinate with other eyecare professionals, such as referring to sub-specialists focused on the retina or cornea or co-managing post-operative care with optometrists. While the information currently required to be part of the clinical summaries focused on the patient's allergies, problem list, and history is vital for ophthalmologists, they also need information on the physiological function and the anatomical status of the eye, visual system, and its related structures, which is not included in the clinical summary. Even EHR systems that are designed specifically for ophthalmology do not include this data in clinical summaries because there is no certification requirement to do so. This lack of ophthalmic data in the clinical summary may also prevent some ophthalmologists who co-manage post-operative care with other physicians from reporting certain MIPS quality measures. Currently, some surgeons who perform cataract surgery, but do not provide all the post-operative care to the patient, are unable to report Quality measure 191, Cataracts: 20/40 or Better Visual Acuity 90-Days Following Cataract Surgery, because another clinician, such as an optometrist, takes the final visual acuity. This becomes a problem for completing the measure because often, the optometrist performing the final visual acuity cannot exchange the data electronically. In addition, if the final visual acuity is received electronically from the optometrist providing post-operative care, some surgeons' EHR systems may only incorporate new information about a patient, such as the visual acuity, by creating a new patient visit even though the operating surgeon did not see the patient to determine the final visual acuity. This lack of interoperability is not only burdensome in that it negatively impacts MIPS performance, but it requires physicians and practices to develop non-electronic "work arounds" to access relevant clinical information. **We recommend the burden reduction strategy include provisions aimed at the seamless electronic exchange of clinically relevant information.**

- **ASCRS also recommends that ONC include provisions in the burden reduction strategy to ensure smaller specialty-specific EHRs generally used by office-based clinicians, such as ophthalmologists, are interoperable with other systems.** In recent years, many primary care physicians and hospital-based specialists have joined or formed larger groups, many centered around large hospital systems. Often, these large groups use the same EHR system, allowing all physicians access to patients' records to get full details on history and treatment. While this arrangement may be preferable for other practitioners, ophthalmologists have not followed this pattern. Ophthalmic care is provided solely in the office or in outpatient facilities and paid only under Medicare Part B, with no inpatient encounters. And, as noted above, ophthalmologists tend to coordinate care with other eyecare physicians rather than primary care or specialists focusing on other organ systems. Due to these factors, ophthalmologists continue to practice in solo or small groups and tend to use EHR systems designed for ophthalmic care, instead of the systems used by hospitals or large groups.

  In seeking to increase or protect their market share, most EHR systems use some method of data-blocking to ensure that physicians outside their systems do not have access to all clinical data, and often make what is required to be shared through the certification criteria difficult to use. EHR vendors' data-blocking may not have a negative impact on physicians' ability to share

information if they are all using the same system. However, ophthalmologists, who generally do not practice in large or hospital-based groups, are often unable to share information electronically, since they must communicate using different EHR systems. The ability to share clinical data should not depend on the type of EHR a physician uses. **The burden reduction strategy should address interoperability of smaller EHR systems, like those primarily used by ophthalmologists, so that all physicians are able to share clinical data.**

Communication with Patients

- **We recommend ONC include provisions in the burden reduction strategy to improve electronic tools to communicate with patients.** While many ophthalmic patients may be elderly and/or have limited vision that can make electronic communication difficult, some patients do want to communicate electronically. However, the methods currently available through EHR systems are often difficult to use or limited in their utility**.** While we recognize that personal health information must be transferred through secure systems, this often means that patients' data is difficult to access. Patients are forced to log into cumbersome patient portals that may require several clicks or steps to authenticate and confirm the patient's identity. When they can access the portals, patients may not be able to find the relevant information they are looking for or may face additional steps or roadblocks to accomplish the task they set out to do. For example, some practices report that sending secure messages through the portal is not useful because they are limited to an arbitrary number of characters, making it difficult to provide full details. Ophthalmologists are burdened by using inflexible patient communication technologies and should have access to innovative tools and methods for exchanging information with patients. **We recommend the burden reduction strategy encourage the development of more user-friendly and clinically relevant patient engagement tools.**

Prior Authorization

- **Insurers' ever-increasing use of prior authorization continues to be a major source of frustration and burden for physicians and practices.** In the last decade, the use of prior authorization has increased dramatically, and physicians are often forced to use different methods to respond to each different insurer. Some payers may require information to be faxed, while others require the use of online portals—all of which reduce the amount of time physicians have to treat patients. While we continue to believe many prior authorization requests are unnecessary and limit or delay patients' access to care, we continue to encourage ONC and CMS to require that the prior authorization process be standardized and electronic. Ideally, prior authorization tools should integrate with physician EHRs and be able to extract necessary clinical information to support the physician's prescribed treatment and obtain the needed authorization. **We appreciate that ONC has included improving the prior authorization process as an element of its draft strategy, and we encourage the adoption of new technologies that accelerate the process and reduce administrative burdens on physicians.**

Conclusion

Thank you again for the opportunity to provide input on the development of the HIT Burden Reduction Strategy. Ophthalmologists rely heavily on their EHR and HIT systems to assist in providing patient care

but are often burdened by reporting requirements that are not clinically relevant or must use rely on tools that are not designed for ophthalmic care. **While we welcome efforts to reduce burden, we continue to oppose E/M policies finalized for 2021 and recommend the strategy be modified to incorporate recommendations from the medical community that are resource-based. In addition, we encourage further efforts to reduce the burden of the PI category of MIPS by removing the all-or-nothing scoring and awarding full credit in the category for EHR integration with a QCDR.**

If you have questions, please contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.

Sincerely,

Thomas W. Samuelson, MD
President, ASCRS