



May 3, 2019

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**RE: RIN 0938-AT79; Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHPO Managed Care Entities, Issuers of Qualified Health Plans in the Federally Facilitated Exchanges and Health Care Providers.**

Dear Administrator Verma:

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 feedback on this proposed rule.

As physicians who see a high volume of Medicare beneficiaries, most ophthalmologists have integrated EHRs into their practices and have successfully participated in CMS' programs—first under Meaningful Use and now as part of the Merit-Based Incentive Payment System (MIPS). As widespread adopters of health IT, ophthalmologists have implemented resources, notably the IRIS Registry, that integrate with EHR to provide information on clinical outcomes.

Despite this willingness to use new technology, ophthalmologists and their practice administrators often express frustration at the lack of interoperability between EHR systems, particularly in sharing a patient's ophthalmic health information. **ASCRS and its members share CMS' commitment to improving the interoperability of electronic health information and support several of the policies included in this proposed rule, such as giving patients access to their electronic health information. However, we are concerned that CMS is placing too much emphasis on improving quality and reducing cost simply by providing patients with information on claims history from private and state-based payers. In addition, we are skeptical that many patients, especially elderly patients who are likely to be treated by ophthalmologists, will be able to easily access and use this information to make educated healthcare decisions. In fact, some may not be able to access the information at all. We recommend CMS set reasonable expectations about how useful this information will be to Medicare patients.**

Specifically, we will discuss the following provisions in this comment letter:

- **Support for requiring Medicare Advantage (MA), Medicaid, and exchange plans to make data on claims and treatment history electronically available to beneficiaries through open application program interfaces (APIs). However, patients should also be given access to information on quality and clinical outcomes, since they will not be able to make assessments on their healthcare through claims data alone. We are concerned that CMS is seeking to**

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**achieve improvements in cost and quality through this proposal, but without full information—including interoperable medical records that can be shared with the patients’ physicians—that goal may not be achievable.** In addition, for MA plans, we encourage CMS to require that patients have improved access to information about plan networks and utilization management strategies, such as step therapy and prior authorization requirements, which may impact beneficiaries’ access to care and out-of-pocket costs.

- **Support for requiring MA plans to make their provider directories available through APIs.** However, we continue to recommend that plans be required to ensure their directories are up-to-date and accurately display information regarding the providers included in the plan.
- **Concern that CMS’ proposal to post publicly the names of physicians engaging in data blocking does not address how physicians excluded from MIPS or claiming a hardship will be listed.** Since CMS proposes to base the reporting on data blocking on MIPS attestation, CMS must address how physicians who are ineligible for MIPS, such as those under the low-volume threshold or those participating in Advanced Alternative Payment Models (APMs), or any physician granted a hardship exemption for the Promoting Interoperability category, would be treated under this provision in the final rule.
- **In response to CMS’ request for information on patient matching, ASCRS recommends CMS focus on providing physicians and practices a way to identify patients when they switch plans.** Currently, physician practices use a combination of demographic details, such as name, date of birth, and most importantly, plan identification number, as that is unique to the patient. Practices need a means of matching a historical identification number that may be present in the patient’s record with the new plan’s identification number when the patient switches plans.
- **ASCRS continues to strongly oppose step therapy and urges MA plans to reduce their use of prior authorization, as both activities reduce patient access to care and increase physician administrative burden.** However, we are encouraged by CMS’ request for information on strategies to increase interoperability and reduce the need for these activities when patients change plans. We recommend that CMS focus on improving patient matching so that step therapy and prior authorization determinations will follow patients when they switch plans and not force them to begin again with an ineffective treatment.

Our full comments on these issues are below.

#### ***Patient Access to Private and State Plan Data through Open APIs***

**ASCRS supports CMS’ proposal to require that MA plans, state Medicaid, and exchange plans provide patients with access to their claims and treatment history electronically through an open API.** Patients have a right to access this information and should be involved in their healthcare decisions, including choosing cost-effective treatments. However, we caution CMS that patients should not be encouraged to make decisions based solely on cost and should have access to information on clinical quality and outcomes as well. Furthermore, patients should have the information to understand how their plan choices may be impacting their treatment options, such as MA plans’ narrow networks limiting access to physicians who specialize in certain diseases or procedures. Finally, this proposal may not achieve CMS’ goal of empowering ophthalmology patients to use this electronic information to make healthcare

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decisions, since ophthalmologists tend to treat an older cohort of patients who may not be familiar with or have access to the technology needed to access this data.

- **Patients should have full electronic access to claims, treatment, and quality information to help them choose the best treatment option and physician to provide the treatment.** Medical treatments and plan options are complex, and claims data alone will not give a patient a full picture of his or her healthcare information. If CMS envisions that patients will be able to use this information in third-party applications to make better decisions, it must ensure that complete information is available. For example, a patient may use an app to analyze his/her claims data and determine if there is another MA plan available that may have lower premiums. However, it is unlikely that the patient could get full information on whether the new plan would require step therapy for Part B drugs, which could result in poorer outcomes. **Patients should be encouraged to make cost-effective healthcare choices but should have full understanding of not only the cost, but also the quality of the treatments they are selecting.**
- **Physicians should have complete electronic access to the patient's medical records to assist the patient in making appropriate care decisions.** While we realize that the interoperability of medical records is outside the purview of this proposed rule, the records are another element of the complete picture of a patient's health history, along with claims and quality information, that is necessary in the decision-making process. While many patients may be savvy and seek as much information as they can when making care decisions, they must work with their physicians, who have the requisite clinical knowledge to ensure these decisions are appropriate. Conversely, some patients, such as relatively older Medicare beneficiaries who are most likely to be treated by ophthalmologists, may not have the ability to access and use this information. Regardless of whether the patient can access the information or not, physicians cannot help their patients make decisions solely through information available through claims. **We are concerned that CMS is placing too much emphasis on changing patient behavior solely through making the proposed information available.**
- **Even if this increased flow of data could prompt patients to choose more cost-effective providers, physicians, especially in small practices, have very little ability to negotiate reimbursement rates with MA plans, regardless of their clinical quality or efficiency.** Most ophthalmologists practice in small groups and rarely have the market share or resources required to negotiate reimbursement rates with major insurers offering MA plans. In some instances, ophthalmology practices are dropped or excluded from an insurer's network with no reason stated. Given this reality, it is unlikely that even if this proposal is finalized and patients are given electronic access to their claims data, they will be able to make an informed decision on cost or quality of the healthcare they are seeking. Since the MA plans are setting the prices and impacting treatment provided through step therapy or prior authorization, the patient and the physician have very little opportunity to seek or offer alternatives. **In addition to providing claims information electronically to patients, MA plans should be required to provide full transparency about their networks, coverage decisions, and quality of the care offered to ensure beneficiaries are making decisions not based solely on a price that is arbitrarily set by the insurer.**
- **ASCRS recommends that CMS set more realistic expectations for how well patients will be able to use this electronic data to make decisions that have a significant impact on the cost of**

**their healthcare.** While we continue to believe patients should have access to their data, there are few opportunities for patients to effect much change. As noted above, ophthalmologists treat an older cohort of Medicare beneficiaries. Through experience with such programs as Meaningful Use and now MIPS, ophthalmologists have found that the majority of their patients are not able to access nor interested in accessing their health information electronically. In addition, many patients may have limited vision, which impacts their ability to access electronic information. In cases where CMS intends for patients to make more informed decisions about their MA plans, beneficiaries are limited in their choices of physicians due to narrow networks and may not be aware of certain limiting features of their plans, such as step therapy. Furthermore, many ophthalmology practices report that patients routinely are unaware that they are even covered by an MA plan. **While it may be a laudable goal to empower patients to make cost-efficient decisions, it is unreasonable to expect that given factors of patient age, lack of choice under various plans, and the limited usefulness of claims data, there will be widespread achievement of that goal.**

#### ***MA Plan Provider Directories Available through Open APIs***

- **ASCRS supports requiring MA plans to make their provider directories available through open APIs, but we also believe plans should be required to ensure their directories are accurate and up-to-date so that beneficiaries know if the physician of their choice is participating in the plan.** As noted above, ophthalmologists are often dropped or excluded from MA plan networks and given no opportunity to appeal the decision. While we appreciate that CMS has taken steps to ensure that these changes do not happen during the middle of the benefit year, it has been our members' experience that when plan networks do change, the plans are slow to update their provider directories. In addition, they may not include up-to-date information about participating providers, such as new contact information or office locations. **Beneficiaries should have electronic access to provider directories through open APIs, but they will not be able to make informed decisions about their healthcare providers without the assurance that the plan's directory is accurate. We recommend CMS require plans to keep directories updated.**

#### ***Public Disclosure of Data Blocking***

- **CMS should clarify how physicians who are not eligible for MIPS or are granted a hardship will be listed when the names of physicians who are engaging in data blocking are posted publicly.** CMS' proposal to base its determinations on which physicians are engaging in data blocking based on attestation under the Promoting Interoperability category of MIPS would cover most ophthalmologists because a high percentage participate in MIPS and the Promoting Interoperability category. However, some ophthalmologists in small practices take advantage of the small practice hardship exemption because they either do not have EHR or do not want to participate in the category. Finally, a limited number of ophthalmologists are excluded from MIPS entirely if they are either new to practice, under the low-volume threshold, or participating in an Advanced APM. CMS does not discuss how physicians falling into these categories will be treated under this proposal, and we are concerned that without a solution, patients will inaccurately infer that the physicians are engaging in data blocking. **We recommend CMS address this issue in the final rule.**

***Request for Information: Patient Matching***

- **Ensuring patients' information is correctly matched when exchanged electronically remains a challenge for physicians, particularly ophthalmologists in small practices.** Lacking national patient identifiers, practices previously relied on Social Security Numbers (SSNs) as the prime means of matching patients. As the use of SSNs has become discouraged, practices rely on matching several data points to ensure accurate patient information. For patients with Medicare Part B, the SSN has been replaced by the Medicare Beneficiary Identifier (MBI), and it remains relatively simple to match patients. However, for patients with MA or other private plans, practices are forced to confirm name, date of birth, and policy identifier. While the insurance policy identifier is unique to the patient in that particular plan, if a patient changes plans, it no longer becomes a useful data matching point.
- **CMS should consider facilitating a method of cross-referencing insurance policy numbers so physicians can be sure they are exchanging accurate information about the patient.** If a patient changes insurance carriers, or ages into Medicare, practices should have some means of referencing historical identification numbers to compare to current policy numbers. While this will make it easier to match patient information, it could pose a cybersecurity threat and should be undertaken with caution to ensure patient information is secure. **These security considerations should be addressed since patient safety depends on physicians receiving accurate information.**

***Request for Information: Interoperability to Reduce Burdens Associated with Step Therapy and Prior Authorization***

- **ASCRS strongly opposes step therapy and recommends that it not be used in MA or Part D. Despite our continued opposition, at the very least, CMS should require that MA and Part D plans make patient information related to step therapy interoperable electronically to reduce treatment interruptions and physician administrative burden.** Step therapy, or "fail first," is a harmful utilization management technique used by insurers to require that patients begin treatment with a less expensive option before progressing to a more expensive one. While we recognize that CMS has attempted to institute limited guardrails for MA plans using step therapy for Part B drugs, such as encouraging insurers not to require a patient to re-start a cheaper drug that did not work if he or she changes plans, we are concerned that plans will not make this information easily sharable and, in effect, cause patients to go through the same step therapy with any new plan. Furthermore, electronic exchange of this information between insurers would greatly reduce physicians' administrative burden if they are not required to justify the treatment that works best for their patients any time there is plan change. **We recommend CMS require that MA plans make information about patients' step therapy available for sharing electronically.**
- **In addition, ASCRS continues to recommend that CMS take action to reduce MA and Part D plans' use of prior authorization, as it delays beneficiaries' access to care and is an administrative burden for physicians and practices. We recommend CMS require standardized**

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**electronic processes be put in place, so physicians will be able to provide treatment to patients sooner.** Similar to our comments related to step therapy, while we would prefer that CMS curb the use of utilization management tools because they are potentially harmful to patients, increased interoperability and standardized electronic process related to prior authorization would reduce administrative burdens on physicians. Currently, every insurer and plan has its own method of handling prior authorization, forcing physicians and their administrative staff to respond in multiple ways with differing documentation requirements. Standardized processes, such as the consensus endorsed by the American Medical Association, American Hospital Association, and America's Health Insurance Plans, have the potential to streamline prior authorization and eliminate some of the delay in treatment. **Coupled with improved interoperability, we recommend CMS require MA and Part D plans to adopt streamlined and electronic prior authorization processes.**

### **Conclusion**

Thank you again for the opportunity to provide comments on this proposed rule. ASCRS continues to support improving the interoperability of electronic health information. **We recommend CMS finalize its proposal to require plans to make claims and treatment information available electronically. However, we continue to caution that without full information on the patient, such as medical records, and quality and outcomes information, patients will not have all the necessary information to make appropriate healthcare decisions. Furthermore, even with this information, due to the age of the Medicare population being treated by ophthalmologists, many beneficiaries may not be able to access the information or use it to make decisions. In addition, we recommend CMS modify its proposal to indicate whether a physician engages in data blocking to address how physicians excluded from MIPS or who are granted hardships will be listed.**

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

Sincerely,



Thomas W. Samuelson, MD  
President, ASCRS