American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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September 6, 2017

Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Call for Public Comment period for the Vision Screening and Referral in Children

To Whom It May Concern:

On behalf of the American Academy of Pediatrics (AAP), a non-profit professional organization of more than 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of all infants, children, adolescents, and young adults, I write to offer AAP's input on the Center for Medicaid and Medicare Services (CMS) request for comment on the Vision Screening and Referral in Children electronic clinical quality measure.

Specific responses to the questions posed by CMS are as follows:

Whether the data elements are available in an enterprise electronic health records (EHR)

EHRs may include discreet results for tests, but these are unlikely to have been mapped to SNOMED or any clinical taxonomy. Additionally, referrals are unlikely to appear, as optometry does not require a referral in many cases. Clinical conditions are likely to be identified using ICD/SNOMED.

The AAP is concerned about having the detailed results (i.e., 20/30, 20/40, etc.) as part of the numerator because there are many ways results can be entered into a system. In many practices, it may be just a text entry, or it may be typed in as "normal" instead of 20/30. This can be true for the vision chart as well as the photo screener.

Finally, there is no universal way for EHRs to track "patient referred for specialty exam."

The feasibility of collecting and submitting data on this measure under CMS's quality reporting programs

The AAP believes that for data collection purposes, a Current Procedural Terminology (CPT) code based metric would be much better. For example: was vision screening done between ages 3 and 6 years/yes or no?

The usefulness of the measure in assessing the quality of care for Medicaid and Medicare beneficiaries

AAP's Bright Futures recommends that not all children should be screened, but this measure only includes two conditions for exclusions. For example: children at-risk for retinopathy of prematurity, or children with developmental conditions with risk of eye complications may not be good candidates for screening.

Snellen is not a recommended screening procedure for children under 72 months of age. LEA and HOTV optotypes are the recommended chart-based screening tools. A clinician using Snellen to provide screening to a child at 48 months would not be providing recommended care.

The appropriateness of the measure for assessing performance of physicians

The AAP finds this measure to be too aggressive. If screening rates are less than 50%, that warrants a specific measure to drive screening in pediatric practice. There is nothing in the background to suggest that failed screens are not referred consistently by clinicians within the rationale. To that end, there should be a single yes/no measure to assess screening rates. If there is literature to support a referral measure, that should be separate.

Additionally, preventive visits are not required. Ideally, physicians would screen at any opportunity. As the measure is written, if a patient has not been seen for a well visit since age 3 and is now 5, she would count against the clinician. Similarly, a 5-year-old transferring into the practice would count against the new clinician who did not screen because the patient's record indicated that her previous provider had screened at age 4.

This measure includes a look-back period of two years. So, if a pediatrician sees a 3-year-old who then leaves the practice, and this physician typically screens at age 4, this would count against the pediatrician.

The AAP also believes that there should be a denominator exclusion or exception for situations where a patient is not screened because the pediatrician is aware that the patient went to an optometrist (even if there is no diagnosis of amblyopia or blindness).

Additionally, many children are screened as part of a preschool or child care program, which does not generate a claim nor an insurance record. A question arises if a pediatrician has received the screening results: does this physician plug them into the patient's record? Or does she have to administer the screening on-site, regardless of the other result, and generate her own 9917x? AAP recommends logic to indicate that a vision screening has been done by another provider.

Finally, the measure as written does not include logic to protect against a child aging out of the sample set. For example: A child is 5 years old at the start of the measurement period but was never seen by his pediatrician. The child turns 6 and is screened with a pass during the measurement period. His doctor does not make a referral. This patient should be included in the numerator as a pass, not as a fail.

Whether the codes included in the "vision and visual acuity assessment" value set capture chart-based and instrument-based vision and visual acuity screenings that occur in a pediatric primary care setting

The AAP makes the following recommendations:

- The value sets are sparse, and therefore, the AAP recommends supplementing the code lists;
- The following codes are not included:
    - unilateral blindness
    - cortical blindness
    - unqualified vision loss
    - unspecific disorder of binocular vision;
- In the measure specifications, only LOINC is used for vision tests. CPT should also be used, as EHRs will generate this more consistently than LOINC. Current CPT codes would capture this measure:
    - 99173: quantitative, such as Snellen
    - 99174: remote instrument-based
    - 99177: on-site instrument-based
    - 0033T: automated VEP

General comments from the AAP

The AAP believes that measuring vision screening, with the goal of early identification and treatment of amblyogenic risk factors, is of key importance in early childhood. The AAP applauds the effort to identify a pediatric vision screening measure that works for clinicians in practice. However, the AAP asks that CMS recognize that it is very difficult to do screening well without instrument-based screening.

Additionally, if the vision screening is failed, i.e. the result is "Refer", the measure asks for "Referral to an eye care specialist." The AAP is concerned that it is unclear what constitutes a referral. For example: Does this mean an appointment is recommended, an appointment was made, or that the appointment was actually followed through on? Most insurance plans do not require referrals to optometry, so it is unlikely that many pediatricians (even those who consistently track referrals) generate a new e-form within the EHR.

The AAP would also like to bring to your attention that there is a referral reason that is not listed in the guidance: if there is a significant refractory difference between two eyes. For example: if a 3-year-old screens for left eye 20/20, right eye 20/50, and binocular vision 20/30, all screens meet the threshold for a 3-year-old of 20/50. The EHR says, "left eye PASS, right eye PASS, binocular PASS" but there is still an "ALERT ALERT Anisometropia – refer!!" The AAP believes that CMS should clarify this guidance by determining, for the purposes of this measure, if this counts as a pass or fail.

Specifically related to the numerator and the denominator the AAP would like to suggest the following:

- Denominator: The AAP suggests the use of denominator exceptions rather than exclusions in most conditions, and an expansion of the exceptions. Blindness is an

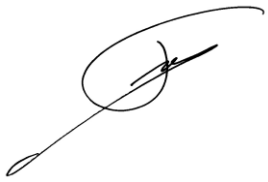
exclusion, but if the physician has a patient with glasses and does not perform screening because her patient has seen an ophthalmologist/optometrist, does that suffice? We recommend including "Seen by ophthalmologist/optometrist, wears glasses" as an exception.

- Numerator: The AAP would like to see the numerator specifications include billing codes (99173, 99174, 99177). This may motivate payers who do not currently recognize these as non-bundled, preventive, separately payable services.

Finally, health insurers who carve out vision and have that part of the plan managed by another vision services plan, may not be timely in reporting their claims back to the insurance carrier, or there may be differences in the claims platform between the vision services plan and the insurance carrier that impedes the insurance carrier from having data for its quality program that utilizes claims data and quality metrics. Pediatricians see something similar in fluoride varnish quality programs where Medicaid has a dental benefit manager and the Medicaid Managed Care Organizations (MCOs) who are doing the reporting only know who is reporting 99188 to the MCO, not D0190/D1206 to the dMCO. The AAP urges CMS to take this scenario into account when continuing to develop this measure.

The AAP appreciates the opportunity to comment on the Vision Screening and Referral in Children eCQM, and thanks you for your attention to our concerns and suggestions. If the AAP can be of further assistance, please contact Patrick Johnson in our Washington, D.C. office at 202/347-8600 or pjohnson@aap.org

Sincerely,



Fernando Stein, MD, FAAP
President

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