June 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
U.S. Senate
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the American Society of Retina Specialists (ASRS), thank you for the opportunity to provide feedback on your recent white paper, Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B.

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

We provide answers to selected questions posed in the white paper below:

Medicare Physician Fee Schedule Conversion Factor (CF)

- As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?

ASRS strongly recommends that Congress authorize an inflationary adjustment to the Medicare physician fee schedule (MPFS) conversion factor. This position is also held by the American Medical Association (AMA), the Alliance of Specialty Medicine, and across the medical community.

As noted in the Committee’s white paper, the MPFS is the only Medicare payment system that is not automatically updated to reflect price fluctuation in the economy. A regular and predictable inflation-based update, such as one based on the Medical Economic Index (MEI), is the most important action Congress can take to ensure the stability and viability of physician practices.

Retina practices, like any other small business, have been negatively impacted by recent high inflation. The lack of Medicare payment increases means retina practices are struggling to retain and attract qualified staff and cannot expand to meet patient need. Without adequate staff and resources, patients trying to see a retina specialist will face increasingly long waits before receiving care for vision-threatening disease. In fact, private practices have fallen so far behind in their purchasing power after decades of inadequate payment levels, we recommend that Congress include a one-time payment update to the conversion factor that brings payments in line with current price levels and then in subsequent years, use the MEI for annual adjustments.
We do not recommend Congress continue to rely on pre-setting specific update levels as it did in MACRA. The 0.5% yearly updates included in the first few years of the program were not significant enough to overcome reductions caused by multiple budget neutrality adjustments and, in hindsight, came nowhere near meeting the actual costs physician practices faced. Adjusting payments based on a yearly inflationary index will align reimbursements with current economic conditions—whether higher or lower than expected.

- **Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation?**

According to the 2022 Quality Payment Program (QPP) Experience Report, almost 40% of physicians were qualified participants in A-APMs. Despite that growth, retina specialists—and specialists in general—have very few opportunities to participate in A-APMs and the overwhelming majority must participate in MIPS. Specialists’ inability to join A-APMs is largely out of their control. Existing entities are hesitant to invite them because they believe it will negatively impact their cost scores and CMS has not been willing to implement specialty-specific models. Given that, Congress should consider extending the greater payment update to physicians who are not able to join A-APMs and potentially share in their bonuses.

**Budget Neutrality**

- **What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting processes?**

ASRS continues to support the evidence-based AMA Relative Value Update Committee (RUC) process as the most accurate method of determining value. This process allows clinical experts to weigh-in on the resources needed to furnish a service, which will help provide a better estimate of how often the service will be billed. When CMS bypasses this process by assigning an arbitrary value to a new service, as it did with the new E/M add-on code G2211, it disrupts the relativity of the fee schedule and can trigger significant budget neutrality adjustments.

For new services in particular, ASRS—along with the AMA and the Alliance of Specialty Medicine—believe some transitional grace period should be created to allow time for physicians, practices, and payers to get used to the new service and integrate it into their processes before they impact budget neutrality adjustments. Finally, CMS should have the authority to reassess the utilization estimates in later years and make changes to the conversion factor to reflect any inaccurate adjustments.

- **Should the Committee consider additional parameters to align the statute’s budget-neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?**

In addition to making reforms to the process for utilization estimates, ASRS recommends Congress increase the minimum threshold to trigger a budget neutrality adjustment. The current $20 million
threshold was set decades ago and does not reflect current economic conditions. As such, even minor adjustments to service values or changes in practice patterns can have significant repercussions across the fee schedule causing payment fluctuations irrespective of the services’ value. The threshold should be raised immediately and Congress should regularly assess whether it will need increases in future years. This recommendation is in line with the AMA’s position, and we recommend Congress consult the AMA on their estimates for needed changes to the limit in the future.

A-APMs

- How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?

As noted above, retina specialists are among the sub-specialists with few, if any, opportunities to participate in current A-APMs. Not only do retina specialists tend to practice in small, independent practices that are not part of integrated groups, a substantial part of the care they provide involves administering high-cost Part B drugs, which disincentivizes the participants in established models from including them in their networks.

Patients suffering from age-related macular degeneration (AMD), diabetic retinopathy, or other chronic and potentially-blinding retinal diseases require regular physician-administered injections of anti-vascular endothelial growth factor (anti-VEGF) medications. The FDA-approved versions of the drugs, including available biosimilars, are among the most frequently-used with the highest annual spending in Part B. An off-label, compounded drug, Avastin, is less expensive, but is often not as effective at restoring or retaining patient’s vision. Retina specialists, or any physician who administers drugs to their patients in the office, cannot control the price of drugs and should not be held responsible for manufacturer’s pricing decisions. Congress could incentivize more existing A-APMs, such as ACOs, to include retina specialists in their networks if Part B drugs were excluded from cost calculations.

- What programmatic flexibilities, with respect to A-APMs or smaller models or pilots, would help to ensure a broader and more diverse array of options for clinicians?

ASRS, as well as the AMA and the Alliance of Specialty Medicine, continues to recommend Congress require CMS to test and implement models developed by physicians and supported by the Physician-Focused Payment Model Technical Advisory Committee (P-TAC). Physicians providing the day-to-day care for a diverse array of patients in different settings know best how to deliver the care efficiently and at a high standard of quality. CMS’s refusal to entertain implementing any of the models recommended by P-TAC to date not only prevents making the modifications sought by the developers but has had a chilling effect on the development of additional models. Specifically, these new models could be smaller and geared toward more episodic or disease-based care that specialists and sub-specialists provide. Congress should step in to ensure physician-developed concepts are, at a minimum, tested by CMS.
MIPS

- What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?

As we noted in our recent submitted testimony to the Committee, ASRS supports what Congress was attempting to do in MACRA by creating a streamlined program to reward physicians for providing evidence-based care that improves beneficiary outcomes. Our recommendation that MIPS be sunset has grown out of frustration with CMS’s problematic implementation of the program, not its goals. As an alternative, ASRS recommends that Congress replace MIPS with a quality improvement program whose structure and scoring are not as prescribed to allow for activities that can be tailored to address identified gaps in care.

For example, when looking specifically at chronic care, calendar year-based performance periods can hamper measurement. ASRS struggled to develop measures for the diseases retina specialists treat most frequently, such as AMD and diabetic retinopathy, because the treatment can last for several years. It can be difficult to identify measurable endpoints within the year and patients with Medicare Advantage or other private insurance (who are included in MIPS), are almost all subjected to step therapy, can take several months to stabilize. In addition, new technologies such as home monitoring and artificial intelligence (AI) hold promise for helping improve outcomes for patients with chronic retinal disease. Reimbursement for these services is not well-addressed under the PFS, and it’s unclear how any potential improvements would be accounted for in MIPS currently. ASRS and the Alliance of Specialty Medicine agree that Congress should provide flexibility for physician input on innovative approaches to improve quality.

- Are there existing practice improvement activities or incentives, such as data registry participation, that should continue as a means of promoting individual clinician quality of care?

ASRS continues to support the inclusion of clinical data registries as a component of quality improvement, but cautions against an over-reliance on them. Registries currently track and maintain vast amounts of patient data with very little oversight to ensure the accuracy of the data inputted or to validate features such as AI-based algorithms designed to interpret free text in electronic records. There is also no clear evidence suggesting that patients are comfortable with their personal data being aggregated in such a way. Without stronger oversight, ASRS cannot support proposals that seek to replace all participation in MIPS, or its successor, with involvement in a registry.

Ensuring the Integrity of the PFS

- What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS’s RVU and rate-setting processes?

ASRS, and our fellow members of the Alliance of Specialty Medicine, are participants in, and strong supporters of, the AMA’s RUC process. The RUC is a body of clinical experts who are best able to weigh the evidence, maintain relativity, and establish values for physician services. We strongly oppose any effort to reduce or eliminate the RUC’s role. However, the RUC’s work product can only be as good as
the information it receives. ASRS and other participants across medicine have long-sought more accurate and real-time claims data from CMS to help understand how and at what frequency physicians are providing specific services. We recommend that Congress require CMS to provide the RUC with more timely data to assist in assigning values.

- For more than 25 years, a Refinement Panel provided a relative value appeals process for CMS’s annual PFS processes. Should the agency consider reinstating such a panel, and if so, what modifications, if any, would help to ensure independence, objectivity, and rigor?

ASRS supports reinstating the Refinement Panel and recommends that Congress require CMS to do so. ASRS, along with the AMA, strongly encourage that the Refinement Panel be reinstated in its original format that allowed interested stakeholders and third-parties to appeal and provide evidence supporting alternate values than those finalized by CMS. At that time, CMS was bound to accept the panel’s recommendation. Later on, CMS weakened the panel through rulemaking, eventually eliminating it completely—over the objections of ASRS and the medical community. Bringing back the Refinement Panel would restore physician’s due process with an outlet for appeal and further ensure that values in the fee schedule are accurate and evidence-based.

- What third-party entities could produce the most credible and reliable analysis of CMS’s RVU determination and rate-setting processes, and what key areas should such analysis examine?

ASRS and the Alliance of Specialty Medicine believe that the only third-party entity that can provide credible and reliable analysis of RVU determination is the RUC. As stated above, we strongly oppose any efforts to diminish its influence or seek alternate methods of valuing physician services. The RUC is a consensus-driven body of experts who base their determinations on data supplied directly from physicians providing the services in question. Only physicians who have direct experience with a particular service have the ability to weigh both the time and intensity required to furnish it relative to all other services. We do not believe that an alternative system could attract the requisite experts to make credible determinations.

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We thank the committee again for the opportunity to provide feedback on this white paper. We would be happy to provide you with any assistance or additional information you may need. Please contact Allison Madson, vice president of health policy, at allison.madson@asrs.org for assistance.