ASRS American Society of Retina Specialists

October 31, 2022

The Honorable Ami Bera, MD
US House of Representatives
Washington, DC 20515

The Honorable Larry Bucshon, MD
US House of Representatives
Washington, DC 20515

The Honorable Kim Schrier, MD
US House of Representatives
Washington, DC 20515

The Honorable Michael Burgess, MD
US House of Representatives
Washington, DC 20515

The Honorable Earl Blumenauer
US House of Representatives
Washington, DC 20515

The Honorable Brad Wenstrup, DPM
US House of Representatives
Washington, DC 20515

The Honorable Bradley Schneider
US House of Representatives
Washington, DC 20515

The Honorable Mariannette Miller-Meeks, MD
US House of Representatives
Washington, DC 20515

RE: ASRS Comments on Medicare Physician Payment and Value-Based Programs

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

Thank you for the opportunity to provide input as Congress begins its critical work of addressing shortfalls in Medicare physician payment and further development of value-based payment programs.

The American Society of Retina Specialists (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.

As you and your colleagues in Congress begin consideration of potential reforms, ASRS recommends focusing on the following items:

- **Implement predictable, inflation-based updates to the fee schedule.** The physician fee schedule is the only Medicare payment system without an inflationary adjustment factor.

- **Address budget neutrality requirements that currently destabilize the fee schedule.** Necessary and ongoing updates to individual codes should not trigger massive revaluations for other, unrelated services.

- **Direct CMS to modify its 2021 policy related to E/M codes** by applying increased visit values to global surgical codes and eliminating the unnecessary add-on code.

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- **Implement a value-based alternative to the Quality Payment Program (QPP)** that focuses on identified gaps in care and structural barriers that prevent beneficiaries from receiving preventative or timely care instead of relying on one-size-fits-all programs that currently function as reporting for reporting's sake without adding value to the system.

- **Require CMS to test and implement physician-developed alternative payment models (APMs).** CMS has yet to take action on any physician-developed models that have been endorsed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), and thereby chilling any further innovation toward value-based care.

Predictable, Inflation-Based Updates to the Fee Schedule

The Medicare physician fee schedule does not currently have a built-in inflationary adjustment mechanism. Unlike other Medicare providers, such as hospitals or nursing facilities, physicians will receive no update to their payment for 2023 to reflect record inflation. In fact, due to budget neutrality adjustments and ongoing sequestration, physicians currently face a potential cut of more than 8% in 2023, unless Congress acts. We appreciate that the sponsors of this request for information have nearly all sponsored or co-sponsored legislation to prevent a cut by modifying the conversion factor for 2023. However, simply maintaining the status quo is unsustainable and insufficient to meet the financial demands currently placed on retina specialists, and physicians in general.

Retinal disease disproportionately affects the elderly population, so retina practices are dependent on Medicare as the biggest payer and driver of their reimbursement rates. Like all other businesses, inflation has impacted retina practices heavily in 2022. Retina practices report difficulty recruiting and retaining staff, particularly when other providers like hospitals are able to offer higher compensation. With flat or declining reimbursements, retina and other independent practices will further struggle to have enough staff on hand to meet the growing patient demand due to our aging population and increased prevalence of retinal diseases. Furthermore, inflation has directly impacted retina practices' ability to purchase the hardware necessary to run a clinical practice due to increasing costs of medical equipment, increasing cost of the necessary ocular imaging hardware and increasing cost of the information-technology systems required.

Even before inflation hit record levels, practices faced steep costs of complying with quality reporting programs and maintaining EHR systems; they must manage increased administrative costs, such as from private insurers' prior authorization requests; and continue to need to make practice accommodations and pay for personal protective equipment due to the ongoing challenges related to the lingering COVID-19 pandemic.

Astronomical building costs and supply chain delays are preventing practices from expanding to meet patient demand as well. In response to recent inflationary pressures, many practices have had to limit their schedules or close satellite and rural offices. However, practices' ability to meet patients in their own communities is also hampered by outdated Stark Law/anti-kickback provisions that set minimum staffing and operating hours for satellite locations that may not be feasible or warranted. Without increased physician reimbursements to meet record inflation along with these economic demands, Medicare beneficiaries will experience more profound limited access to care.

ASRS strongly recommends Congress implement an appropriate and predictable inflationary adjustment factor into the fee schedule as early as the 2023 payment year. While we are currently experiencing record inflation that exacerbates the situation, the lack of regular inflationary updates over the last two decades has accumulated to seriously erode practices' purchasing power, regardless of today's pressures. This situation should be corrected and prevented from happening again in the future.

Furthermore, Congress should eliminate all sequestration on Medicare payments. This decades-long problem has hampered physicians' purchasing power and is solely based on Congress' inability to develop long-term solutions to fiscal issues.

Prevent Instability from Budget Neutrality Adjustments

ASRS recognizes that budget neutrality requirements are a key factor in ensuring the continued financial health of the Part B program. However, the current zero-sum system subjects physicians to arbitrary cuts, even when much-needed updates are made. Pitting physicians into have and have-not camps further prevents significant progress in a move toward more value-based care.

When CMS undertook a revision and revaluation of evaluation and management (E/M) codes for the 2021 payment year, ASRS was pleased that the agency accepted the medical community's recommendations that the office visit codes be modified to reflect the complexity of the medical decision-making or the time spent on patient care, rather than based on a review of elements that may not be medically-necessary. This update was well-overdue and the codes now better reflect the way office-based care is furnished.

The implementation of these codes in a budget-neutral system, however, created such a massive redistribution of value that it threatened the financial well-being of proceduralists' practices, like retina specialists and other surgeons, and has required Congress to intervene ever since. Other long-put-off, but necessary, updates to practice expense and clinical labor pricing have the similar potential to destabilize the fee schedule by drastically redistributing value when no actual change in work has taken place. **Congress must provide CMS with some authority to waive, bypass or eliminate budget neutrality when revisions are necessary to reflect updated prices or practice patterns.**

The constant threat of budget neutrality also impedes innovation toward more value-based care. New models and practice patterns have the potential to increase quality and value in the Medicare program, but if they also have the potential to disrupt the fee schedule, they are sure to face strong opposition from any parties that may be negatively impacted by them. To ensure the Medicare program is moving toward a more value and team-based system, Congress should provide CMS with the authority to prevent new models from destabilizing the fee schedule.

Modify CMS' 2021 E/M Policy

While we continue to support the updated values for E/M codes, ASRS opposes key elements of the policy CMS implemented along with new values in 2021, which are exacerbated by the budget neutrality

issues mentioned above. **We recommend Congress require CMS to apply the updated office visit values to post-operative visits bundled in 10- and 90-day global surgery codes and to eliminate the so-called "add-on" code entirely.**

Based on unreliable evidence that not all the visits included in global packages were occurring, CMS opted not to increase the values of post-operative visits included in 10- and 90-day surgery codes. ASRS and the surgical community have strongly opposed this and recommended it be fixed for several years. Failing to adjust the post-operative visit values disrupts the relativity of the fee schedule and violates the Medicare statute requiring equal reimbursement for equal work. We have maintained that if there are concerns that individual codes include more visits than are currently furnished, then they should be revalued through the existing Relative-Value Update Committee (RUC). We thank members of Congress who have urged CMS to correct this issue in past years, but believe that the agency will not act without a statutory mandate. We strongly recommend Congress include this fix in any physician payment legislation.

Furthermore, we request that Congress completely eliminate CMS' poorly-defined E/M "add-on" code (G2211). Congressional action in 2020 prevented CMS from implementing this code for three years. CMS has failed to provide adequate rationale for its necessity and defined it so broadly it could potentially be appended to any E/M code, creating yet another massive redistribution of value in the fee schedule.

Focus the Quality Payment Program (QPP) on Identified Gaps in Care and Structural or Systemic Barriers to Care

Since the implementation of MACRA, retina specialists have been high-achievers in the MIPS program. However, that achievement is based on reporting on measures and activities that are not always clinically-relevant; requires significant expense, time, and administrative effort to complete; and has not led to any meaningful improvement in the quality of retina care.

Despite the lack of a measurable improvement, it is unclear that there actually are gaps in retinal care, or a wide divergence in the quality of care offered by individual physicians. Consistent, universal high achievement on the current measures in the MIPS program would indicate that regardless of location or practice, a beneficiary under the care of a retina specialist is receiving services within the standard of care. Retina specialists are constantly engaged in clinical research to improve outcomes and the patient experience; however, they are generally seeking advancement beyond what is already considered excellent quality of care. MIPS measures, and the standards they are based on, cannot (and should not) change at the same pace as clinical research, and should only change when there is consensus from clinicians that the standard of care needs to change. Therefore, if a physician can demonstrate that he or she is meeting the consensus quality standards of the specialty, participating in annual reporting becomes an administrative exercise and burdensome, rather than informative.

Instead of continuing a program that becomes meaningless for clinicians who are delivering high-quality care, Congress should direct CMS to focus its attention on identifying actual gaps in care or working to address structural or systemic barriers that prevent patients from receiving timely or appropriate care.

Specific gaps in care can be identified through a variety of ways: surveys of clinicians and beneficiaries; analysis of claims data to determine what procedures have the highest complication rates, lead to the most hospitalizations, have different outcomes based on patient demographics; or any number of other potential factors. Once those gaps are identified, then the program should be developed to correct them. Quality improvement should move from across-the-board programs, like MIPS, and toward targeted, and clinically-valid interventions that are proven to lead to better outcomes.

Systemic and structural factors are well-documented as key drivers of poor outcomes and should be a key focus of quality improvement going forward. Retina specialists, like other sub-specialists, rely on other physicians to send patients who need focused care to them. However, if the patients are not even able to access the referring physician's services, they are unlikely to ever make it to the sub-specialist level. Retina specialists can continue to provide high quality care, but if Medicare does not work to address the factors outside the physicians' control, beneficiaries—particularly those with structural barriers to care—will continue to suffer avoidable poor outcomes.

For example, a retina specialist may have perfect scores on the quality measures he or she reports, i.e., well-stabilized chronic disease patients and very low surgical complication rates. As a result, he or she scores well in MIPS and earns a bonus. However, if diabetic patients have not been informed by a primary care provider that they need to be screened for diabetic retinopathy, or have trouble getting to doctors' appointments because of transportation needs or lack of a family or care-giver to accompany them, they are unlikely to make it to a retina specialist and are at risk of irreversible vision loss. While there is currently a MIPS quality measure related to diabetic eye exams, there is no mechanism (or incentive) in the program to identify the patients who are not receiving the care they should be or to assist patients overcome the obstacles that prevent them from receiving care.

Furthermore, higher rates of diabetes are well-documented in certain populations such as Black, Hispanic, and Indigenous cultures. Interventions targeted at assisting any patient comply with the heavy treatment burden of diabetic eye disease should be directed at these patients—as well as programs aimed at pre-diabetes prevention and other factors that contribute to the incidence of disease in these groups.

As we look toward a new value-based system, ASRS strongly recommends Congress resist the temptation to impose yet another across-the-board mandatory program. By attempting to provide options for all potential participants, the MIPS program has become a meaningless exercise in reporting data and not working to meet the challenges like those discussed above. Focused and targeted programs that incentivize addressing identified gaps in care; at-risk populations and those having difficulty accessing care; and specific services and procedures with poor outcomes will be far more effective in improving beneficiary outcomes than yet another reporting program.

Require CMS to Test and Implement Physician-Developed APMs

Addressing the unmet needs of Medicare beneficiaries, like the example above, is not a new goal and the development of APMs have sought to meet those challenges. However, there has been very little opportunity for retina specialists, or other specialists, to participate in these models. MACRA provided physicians with a pathway and incentives to develop them, but CMS has prevented any outside

innovation and thus squandered the incentives Congress provided to move Medicare to a more value-based system.

Currently, very few retina specialists participate in APMs. Accountable Care Organizations (ACOs), the most readily-available APMs, are primary care-focused and have not sought to include retina specialists chiefly because of the high-cost Part B drugs retina specialists use to treat chronic retinal disease, such as diabetic retinopathy or age-related macular degeneration. In fact, several retina practices report that they have received threats of non-referrals from local ACOs (to which they do not belong) to modify their drug administration patterns because the ACO believed they were negatively impacting its cost scores. While this may seem nonsensical because retina specialists do not control the cost of the drugs they administer and caring for a high percentage of blind patients would be much more impactful on an ACO's total costs, this situation persists and prevents retina specialists from moving from MIPS to APMs with currently available models. Congress could potentially improve specialists' participation levels in ACOs or other models by exempting Part B drugs from cost calculations.

Retina specialists would also be unlikely to develop a specialty-specific APM because CMS has indicated it is uninterested in models developed outside of its Innovation Center. CMS has refused to even study the feasibility of any of the models developed by physicians that were endorsed by the PTAC and has made public statements to indicate they will continue to focus on primary care models and not develop APMs for specialists. This situation has created a stalemate where a significant percentage of the physician population has no current option for APMs, none on the horizon, and no mechanism to develop one. In the meantime, the additional 5% payment bonus for APM participants Congress included in MACRA will expire at the end of this year. ASRS and others in the medical community support extending it, however, without action from Congress to spur new models, it is unlikely that retina specialists will have any opportunity to access it.

Congress should require CMS to test—on a small and voluntary basis—new models developed by physicians or other providers. Physicians are closest to their patients and know their unmet needs. They should have direct input in how to address them.

Thank you for this opportunity to provide feedback. Please contact Allison Madson, vice president of health policy, at allison.madson@asrs.org for assistance or if you have questions.

Sincerely yours,

Judy E. Kim, MD, FASRS
President