ASRS American Society of Retina Specialists

June 27, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS-5517-P)

Dear Acting Administrator Slavitt:

The American Society of Retina Specialists (ASRS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule (CMS-5517-P), published on May 9, 2016 in the Federal Register, regarding the new Quality Payment Program (Program) implementing MIPS and APMs under the Medicare Access and Chip Reauthorization Act (MACRA). ASRS is the largest retinal organization in the world, representing more than 2900 members in every state, the District of Columbia, Puerto Rico, and 59 countries.

We appreciate the administration's outreach to the physician community during the comment period on this important proposed rule, including its listening sessions, briefings, webinars, and meetings with the AMA and national medical specialty societies. ASRS would appreciate the opportunity to continue this initial open dialogue to ensure that the transition to the new Program will be as smooth as possible. The magnitude of the changes proposed under MACRA cannot be overstated. The new Program not only imposes another consecutive year of changes to reporting requirements for physicians to digest and navigate, but it also imposes the most sweeping policy changes to Medicare payment since the RBRVS. While we appreciate that CMS has provided flexibility in its proposal to implement MACRA, as aptly noted in its recent listening session, the desired flexibility leads to increased complexity.

Overall, ASRS supports the thirteen high-level recommendations that the American Medical Association (AMA) submitted in its comment letter. Given this general support, the ASRS will focus its comments on improving the MIPS program as alternative payment methods do not currently exist for retina specialists. We specifically request that CMS make the following changes:

- Shorten the initial performance period, and push back the start date so the performance period is closer to when incentive payment will be made
- Provide physicians with the flexibility to select either a shorter reporting period or the full calendar year (with an optional look-back to January 1 in 2017) if they believe it is more appropriate for their practice
- Adjust the first year's performance period to a maximum of six months

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- Assist small practices with successful implementation of the Program Reduce the thresholds for all reporting mechanisms to no more than 50% of Medicare Part B patients
- Reinstate the quality measures group reporting option
- Simplify reporting burdens and improve chances of success by creating more opportunities for partial credit and fewer required measures within MIPS
- Exempt specialists, such as retina specialists and other ophthalmologists, who do not provide primary care, from the requirement to report population-based measures
- Improve risk adjustment and attribution methods before implementing the resource use category
- Eliminate cost measures developed for hospital-level measurement
- Remove the pass-fail component of the Advancing Care Information (ACI) score
- Reduce the number of required Clinical Practice Improvement Activities (CPIAs) and include continuing medical education and fellowships as 'Eligible Activities'

Implementation Timeline

Given the magnitude of changes and the complexity of the proposal, ASRS believes it is critical that implementation be carefully planned and not rushed to ensure successful participation. The implementation timeline CMS proposes is too short. We do not believe physicians will be ready to participate on January 1, 2017. Individual practices must have time to digest the new rules and assess the best approach to implementation for their particular circumstances. We believe extra time will also be helpful for electronic health record vendors, registries, and others to update their systems to accommodate the new program requirements. In fact, rushing implementation will likely exacerbate current usability issues and add to the existing problems with technology. **We therefore urge CMS to shorten the initial performance period, and push back the start date so the performance period is closer to when incentive payments will be made.**

In addition, we urge CMS to allow more suitable reporting periods for both the MIPS and APM programs. A full calendar year requirement can create significant administrative burden for practices and limit innovation while not improving the validity of the data, particularly in categories where measures are not automatically calculated by CMS. Instead, physicians should be able to select a shorter reporting period or use the full calendar year (with an optional look-back to January 1 in 2017) if they believe it is more appropriate for their practice.

Overall, ASRS is concerned that requirements of the new program will disproportionally affect small practices. The majority of our members are in small practices with five or fewer physicians. Since the release of the proposal, numerous organizations have voiced concerns about the potential impact of MIPS on solo and small physician practices due to the regulatory impact analysis wherein CMS estimates that 87% of solo practitioners will receive a negative payment adjustment and 67% of practices with 2-9 providers will receive a penalty**. Given these estimates and the complexity of the program, it is imperative that CMS assist small practices with successful implementation of the Program.**

QUALITY PERFORMANCE CATEGORY

Reinstate the 50% Thresholds and the Measures Group Reporting Option

Overall, ASRS appreciates that CMS has proposed to increase flexibility for physicians. We appreciate that CMS is eliminating an "all or nothing" approach to reporting for quality measures so that physicians will get partial credit based on the number of measures reported and not scoring measures reported that don't meet all of the required criteria. We also appreciate that CMS would require fewer measures to report, reducing the number of quality measures required from nine to six and allowing physicians to choose measures relevant to their practice. In addition, we appreciate that reporting can still be accomplished through a variety of mechanisms. We believe it is still important, however, that CMS not reduce the number of measures that may be reported through claims until the challenges around electronic reporting are eliminated, and, further reductions are made in the required number of quality measures to be reported.

Despite increased flexibility, the CMS proposal increases the reporting burden. Under PQRS, physicians currently report quality measures for 50% of all Medicare Part B patients via registry, claims, EHR or the Group Practice Reporting Option, or 20 patients if reporting via measures groups. Under the MIPS proposal, CMS eliminates the measures group option and requires physicians reporting via registry or EHR to report measures for 90% of all their patients, regardless of payer, and physicians reporting via claims to report measures for 80% of all Medicare Part B patients.

ASRS believes these proposed increased thresholds are too high, particularly under a new system of reporting and scoring that physicians must learn. In addition, we oppose the proposed elimination of the new quality measures group for diabetic retinopathy, along with most other quality measures groups. ASRS supported the new measures group as a reporting option because it is a more holistic approach to evaluating quality allowing for a big picture view of patient care for particular conditions. CMS did create lists of measures by specialty to assist in reporting, however these "specialty measure sets" are not the same as measures groups, which are designed around a particular patient condition. The specialty measure sets include measures for an entire specialty, including subspecialties such as retina within a specialty (ophthalmology); as such, the measures are not all relevant or applicable to each subspecialty or practice. In addition, the measures groups theoretically provide more meaningful information, and the lower reporting burden would have the potential to increase participation in PQRS.

We urge CMS to continue to work toward the goal stated in its proposed rule of reducing provider burden by lowering the proposed reporting thresholds and reinstating the quality measures group reporting option.

<u>Simplify Reporting Options, Reduce Number of Required Measures, and Exempt Non-Primary Care Specialists from Population-Based Measures</u>

The ASRS joins the AMA in urging CMS to reduce the number of required quality measures to four, eliminate the outcome/high priority and cross-cutting measures requirements, and make global and population-based measures optional. ASRS is particularly concerned that the global and population-based measures could potentially hold physicians, especially certain specialists, responsible for care they did not provide. These population health measures were developed for use at the community or hospital level and tend to have low statistical reliability when applied at the individual physician level and to smaller groups. These acute and chronic care composites and all-cause hospital readmission measures focus on the delivery of primary care, which does not apply to ophthalmology. **Given the potential for misattribution, we join the American Society of Cataract and Refractive Surgery (ASCRS) in**

urging CMS to apply the same rationale as it did in the ACO rule1 and exempt non-primary care specialists, such as retina specialists and other ophthalmologists from these additional primary care measures.

Risk Adjustment and Scoring Benchmarks

In general, ASRS opposes current risk adjustment methods for all of the MIPS categories. CMS must develop a more sophisticated risk adjustment method that includes more granular comparisons among specialties and subspecialties, adequately accounts for patient comorbidities, patient compliance, patient demographic and socioeconomic factors, and improved attribution methods. Any new risk adjustment method must be successfully tested to ensure that it does not adversely affect physicians treating low-income, minority or elderly patients.

Further, scoring benchmarks should be set with these considerations in mind. Physicians who treat patients with chronic conditions, such as age-related macular degeneration or diabetic retinopathy, are not able to cure patients. Instead, treatment is limited to managing the progression of the disease to ensure patients do not lose their eyesight completely. In many cases, the success of the treatment depends on patient compliance with the treatment protocol and the particular characteristics of the patient. Physicians should not be held responsible for unrealistic outcomes or outcomes entirely dependent on patient compliance or patient conditions. The subpopulation of diabetic patients that retina specialists treat are among those with the poorest control of their disease and most already have diabetic retinopathy when they are first seen by the retina specialist. Retina specialists do counsel their patients to underscore the critical need to comply with the treatment plan established by their primary care physicians to maintain better control of the disease and minimize further deterioration of their eyesight, yet a retina specialist has little influence on the patient's systemic diabetes control which is managed by the patient's endocrinologist or primary care physician. ASRS believes it is not appropriate to penalize a retina specialist for a patient's poor metabolic control or other chronic comorbidities.

CMS should work with medical specialty societies to determine how to develop an effective risk adjustment method. CMS should focus on eliminating flaws that have made practices with the most high-risk patients more susceptible to penalties than other physicians.

RESOURCE USE PERFORMANCE CATEGORY

ASRS appreciates that performance in the resource use category would be assessed using measures based on administrative Medicare claims data, such that no data submission would be required. Physicians and groups would automatically be assessed on resource use for Medicare patients only, and only for patients attributed to them. Those who do not have enough attributed cases to meet or exceed the case minimums proposed would not be measured on resource use, but would be re-weighted. This is particularly important for retina specialists and other specialty physicians who should be exempt from aspects of the scoring under this performance category.

CMS should work with physicians and medical societies to determine how to reweight performance categories when needed. CMS should not over emphasize the quality category when determining how to reweight a missing MIPS component. Rather, the rule should allow for flexibility in

[1] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations (CMS-1461-P) Final Rule June 9, 2015 (80 FR 32691)

how to redistribute the different performance weights, and CMS should work with affected physicians and medical societies to determine an appropriate approach.

Overall, ASRS continues to have major concerns with aspects of the Value-Based Payment Modifier (VM) that CMS proposes to carry over to the Resource Use performance category. ASRS has repeatedly stated that CMS must address weaknesses in its methods of adjusting for differences in physician specialty and subspecialty as well as patient risk, and must improve feedback to physicians to avoid unintended consequences of the VM. CMS must address weaknesses in its methodologies that fail to distinguish between specialists and subspecialists in the same field. Without refinements to VM attribution methodologies, many subspecialists, like retina specialists, may be inappropriately labeled as high cost utilizers due to inaccurate attribution methodologies. For example, subspecialists that routinely provide high cost drugs or procedures would not be distinguished from physicians in the same specialty who do not provide similar treatment to similar patients, leading to inaccurate "comparisons" and misleading information provided to patients.

We believe there must be appropriate peer comparisons, including at the specialty and subspecialty levels, of services provided and billed, to assess individual provider quality and resource use prior to publishing such comparisons for patients. Absent apples to apples comparisons, the data is not truly meaningful to patients and in fact, may be harmful, not only for the physicians, but also for patients who are forced to make decisions that are based upon inaccurate or meaningless data.

Despite acknowledging these problems in the preamble, CMS proposes the continuation of two measures from the VM: total costs per capita for all attributed beneficiaries (total costs measure) and Medicare Spending per Beneficiary (MSPB). As stated previously, the current VM cost measures are primary care-focused and should not be applied to retina specialists. These measures would potentially attribute high costs of treatment of patients for non-retina related conditions to retina specialists due to the flawed attribution process based on billing evaluation and management codes. We believe it is not appropriate for CMS to evaluate specialists for their costs using measures that do not apply to specialty providers, such as retina specialists. Further, these measures are inappropriate as they were developed for use in hospitals and other settings and have not been tested for use in physician offices.

As the current cost measures are primary care-focused, ophthalmologists would potentially receive a penalty based on care they did not provide. ASRS urges CMS to remove these cost measures. Alternatively, if CMS does not eliminate these cost measures, CMS should adopt the same exclusions for the resource use category attribution process as currently used for ACOs, so that specialists, such as ophthalmologists, are not penalized for costs they cannot control. Either way, CMS should reweight the proposed composite score weight for resource use from 10% to a lower percentage for the first performance year or beyond while it improves upon attribution methods.

<u>Episode-Based Measures</u>

ASRS appreciates that CMS has acknowledged difficulties with attribution under the current measures and will transition to episode-based measures. CMS proposes to add 41 episode-based measures to account for differences among specialties. Because CMS recognizes the need for improved attribution, it

plans on making refinements to its attribution methodology starting in 2018, but this will not be in time for the 2017 reporting period, which will impact the 2019 payment adjustment.

Continued use of the flawed cost measures utilized in the VM will perpetuate inaccurate and inequitable comparisons of costs among physician practices. While we believe episode groups may be a better way to assess a physician's resource use, we are concerned about using episode groups in conjunction with existing cost measures. Until CMS develops a risk adjustment method that can accurately account for various patient factors, distinguish among subspecialty physicians, and that has been sufficiently tested, CMS should not move forward with these measures.

ADVANCING CARE INFORMATION (ACI) PERFORMANCE CATEGORY

ASRS appreciates and supports many of the changes that CMS proposes for the Advancing Care Information category as they offer more flexibility than prior Meaningful Use requirements. Overall, ASRS appreciates that physicians will have the ability to customize the program to better suit their needs, that a physician may still receive 50 points from the base score merely for reporting even if they are unable to meet increased thresholds for the performance score measures, that CMS eliminated the quality reporting component of Meaningful Use which was redundant to reporting quality under PQRS, and the exception for physicians who do not administer immunizations under the public health and clinical data registry reporting objective since the current public health registries are primary care-focused and not applicable to retina specialists and other ophthalmologists. We appreciate the flexibility offered in the proposed rule, which permits physicians to continue with Modified Stage 2 of Meaningful Use. We also understand that those participating in a registry will be able to achieve a bonus point.

Overall, however, there are still issues with patient engagement, health information exchange, and public health and clinical data registry reporting requirements. **ASRS opposes measures in the ACI category that hold providers responsible for information over which they have no control and recommends they be removed.** While we agree that patient engagement, care coordination and health information exchange are important goals, we continue to believe that the requirements for Patient Electronic Access and Health Information Exchange hold providers responsible for the actions of patients and other physicians outside of their control.

The CMS proposal for the performance score is similar to Stage 3, which the medical community opposed. Some of the required measures are not appropriate for retina specialists, as the majority of our patients are older Medicare patients with conditions that limit eyesight. Because this population of patients is not likely to use a computer, it adversely impacts our members' ability to meet the requirements of several of these measures. For example, physicians would be held accountable for 10% of their patients to view, download, or transmit their health information. Most of our members were not able to reach the previous goal of 5% under the original proposal for Stage 2. It is highly unlikely physicians will be able to meet the thresholds. Retina specialists in rural areas have even more difficulty meeting these measures, as many of their patients do not have access to a computer. As result, retina specialists will continue to struggle to meet the Patient Electronic Access to Health Information and the Coordination of Care through Patient Engagement objectives.

Similarly, we oppose the measures included in the Health Information Exchange objective requiring the action of other providers and recommend that thresholds under the performance score not be set at levels unattainable by our members. Overall, the Health Information Exchange Objective does not adequately

reflect EHR interoperability. It is a poor metric for interoperability as the focus is on the quantity of information exchanged and not the relevance of the exchanges. EHR vendors often design their systems to make them just interoperable enough to meet existing Meaningful Use requirements, but not to facilitate true interoperability. We urge CMS to re-focus the ACI category on specialty-specific interoperability use cases rather than the quantity of data exchanged.

Remove the Pass-Fail Component to ACI Score and Maintain Hardship Exemptions

The proposed rule retains a pass-fail element in the base ACI score. Instead of this approach, **CMS should provide credit for each measure reported, even when it is a simple yes/no or attestation measure**. CMS should also reweight the base score to 75% of the total ACI score. In general, ASRS supports the AMA comments on and recommendations for reworking the methodology and weighting of the base score and the performance score as the proposed ACI scoring methodology is extremely complex, creates perverse incentives and increases the reporting burden on physicians.

CMS should set the performance score benchmarks at levels that can reasonably be achieved by all providers, particularly in the first performance period. When developing scoring benchmarks for the performance component of the ACI category, CMS should not hold physicians responsible for actions outside their control. We oppose benchmarks similar to those in Stage 3, since the measure thresholds are far too high for many providers.

Finally, we urge CMS to maintain all existing Meaningful Use program exclusions and hardships, including for physicians who do not refer patients, have insufficient broadband availability, unforeseen circumstances or vendor issues. If a provider receives a hardship exemption in this category, the weight of the ACI performance category should be reweighted among the other three performance categories so the provider is not penalized.

CLINICAL PRACTICE IMPROVEMENT PERFORMANCE CATEGORY

We appreciate that CMS provides consideration for individuals or groups with fewer than 15 physicians and those practicing in health care shortage areas, as they only have to perform two Clinical Practice Improvement Activities (CPIA), regardless of scoring weight, to get the maximum score for this category. We specifically support the fact that CMS provides credit to physicians for participating in a qualified clinical data registry or clinical data registry run by a medical society when the data collected is used for quality improvement or when data is collected for ongoing practice assessment and improvements in patient safety.

Since the proposed list of CPIAs is heavily tilted toward primary care practices and does not provide many options for specialists, we recommend that additional activities, such as participating in continuing medical education (CME) or fellowships, be included in the list of available CPIAs. Further, we urge CMS to expand the high-weighted CPIA options or reduce the total number of required CPIAs. Only a few CPIAs are high-weight and key patient quality activities are only medium weight. Given the patient benefit associated with these activities, CMS should provide more credit for these important care activities. Physicians could be required to report on as many as six different activities in order to receive the full CPIA score. While the activities vary, six different requirements may quickly become overly burdensome, especially given the low-weight of this performance category compared to others.

We applaud CMS' plan to develop a process for future years of MIPS where stakeholders can recommend activities for potential inclusion in the CPIA inventory. We urge CMS to be flexible and include as many proposed CPIAs on the final list as possible.

We oppose the CMS proposal to make the CPIAs a baseline requirement that will continue to have more stringent requirements in future years so that physicians must demonstrate continuous improvement over time. MACRA, however, does not provide for scoring based on improved performance under CPIA, and we urge CMS to maintain the proposed attestation method in future years.

Concerns about Accuracy and Validity of Information on Physician Compare

MACRA requires that CMS publicly report on Physician Compare the CPS score for each MIPS-eligible clinician, performance of each MIPS-eligible clinician for each performance category, and periodically post aggregate information on the MIPS, including the range of composite scores for all MIPS-eligible clinicians and the range of performance of all the MIPS-eligible clinicians for each performance category. CMS proposes that these data, to the extent that they meet the previously established public reporting standards, will be added to Physician Compare for each MIPS-eligible clinician or group, either on the profile pages or in the downloadable database, as technically feasible.

As the law requires public reporting of performance information to be statistically valid and reliable, we believe that CMS should only report at the group practice level and not at the individual level. ASRS has expressed its concerns about the accuracy and validity of reporting information about individual physicians on Physician Compare. CMS must have adequate sample sizes for statistically valid comparisons between and among physicians and practices. Further, we oppose the attribution methods used as they are an inaccurate indicator of a physician's overall performance. Patients using Physician Compare to research physicians would not be provided an accurate assessment particularly of subspecialists. In addition, there have been many errors with data previously posted on Physician Compare, and CMS must perfect its data collection process and fix the current data issues before releasing more data to the public via the Physician Compare website.

CONCLUSION

We urge CMS to work with medical specialty societies as the Quality Payment Program is refined, particularly on issues such as the development of episode-based measures, patient relationship codes, and risk adjustment models. Again, we appreciate CMS willingness to involve the medical community in its efforts so far, and encourage the agency to continue to seek feedback, particularly from specialty societies, to ensure an understanding of the consequences of their rulemaking on specialties, as well as individual and small practices before finalizing certain aspects of this proposal. With that in mind, **we join the AMA in requesting that CMS adopt an interim final rule rather than a final MACRA rule** as we believe an interim final rule will provide needed flexibility and allow for a smoother and more successful implementation. ASRS is eager to provide input as requested in the further development of the Quality Payment Program.

Thank you for the opportunity to present our comments on the proposed rule. If we may provide any

additional information, please contact Jill Blim, ASRS Executive Vice President at jill.blim@asrs.org.

Sincerely,

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President

Mark S. Humayun, MD, PhD
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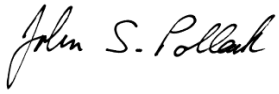

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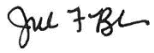

Jill F. Blim, MS
Executive Vice-President

APPENDIX A

ANALYSIS OF PRACTICE REVENUES AND EXPENSES FOR DRUGS ADMINISTERED IN RETINA PHYSICIAN OFFICES

BACKGROUND

On March 8, 2016, the Centers for Medicare & Medicaid Services (CMS) announced a proposed rule to test new models to improve how Medicare Part B pays for prescription drugs and supports physicians and other clinicians in delivering higher quality care.

Currently, Medicare Part B covers prescription drugs that are administered in a physician's office or hospital outpatient department, such as cancer medications, injectables like antibiotics, or eye care treatments. Drugs paid under Medicare Part B generally fall into three categories:

1) Drugs furnished incident to a physician's service in the office or hospital outpatient settings,
2) Drugs administered via a covered item of durable medical equipment, and
3) Other categories of drugs explicitly identified in the law.

PROPOSED RULE AND CHANGES IN PAYMENT THAT WOULD APPLY TO OPHTHALMIC DRUGS ADMINISTERED BY RETINA PHYSICIANS

Medicare Part B generally pays physicians and hospital outpatient departments the average sales price of a drug, plus a 6 percent add-on. The proposed model would test whether changing the add-on payment to 2.5 percent plus a flat fee payment of $16.80 per drug per day changes prescribing incentives and leads to improved quality and value. CMS goes on to say that:

> "CMS expects that the add-on payment of 2.5 percent plus a flat $16.80 fee will cover the cost of any drug paid under Medicare Part B. The flat fee is calculated such that it is budget neutral in aggregate."

While the proposal may be budget neutral in aggregate, the fact is that CMS does not know the impact of specific subspecialties based on provider financials, treatment mix, and so forth.

Therefore, the American Society of Retina Specialists (ASRS) commissioned an independent study by an economics and accounting firm, Quorum Consulting, Inc. (San Francisco, CA) to gather data from retina practices to: (1) determine revenue for injectable drugs; (2) account for direct and indirect costs associated with injectable drugs; in order to: (3) report profit or loss for physician administered drugs that may be affected by the proposed rule.

ABSTRACT OF STUDY METHODS AND RESULTS

Methods

We solicited members of the ASRS to provide detailed financial and cost accounting data. We requested data on revenues (total collections) and costs (expenses) for calendar year 2015. We obtained data on all injectable drugs administered retina physician practices offices (hospital and ASC facilities were not included). The scope of the analysis was specific to FDA approved drugs with product specific HCPCS "J" codes, which are addressed within the scope of the CMS proposal.

Cost Accounting Data Collection

For direct and indirect expenses, we obtained site-specific data on:

Drug Acquisition Costs (by HCPCS code)

a. Acquisition price per unit
b. Added costs
    a. Shipping and handling
    b. Sales tax
    c. Other cost increases
c. Cost offsets
    a. Discounts
    b. Chargebacks
    c. Rebates
    d. Other cost offsets

Other Practice Expenses

a. Practice Expenses
b. Staff Time
    - Salaries and benefits for staff time responsible for acquiring, storing, preparing, transporting, disposing of drugs and drug revenue collections * this differs from GAO allocated based on time spent on these activities
c. Other indirect expenses
    - Space - Physical space used for storing and preparing drugs
    - Equipment - Equipment used for storing, preparing, transporting, disposing of drugs and claims management (office equipment, PODIS, EHR, other IT, etc.)
    - Supplies - Supplies used for storing, preparing, transporting, and disposing of drugs
    - Support Contracts - Contracts for other organizations to provide services supporting acquiring, storing, preparing, transporting, and disposing of drugs (e.g. waste disposal)
    - State provider taxes

Results and Discussion

We obtained detailed revenue (collections) and expenses (direct and indirect costs) for calendar year 2015 from 8 retina practices from around the country. While sites were from regions throughout the country, participating sites all tended to be high volume practices. This is likely due to the fact that sites had to provide data in a short amount of time (to accommodate the CMS comment period), and only high volume sites had accounting and other administrative staff available to provide the requested information. Participating sites also varied in their payer mix and utilization of different types of drugs.

We found that drug acquisition and overhead expenses for injectable drugs included in the analysis were on average 98.9% (range 96.5% to 103.2%) of total collections across the 8 practices. In some cases, practices made a profit on injectable drugs while in other cases had a net loss. There was variation in drug profit or loss by drug and by practice.

It is worth noting that given the limited time available to collect these data, only high volume practices with capable financial staff were able to respond to the survey in this short period of time. Even under these circumstances, not all high volume practices generated profits on office administered drugs. In fact, our belief is that lower volume practices, which provide the majority of patient care in retina around the country would have less purchasing power and higher overhead compared to the study for which we were able to collect data.