May 31, 2013

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of the American Society of Cataract and Refractive Surgery (ASCRS), a medical specialty society representing nearly 10,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care, I am writing to respond to your recent request for input on policies that specifically affect the Medicare physician fee schedule and the fee-for-service system, as you develop a replacement for the flawed Sustainable Growth Rate (SGR) formula. My comments reflect the consensus of our physician leadership.

We want to express our appreciation for your continued commitment to comprehensive Medicare payment reform that provides fair and equitable reimbursement and ensures continued access to specialty care. As you have noted, with the recent favorable Congressional Budget Office (CBO) score for repealing the SGR, this is an opportune time to move forward, and we look forward to working with the committee to enact a much-needed replacement for the failed and flawed SGR formula this year.

We also appreciate your recognition that fee-for-service will continue to be the standard for the longer term for certain physician practices as new payment models are developed and tested. The preservation of fee-for-service as a continued viable option is of the utmost importance to our members. Many ophthalmic practices are simply not suitable for participation in alternative payment models, such as accountable care organizations (ACOs), medical homes, or bundled payment arrangements. Payment reforms should reflect the tremendous diversity of current physician practices. Physicians should be allowed to choose payment models that are appropriate for them, their practice, specialty, and geographical regions, as well as for their patients.

Please find below specific comments regarding the three questions posed by your letter:

**Question 1: Medicare Physician Fee Schedule Payment Reforms With Regard to “Appropriate” Value**

There has been much discussion regarding the current process for evaluating and updating the current Medicare physician payment values that make up the Resource-Based Relative Value System (RBRVS) and criticism of the AMA/Specialty Society Relative Update Committee (RUC)—specifically as it relates to primary care and the impact this has on primary care shortages. It is important to recognize that physician shortages are looming in many specialties, not just primary care. According to the
Association of American Medical Colleges (AAMC), by the year 2025, there will be an overall shortage of 130,600 physicians nationally, equally split between primary care and specialties. Of note, Congress and the RUC have, in fact, instituted policies in statute or practice that have increased primary care payment.

In addition, the RUC has changed values for physician services that resulted in increased reimbursement for primary care including: 1) between 2006 and 2011, payments to specialty physicians were significantly reduced, while payments to primary care increased by 22.5%, 2) the third five-year review of values resulted in a 37% increase for Medicare’s most frequently billed office visit code for family physicians and internal medicine physicians; and 3) the third five-year review also shifted more than $4 billion to evaluation and management (E&M) codes, which are largely provided by primary care specialties. The RUC and CPT have also developed recommendations to support care coordination of patients with chronic diseases for many years. CPT codes and relative values have been developed for telephone calls, team conferences, and case management.

The RUC has also established a process to objectively identify potentially “misvalued” codes. The RUC identified more than 1,000 physician services for review and has made recommendations for revaluing approximately 850 services—including cataract surgery, which was recently “revalued” as a result of this process. More than $1.5 billion has been redistributed as a result of these efforts. This demonstrates the commitment of physicians participating in the RUC process to obtain objective data and the strength and flexibility of the current RUC review process that relies on clinical expertise and objective data.

Additional Factors to be Considered

Primary care and specialty care are two very different types of care and, in our opinion, require different models. The current Resource-Based Relative Value System (RBRVS) was a well-intentioned effort to try and equate cognitive medicine to procedural medicine. It has not worked well for anyone. The major focus of progressive primary care delivery is directed to following two issues: individualize care to the patients (especially those with chronic diseases) and keep patients out of hospitals and emergency rooms. By doing so, great costs savings can be realized, therefore, quality measures should center on these issues for primary care. However, specialty care, and in particular ophthalmology, is more suited to unit measures. In ophthalmology, volume is driven by two factors: the size of the population being served and quality of outcomes. (Volume goes up with increasing population and improved outcomes.) While managed care risk can be done for surgical specialties, surgical specialties are more effective if they are contracted on a case-by-case basis—you pay for what you need and/or what you use. Surgical care is based on measurable and quantifiable procedures, as compared with cognitive specialties and in particular primary care, which may to some extent be measured on how well they limit the need for specialty care in chronic disease situations and public health issues.

Questioning Time as a Factor in Value

It is also important to note that time is a very poor proxy in the value question, especially as it relates to ophthalmology. Our current RBRVS system rewards the slower physician and, in fact, a less practiced or experienced one compared to an experienced and efficient one. The current work RVU is based on time and intensity. Therefore, the more time associated with the procedure, the higher the RVU. Our current system rewards surgeons for being “slow” in the mistaken belief that “faster” surgery is worth less than “slowly” performed surgery. In actual fact, for a given procedure, the surgeon who is efficient
without complications and does a procedure in half the time as another surgeon delivers higher value.

In cataract surgery, for example, longer surgeries are invariably associated with more complications and poorer outcomes. Excellent surgeons frequently take less time to do a better job.

**Use of Quality Adjusted Life Year Calculation**

“Value” is defined by most healthcare authorities as a metric of outcome/cost/satisfaction for appropriate treatment. One example is the Quality Adjusted Life Year (QALY) calculation, which is a measure of disease burden, including both the quality and the quantity of life lived. It is used in assessing the monetary value of a medical intervention or a specific intervention.

The QALY is based on the number of years of life that would be added by the intervention. Each year in perfect health is assigned the value of 1.0 down to a value of 0.0 for death. If the extra years would not be lived in full health—for example, if the patient would be blind, lose a limb, or have to use a wheelchair—then the extra life years are given a value from 0 to 1 to account for this. The QALY is used in cost-utility analysis to calculate the ration of cost to QALY improvement and compare the value of interventions of different health conditions. Lower cost per QALY represents a more cost-effective medical intervention. Unfortunately, this metric is not available for most conditions, but it is for cataract surgery. Studies document a high value for the cataract surgery procedure. Therefore, we can show that the medical technology and advances in cataract surgery result in a higher value for the costs. **This should be considered and factored into the equation when evaluating the “value” of a procedure.**

**Greater Emphasis on Quality Verses Cost**

While higher “value” healthcare is a reasonable goal, the primary focus of reform should be the quality of a patient’s care rather than economic considerations. If carried out properly, quality-focused efforts will shed light on underutilized, misutilized and overutilized care, which will naturally target inappropriate spending. For example, data collection through registries and other robust databases can shed light on appropriateness of care and utilization patterns and therefore educate on how best to achieve more efficient outcomes.

“Value” should be based on individual performance. We do have specific quality measures for the most common eyecare conditions, and we are developing a registry system to facilitate reporting of these measures, which include outcomes and patient-reported experience. Nothing comes closer to demonstrative “value” from the individual physician. Again, participation in this registry has the potential to allow physicians and others to compare and improve practice outcomes. These measures will become updated and more refined with experience. Congress should not try to reinvent the wheel, but should utilize these physician-developed measures and system.

**Comparative Value of a Treatment Protocol**

Another area to note is the comparative value of a treatment protocol. The biggest driver of cost is new technology. Some new technologies are truly breakthroughs; others are simply more expensive, and others are not advancements at all. As the new comparative effectiveness research is completed,

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Medicare should be careful not to cover any new technology until it is proven to be better than existing treatment.

Ophthalmology has two conditions that have been “targeted” in the top 100 treatments for research in this area. They are treatment of primary open-angle glaucoma and treatment of age-related macular degeneration (wet macular degeneration), diabetic retinopathy, etc., with various modalities/drugs. As a specialty, we are investing huge resources to accomplish this study. These studies will help define the highest value way to treat these common and costly diseases. Once defined, such protocols should become the standard of care.

Question 2: Appropriate Utilization of Physician Services – Improving Health and Reducing Spending

Surgical volume is primarily driven by need, i.e., demographics, technology, consumer awareness, and pathology. All of these variables are increasing in this decade and will continue into the next.

Use of Appropriateness Guidelines

In ophthalmology, we have a well-developed resource in the Preferred Practice Pattern (PPP) modules. They cover every major eye condition and are kept updated. These guidelines address both over-utilization and under-utilization of different interventions. While following the PPP guidelines is appropriate practice, this does not mean there is one standard treatment for each condition. For example, caring for one person with mild diabetes is not like caring for a person with severe diabetes. The same can be said of many chronic conditions. Therefore, risk adjustment of care (including patient compliance) is critical to any evaluation of appropriate utilization or of outcome analysis. **We should enforce preferred practice guidelines within specialties.**

It is also important to note that appropriate utilization means “elimination” of underutilization, as well as overutilization. It is clear that for many situations, following the PPP guidelines would result in more utilization of care, not less. For some important and costly treatments, we don’t yet know the exact appropriate utilization. For example, previous experience and published reports have not established the claim that cataract surgery is overutilized. Conversely, there is evidence that especially in certain demographics, patients do not receive the appropriately utilized glaucoma care. In some situations, certain tests are simply not indicated, based on widely available evidence or specialty guidelines, and this should be the determinant of quality care.

Liability Protection for Following Guidelines

In addition, physicians who follow guidelines developed by their specialties should be protected from potential frivolous lawsuits. Defensive medicine is expensive, but it is a natural response to our current malpractice environment. Additionally, physicians should be shielded from liability exposure resulting from their participation in national quality initiatives. If physicians are going to be required to follow government or other mandated treatment protocols, quality metrics and/or guidelines, then they should expect to be protected from litigation if they follow such guidelines, but are nevertheless sued.
**Patient Engagement**

We continue to believe that the patients must have some connection with the price of care they receive. It remains unclear to what extent patients value and rely on cost information for healthcare decision making. Patient education is a critical component of cost measurement. Patients must fully understand the factors that influence cost variations and not automatically assume that there is a consistently direct (or even indirect) relationship between cost and quality.

As more people live longer, they will face more health problems, and this will drive up the volume of services. As new technologies are invented to cure various diseases, this will also drive up volume. Patients getting access to appropriate treatments is very high value and is in fact the essence of good healthcare. On the other hand, inappropriate, redundant and unnecessary treatment is wasteful, and should be eliminated.

To reiterate our prior comments, for situations in which the generally accepted guidelines are followed, there needs to be legal protection for the physician against a lawsuit alleging that the given test should have been performed.

**Interoperability of Medical Records and Meaningful Use Criteria**

A lot of discussion centers on ways to get primary care providers and specialists to communicate better. A key part of communication is the medical record. EMR chart notes are extremely cumbersome even for a single patient encounter, and the reader has a hard time abstracting the key information. This is a time-consuming and tedious process, and often leads to repetition of services and tests simply because the specialist cannot confirm what has already been done.

EMRs are very difficult to interpret between different providers. Take the example of a patient who is referred by a general ophthalmologist to a glaucoma subspecialist. The meaningful use rules have turned what used to be a 1-2 page note into a 6-page note per visit. Assuming the generalist met with the patient several times before consulting the specialist, there can be hundreds of pages that need to be deciphered by the specialist to understand the patient’s condition.

**Therefore, the next stage of meaningful use should take into account the ever-expanding volume of a single visit note and take steps to encourage software engineers to distill the note down to its important components.**

**Shift Eligible Procedures Out of Hospital Out Patient Department (HOPDs) to Ambulatory Surgery Centers (ASCs)**

The largest savings for ACOs, Medicare’s Advantage programs, or managed care systems is to keep the patients out of the hospitals for admissions, testing, and emergency rooms. These goals could be fostered on a national level. It has been estimated that if Medicare shifted just 50% of the eligible procedures out of the Hospital Out Patient Departments (HOPDs) to freestanding Ambulatory Surgery Centers (ASCs), the government could save more than $6 billion in 5 years. We would advocate shifting all of those cases to ASCs whenever possible, particularly ophthalmic procedures.
Question 3: Incentivizing Participation in Alternative Payment Models

The only legitimate way to incentivize physicians to change to Alternate Payment Models will be to base payment structure on appropriate real parameters based on actual quality, and not on parameters primarily driven by cost cutting.

Current payment and delivery reforms focus mainly on primary care and often have little relevance to specialty providers. As a result, participation rates and buy-in among specialists remains low. There is no “one size fits all” approach to quality improvement, and programs that rely on arbitrary measures and insufficiently tested methodologies to alter physician reimbursement will only deter specialists from more engaged participation and restrict patients from accessing high value care.

Physician Specialty Participation in ACOs

Although the Medicare Shared Savings Program (MSSP) regulation has been widely interpreted as allowing non-primary care physicians to practice in multiple ACOs, the Centers for Medicare and Medicaid Services (CMS) is applying exclusivity more broadly than it had indicated in the final rule and is effectively precluding any practice that performs E&M services from full-fledged participation in more than one ACO, regardless of specialty. The policy goes well beyond the exclusivity provisions in the final rule and establishes an arbitrary and inflexible process that has the potential to limit patient choice and restrict the number of hospitals and practice networks with which physician practices can affiliate. This defeats the ACO program’s goal of improving care coordination by prohibiting many specialists from being a full-fledged partner in the same ACO as the hospital or care network they have participated in over the years.

This issue was brought to our attention by one of our members whose practice wanted to participate in all ACOs in their geographical area, and as a result, we convened a group of interested organizations, including the AMA, who has developed a list of possible actions CMS could take to improve that policy. It is important to note we have met with CMS and are working with them in a collaborative manner to resolve the problem.

Integrated Eyecare Delivery

ASCRS is advancing an eyecare delivery model based on a synergistic collaboration between optometry and ophthalmology. This model encourages arrangements in which optometrists employed by ophthalmologists, as well as optometrists employed by the military or industry, play a role in the delivery of non-surgical eyecare. This patient-centered model encourages greater efficiency and coordination of care with ophthalmologists and optometrists working together to meet the growing demands for service and address the pending changes in Medicare and healthcare delivery, and to meet the needs of the 77 million American Baby Boomers nearing retirement age. The areas of coordination include: the management of the postoperative patient, co-management, IOL power calculations, etc.

In addition, physicians should be allowed to create a well-trained and functioning system to treat patients efficiently and with quality, leaving the physician to do what he or she does best—make decisions and coordinate the care. For specialties like ophthalmology, the artificial requirements for the physician to do every part of the exam should be eliminated. The surgeon should be responsible, but ancillary personnel should be allowed to assist in the exam without penalty.
Other Issues for Consideration

In addition, ASCRS supports the adoption of additional viable Medicare payment options in conjunction with a new physician payment system. A patient option should be established for patients and physicians to freely contract, without penalty, for Medicare FFS services, while allowing Medicare beneficiaries to use their Medicare benefits and allowing physicians to bill the patient for all amounts not covered by Medicare.

We appreciate the opportunity to provide input and look forward to continued discussions. For additional information, please contact ASCRS Director of Government Relations Nancey McCann at nmccann@ascrs.org.

Sincerely,

Eric D. Donnenfeld, MD
President