ASRS American Society of Retina Specialists

March 20, 2023

The Honorable Bernard Sanders
Chairman
Health, Education, Labor & Pensions Committee
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
Health, Education, Labor & Pensions Committee
United States Senate
Washington, DC 20510

RE: Health Workforce Request for Information

Dear Chairman Sanders and Ranking Member Cassidy,

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.

Thank you for your committee's bipartisan commitment to addressing challenges in the healthcare workforce and for this opportunity to provide our comments. **ASRS members are increasingly concerned that structural constraints in the Medicare physician fee schedule, including a lack of an inflationary adjustment, are preventing retina specialists from hiring and retaining an optimal level of clinical staff in their practices.** While we realize this issue may be outside the Health, Education, Labor and Pensions (HELP) Committee's jurisdiction, we believe it is foundational to the current workforce problems and we urge you to work with other committees of jurisdiction and across Congress to address this long-term issue.

Our key recommendations for physician fee schedule reform include:

- **Implement regular, 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 eliminate the unnecessary add-on code.

- **Remove all sequestration from Medicare payments.**

BACKGROUND AND THE CURRENT WORKFORCE CHALLENGES IN RETINA PRACTICES

Retina specialists are board-certified ophthalmologists with an additional two years of fellowship training in the medical and surgical management of retinal diseases. They treat chronic retinal diseases

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such as age-related macular degeneration (AMD), diabetic retinopathy, diabetic macular edema and retinal vein occlusion, which are among the most common causes of blindness in the United States. In addition, they provide surgical care to repair retinal detachments and tears, macular holes, and many other potentially-blinding conditions.

For the millions of patients with chronic retinal disease today, the treatment burden is high, often requiring patients to be seen by their retina specialist for intravitreal injections of anti-vascular endothelial growth factor (anti-VEGF) drugs on a regular basis, sometimes as frequently as every four weeks. While this treatment regimen is most disruptive to the patient, managing the volume of patients who all require individual treatment plans is a labor-intensive task for retina practices.

Retina specialists are the appropriate practitioners to provide this medical and surgical care, but they rely on a significant number of clinical and non-clinical staff to assist them in caring for the high volume of patients they see. From administrative staff in the call center, at the front desk, and those working on billing and on the ever-expanding demands of private payer prior authorization, to the technicians who help prepare patients for their exam and treatment by dilating their eyes, check vision, perform diagnostic tests, act as scribes, and prepare the supplies for procedures—it includes many distinct roles, and in most cases, necessitating multiple staff members in every position.

Given the current healthcare workforce challenges already identified by this committee, filling these positions has become an especially difficult prospect for retina practices. The work can be physically demanding and fast-paced, and became potentially hazardous during the COVID-19 pandemic because retina patients still needed injections and surgery—neither of which can be furnished via telemedicine. With declining reimbursement from Medicare and other payers, retina practices—that are forced to employ dedicated staff for unreimbursed work, such as dealing with prior authorizations—are not always able to offer salaries as competitive as other healthcare providers, like hospitals, whose payments have kept pace with inflation. Many practices report that not only do they have difficulty attracting applicants for new positions, but they often lose existing staff to other providers, such as hospitals or specialties that are not stretched as thin.

Lack of clinical and administrative staff has a direct impact on patient care. Without workers to fill these vital support roles, patients have to wait longer to be seen or longer to get appointments. For patients suffering from these chronic diseases, delay in care can mean permanent vision loss. Retina practices are currently stretched to their limits trying to meet patient demand with less-than-optimal staffing levels.

Relief for these challenges is not expected anytime soon—and they may in fact worsen. Most chronic retinal disease is associated with age, and as the Baby Boomer generation begins to reach the age when these diseases become a risk, retina specialists only expect their patient volume to climb. Furthermore, a new drug, pegcetacoplan (Syfovre) was just approved by the FDA in February. It is the first approved treatment for geographic atrophy associated with dry AMD. Up until last month, there has been no treatment for what is estimated to be upwards of a million additional patients who will now be seeking care. Under the current reimbursement framework, it is unlikely retina specialists will be able to meet this explosion in demand.

Ophthalmology, in general, is not facing as significant a shortage of practitioners in the near future as other specialties and primary care. However, the extensive educational requirements to become a

retina specialist and limited graduate medical slots, means there will not be any significant increase in the supply of retina specialists to meet these growing patient demands anytime soon.

ASRS strongly recommends that the HELP Committee, along with other committees of jurisdiction, take action to address reimbursement challenges currently facing retina practices. In addition, we recommend Congress continue to increase the number of graduate medical positions funded through Medicare to ensure that there is an adequate supply of retina specialists to meet future patient demand.

KEY PHYSICIAN FEE SCHEDULE RECOMMENDATIONS

Improving Medicare physician reimbursement is the first step in strengthening the workforce needed to deliver care to patients with retinal disease. Payments made through the Medicare physician fee schedule are not solely for the physician's work. Important components of reimbursement include practice expense, which includes the labor of clinical and administrative staff necessary to run a practice. Adequate and increased reimbursement will help retina practices compete with other providers for needed workers.

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 did not receive an update to their payment for 2023 to reflect record inflation, nor will they in 2024 and beyond without Congressional intervention.

ASRS strongly recommends Congress implement an appropriate and predictable inflationary adjustment factor into the fee schedule. 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 is manifesting itself not just in recruiting and retaining staff, but in purchasing new equipment or expanding facilities to meet growing patient demand.

Congress should also eliminate all sequestration on Medicare payments. This decades-long problem has further 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 tightens competition between providers for available workers.

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 office visit codes be modified to reflect the complexity of 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 long-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 retina specialists and other proceduralists' practices, 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.**

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 this committee 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.

CONCLUSION

Retina practices are currently facing significant headwinds. Record inflation combined with high and ever-growing patient demand are making it difficult for practices to recruit and retain the staff they need to care for patients. Retina specialists, like all other physicians, are uniquely constrained in this environment because they cannot increase their prices to meet demand. To help ensure patients will get the care they need, ASRS strongly recommends the HELP Committee work with its colleagues across Congress to implement long-term Medicare physician fee schedule reform. To address long-term challenges, we recommend that Congress continue increasing the available slots for graduate medical education.

Thank you again for this comment opportunity. ASRS and its members are ready to work with the committee to address these challenges. If you need additional information, please contact Allison Madson, vice president of health policy, at allison.madson@asrs.org.

Sincerely,

Judy E. Kim, MD, FASRS
President