Ophthalmology, CMS, and Advocacy for Quality Healthcare

Michael X. Repka, MD, MBA

David L. Guyton, MD and Feduniak Family Professor of Ophthalmology

Johns Hopkins University

Baltimore, Maryland

December 2024

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Financial and FDA Disclosures

- I have the following financial interests or relationships to disclose:
  - American Academy of Ophthalmology: Consultant, President-elect
  - National Eye Institute: Grant Support to Johns Hopkins

Objectives:

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- To describe the history and future of physician payment – mostly Medicare
- To understand Local Carrier Determination Process and important role for physician input
- To review Step Therapy and Prior Authorization
- DC Update

The Federal Government is the Major Source of US Healthcare Spending - 2022

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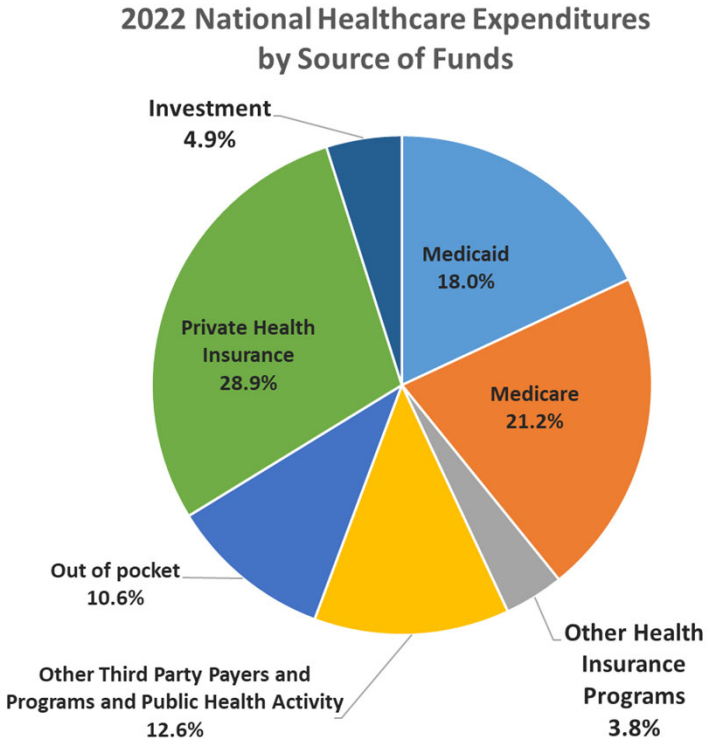

- National Healthcare Expenditures (NHE) grew to $4.5T
  - $13,493 per person
  - 17.3% of Gross Domestic Product (GDP)
- Largest shares of total health spending were sponsored by the federal government (Medicare, Medicaid, DOD,VA,) and households (insurance premiums and out of pocket)
- Medicare spending $944.3B (21% of total NHE)
  - 10% of the Federal Budget

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.cms.gov/files/zip/nhe-tables.zip
Peterson-kff health tracker, www.kff.org

Origins of Health Care Insurance in US

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- Fragmented coverage and delivery in US developed over many years,
  - Unlike European and Canadian systems which had more central planning after WW2
- Roots of coverage
  - Private accident insurance was available in the 19th century
  - Employer paid insurance was the result of wage controls imposed by the federal government during World War II
    - Benefit provide since wages could not be increased
    - Growth continued into the 1950s

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History of Health Insurance – Commercial

- 1929 in Dallas, Texas - Baylor University Hospital program for teachers - 21 days of hospital care for $6 a year
  - later extended to other employee groups in Dallas, and then nationally to become Blue Cross.
- Blue Shield developed in the lumber and mining industries to provide medical care by paying monthly fees to physician groups.
  - In 1939 the first Blue Shield plan was founded in California.
- Employer sponsored health insurance became a US standard in the 1960's through these companies

Employer Sponsored Health Insurance

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- 60.4% of the non-elderly – 165 million people
- providing health insurance through the workplace is efficient
  - advantages to risk management and costs of administration
- The main driver - contributions towards premiums by employers and (in most cases) by employees are not subject to income or payroll taxes
  - substantial federal and state subsidy

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Senior Healthcare Before Medicare

- Before 1965, half of seniors had health care coverage
  - paid three times as much as younger adults,
- The 1960 Kerr-Mills Act provided matching funds to states to assist patients with their bills.
- In the early 1960s, Congress rejected a plan to subsidize private coverage for people with Social Security as unworkable, and an amendment to the Social Security Act creating a publicly run alternative was proposed.
  - Might have been Medicare Advantage for All.

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Medicare in the US

- Federal health insurance program established in 1965
  - for people aged 65 or older
    - regardless of income or medical history
  - expanded to cover people under age 65 with long-term disabilities
- 2024 - provides health insurance coverage to 66 million people
  - 58 million people aged 65 or older
  - 8 million people under age 65

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Medicare Eligibility

- Most people when they reach age 65
- Residents of the U.S., including citizens and permanent residents, are eligible for premium-free Medicare Part A
  - if they have worked 10 years in jobs where they or their spouses paid Medicare payroll taxes and are at least 65 years old.
- Expansion included those under age 65 who receive
  - Social Security Disability Insurance (SSDI) payments become eligible for Medicare after a two-year waiting period.
  - End-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) are eligible for Medicare with no waiting period.

Parts A, B, C and D!

- Part A: Hospital Insurance (HI) program
  - inpatient care in hospitals and short-term stays in skilled nursing facilities, hospice care, post-acute home health care, and blood received at a hospital or skilled nursing facility
  - 63.5 million people were enrolled in Part A in 2021.
  - No premium for most; deductible of $1,676 in 2025
- Part B: Supplementary Medical Insurance (SMI) program – 28 million
  - outpatient services - physician visits, outpatient hospital care, and preventive services
  - monthly premium - $185.00 in 2025 (8% pay more)
    - 25% of cost must come from premiums; taxpayers pay 75%

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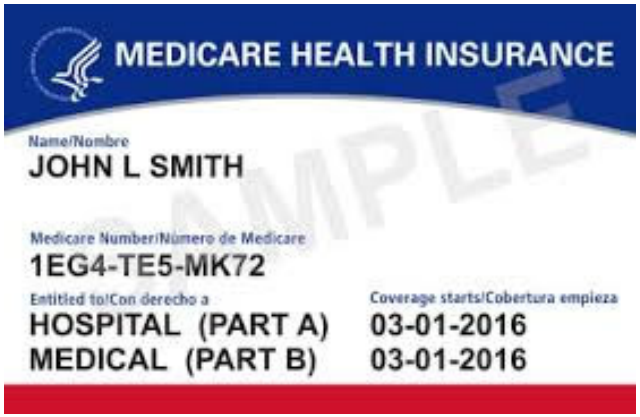

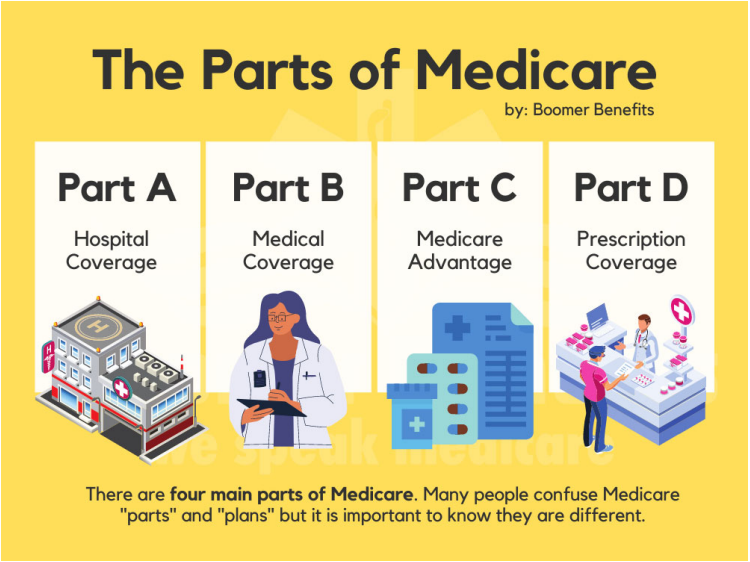

Parts A, B, C and D!

- Part C (Medicare Advantage) – 1985, reinvented in1997 – 33 million
  - private plans that covers all benefits available under Medicare Part A, Part B, and, in most cases, Part D
  - Same monthly premium as for Part B
  - Additional benefits, such as dental services, eyeglasses, and hearing exams
  - Not required to follow Part B Fee Schedule (we sign their fee schedule in the contract)
- Part D - voluntary outpatient prescription drug benefit - 2003
  - private stand-alone prescription drug plans or MA plans.
  - In 2023, an estimated 50 million beneficiaries are enrolled in Part D. Average premium - $40/month

President George Bush signs Part D bill - 2003

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How Medicare Part C is funded

- Plans receive payments from CMS equaling 122% of spending for similar beneficiaries in traditional Medicare
  - Medicare Payment Advisory Commission (MedPAC) has estimated care in Medicare Advantage costs insurers 104% of traditional Medicare (2022 estimate).
- A complex formula leads to the higher payment
  - Benchmark needs to above traditional Medicare spending in at least half of counties
  - Increased numbers of diagnoses increase complexity
  - quality bonus ("Star") program, not available in part B – about $11.8 billion in 2024

Medicare Advantage Growth – surpassed Traditional

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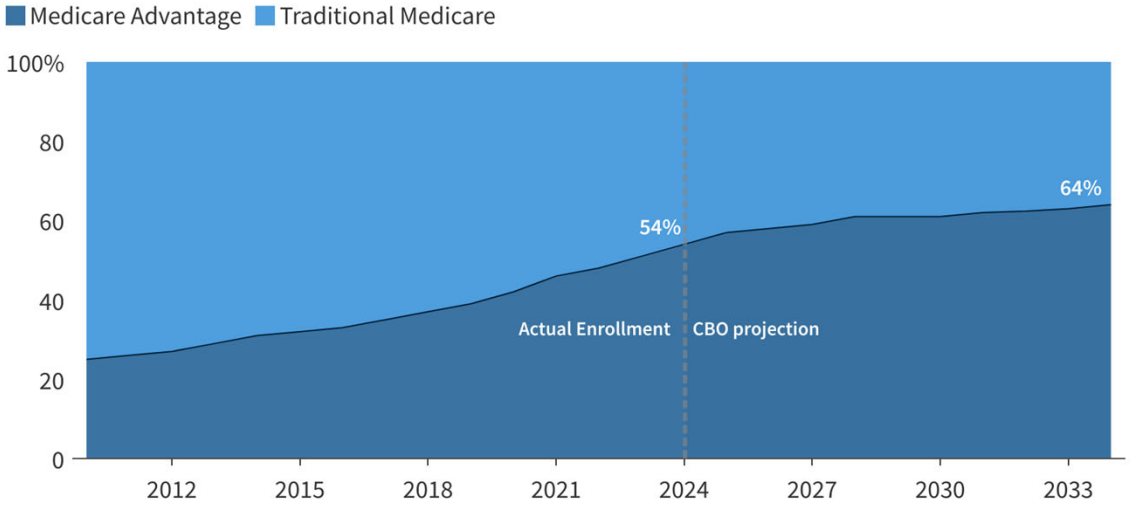
Figure 2

Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. Enrollment numbers from March of the respective year. Projections for 2025 to 2034 are from the June Congressional Budget Office (CBO) Medicare Baseline for 2024.

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- Some no premium plans (premium reduction)
- Extra benefits
  - dental, vision, or hearing services, often for no additional premium
- out-of-pocket limit
  - traditional Medicare has no out-of-pocket limit on spending.
- Limited or narrow provider networks and cost management tools such as prior authorization

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Medigap

- Medigap plans, cover 41% of those in traditional Medicare (12.5 million beneficiaries) (data for 2021)
- Standardized plans offered by private insurance;
- Generally, makes traditional Medicare patients less sensitive to copayment and deductible pressures designed to restrain utilization.

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Medicare Physician Payments – 1965 to 1992

- In the1965 law payment was for "usual, customary, and reasonable" fees as paid by private insurers, and fees could not to be set by government.
- In the mid-1980s there were multiple reports of widely varying fees that Medicare around the country.
- Fees were rapidly escalating.
- In 1989 this led Congress to establish a fee formula called the resource-based relative value scale.
  - Volume Performance Standard – targeted growth so only way to increase fees was to restrain utilization as a group

Medicare – RBRVS in1992

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- Complex formula by Dr William Hsiao
  - estimates the amount of physician work required to perform each coded service, by time, training and intensity, while factoring in overhead and malpractice insurance.
- Fees were developed for thousands of codes in the Medicare physician fee schedule
- The scale is now continuously reviewed and revised.
- Two flaws in retrospect
  - Lowered payment targets going forward
  - Incentive to reduce services to increase fees was global
    - Did not translate locally – just increase services

What is the AMA RUC?

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- CMS administers the fee schedule but is assisted in that task by the physician community through the Relative Value Scale Update Committee (RUC).
- The RUC is run by the AMA, which is not a government group petitioning the government
  - Values relative physician work and provide invoices for equipment and labor to CMS for practice expense calculations
- AAO has a voting seat at the RUC.
  - We also have an advisor(s) to advocate for our services – arguments are formula driven and not based on QOL or other indices

Payments Based on Relative Value Since 1992
Conversion Factor set by CMS – that is $ source

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- **<u>Physician work: WRVUs</u>**
  - Based on ***time*** and ***intensity*** of work on date of service and postop visits
  - Survey-derived data compared ***relative*** to other procedures
- **<u>Practice expense: PERVUs</u>**
  - Based on clinical staff time, equipment costs and time used, necessary supplies, rent, etc
- **<u>Professional liability insurance cost: PLIRVUs</u>**
  - Based on national trends for malpractice premiums
- **<u>Total Value = (WRVU + PERVU + PLIRVU) x CF (2025 = $32.35)</u>**

Medicare Sustainable Growth Rate (SGR): The First Formula - 1997

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- In 1997 Congress tried to slow physician-driven costs by creating the Medicare Sustainable Growth Rate (SGR).
- Congress set an annual target for physician payments based on a multiple factors
  - Could not exceed growth in gross domestic product. If spending exceeded the target, fees would be cut in the next year such that overall physician spending was limited to the target amount. If spending was below the target, fees would be increased
- Did okay initially, but SGR in 2002 called for a nearly 5% reduction; the first of many
  - Congress enacted 17 "doc fixes" over twelve years, freezing fees or granting small increases.
- Congressional overrides led to a cumulative debt of more than $140 billion.
  - By 2015 that debt would have led to a 21.2% reduction in physician fees.
  - Led to passage of MACRA in 2015

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2015 – The SGR Fix

Medicare Access and CHIP Reauthorization Act of 2015

MACRA Background

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- Repealed the Sustainable Growth Rate (SGR) formula
  - Medicine basically had to take the deal
- Changed how Medicare physician payment was supposed to work
  - Emphasized value over volume; desired everyone in APMs by 2020
- Consolidated/replaced existing incentive programs
  - PQRS
  - Meaningful use of electronic health records
  - Value-based Modifier

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Medicare Access and CHIP Reauthorization Act (MACRA)

Most ophthalmologists ended up here

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MIPS' Four Categories for Evaluation

50%

Quality Measures

25%

Advancing Care Information/ EHR Meaningful Use

15%

Clinical Practice Improvement Activities

10%

Resource Use

MIPS Summary – NEJM – "The Promise"

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- MIPS will become the largest physician pay-for-performance scheme in the world …
- first to create a single value-based purchasing framework covering the full spectrum of physician specialties
- new meritocracy will need to be flexible enough to account for the heterogeneous practice styles of the professionals…
- while ensuring that all specialties are subject to fair and robust assessment.

Rosenthal. NEJM 2015;373:1187

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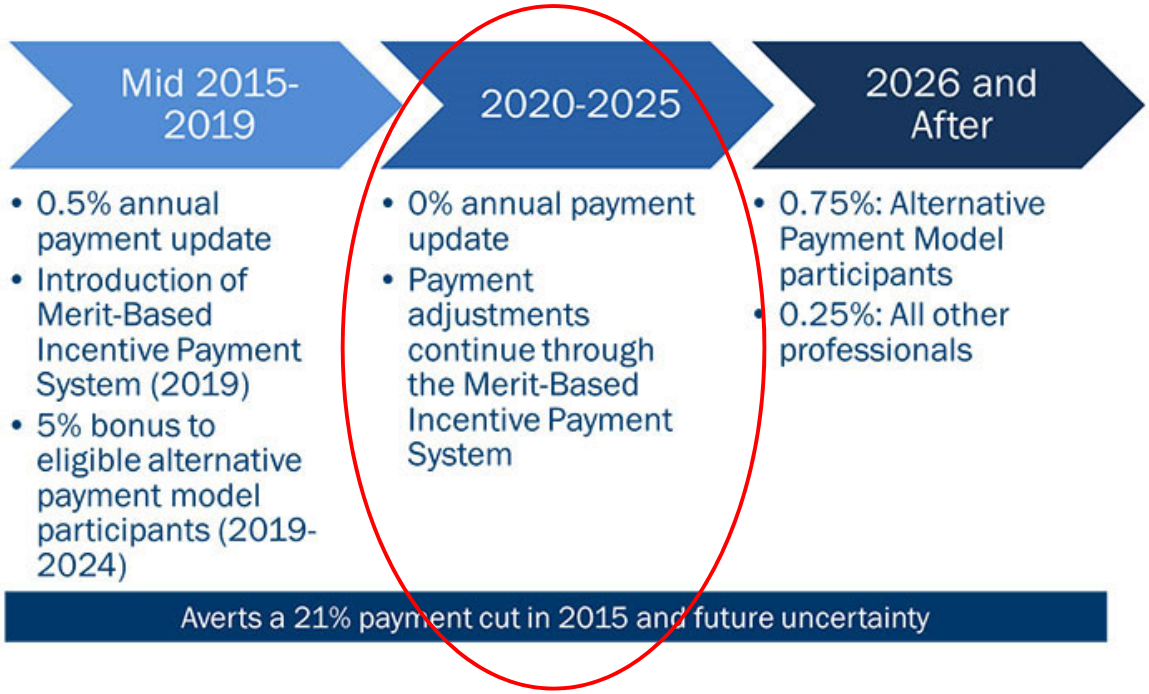
MACRA: 10 years old - 2025

- Increasingly burdensome
- Bonuses are inadequate
- Fee Schedule increases inadequate to pay for the actual cost of care
- Calls beginning in 2020 for reform and a new payment structure (then COVID and discussion went there)



MACRA and MIPS 2025

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- IRIS Registry prevents penalties for most ophthalmologists
  - But the "Cost Measure for Cataract Surgery" is a growing and complicated problem with many at risk for penalties with one bad choice in the OR
- No fee increases after 2020 because Congress assumed they would be back by 2020 to do the next policy update and they had to keep the 10-year cost down to pass MACRA

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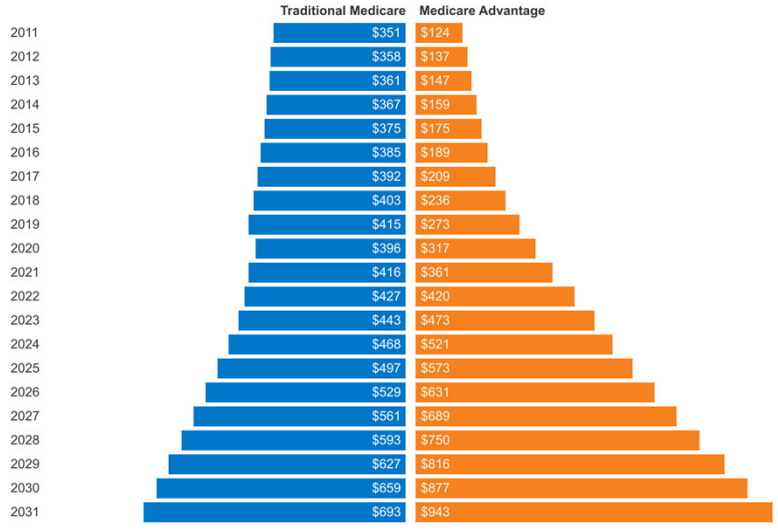
Medicare Payment and the Insurance Industry

Figure 5

Payments to Medicare Advantage Plans for Part A and Part B Benefits Nearly Tripled Between 2011 and 2021 from $124 Billion to $361 Billion and Are Projected to Increase to $943 Billion in 2031

Spending (in billions) on Part A and Part B Benefits in:



SOURCE: KFF analysis of Medicare spending data from the 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

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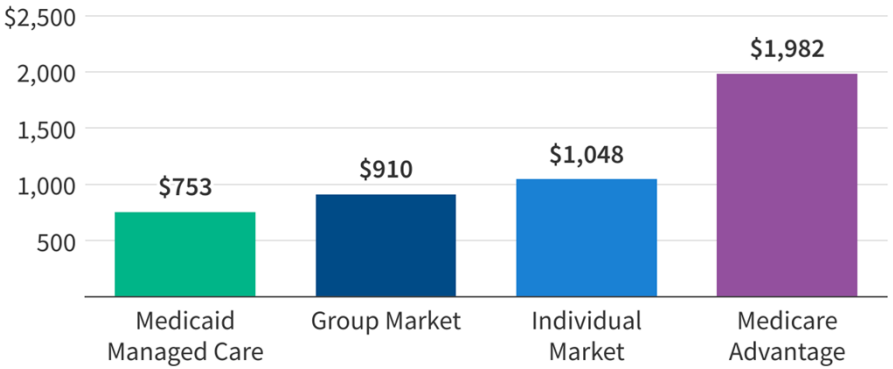
Figure 1

Gross Margins are Highest in Medicare Advantage in 2023

Gross Margins Per Enrollee, 2023



Note: Gross margins per enrollee are the amount by which total premium income exceeds total claims costs, divided by the number of enrollees. Gross margins include administrative costs, tax liability, and profits.

Source: KFF analysis of Exhibit of Premiums, Enrollment and Utilization data from Mark Farrah Associates Health Coverage Portal TM.

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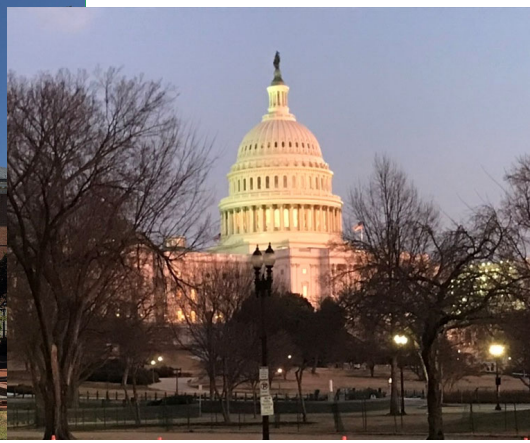
Medicaid

- Medicaid – Federal/State Partnership: Cost Sharing
  - Physician and facility payments set locally and vary widely
- CHIP - Children's Health Insurance Program - 1997
  - CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.
  - More flexible with more funding than Medicaid



Medicaid and CHIP: Enrollment and Spending

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- 85 million participants (78M in Medicaid and 7M in CHIP) (as of 11/2024)
- Medicaid spending 2022 - $804 billion

Fee-for-Service Acute Care	Fee-for-Service Long-Term Care	Managed Care and Health Plans	Payments to Medicare	DSH Payments
$164,442,789,470	$154,390,887,895	$441,061,163,955	$26,274,777,963	$17,896,984,384

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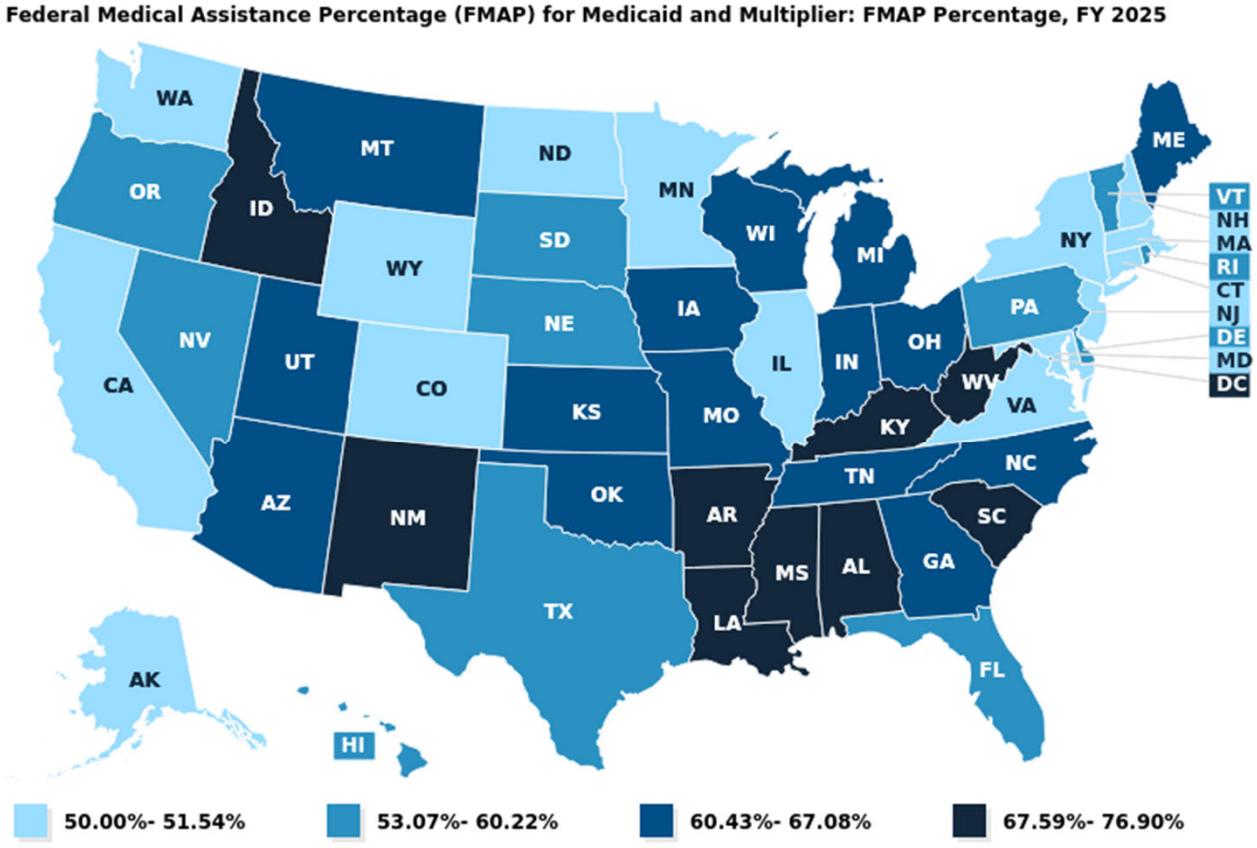
Federal Matching Funding: Set by Statute



SOURCE: KFF's State Health Facts.

- Only programs that qualify as matchable under Medicaid and the FMAP.
- The **Federal Medical Assistance Percentage (FMAP)** is adjusted for the average per capita income for each State relative to the national average.
- By law, the FMAP cannot be less than 50%.
- 0.646 in Ohio (Feds $1.82, OH $1)
- 0.60 in Texas (Feds $1.50, TX $1)

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Medicaid Physician Payments

- States have broad latitude under federal laws and regulations to determine FFS payments so long as the payments:
  - are consistent with efficiency, economy, and quality of care;
  - safeguard against unnecessary utilization;
  - are sufficient to enlist enough providers to ensure that Medicaid enrollees have access to care that is equal to the access by the general population in the same geographic area.
- States are not permitted to set managed care payments.
  - State FFS rates remain important benchmarks for MCO payments in most states, often serving as the state-mandated payment floor.

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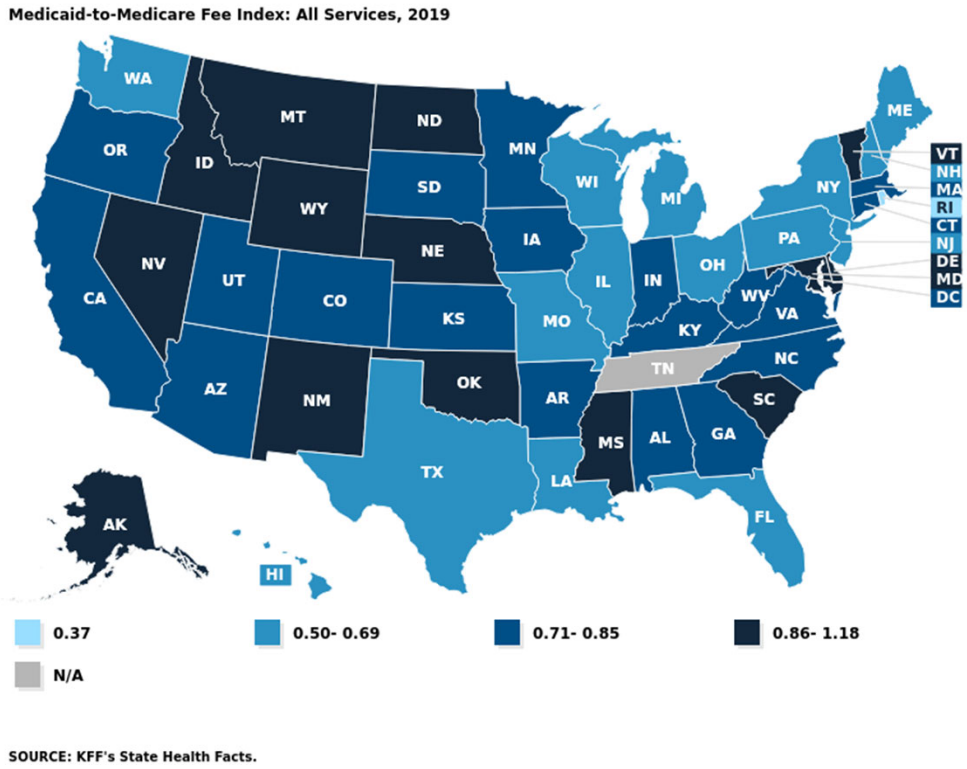
Medicaid Payment as a Fraction of Medicare

- 0.72 for all services in FFS Medicaid
- 0.67 for primary care in FFS Medicaid
- Rates for state MCOs vary



Interactive Maps and Tables at KFF.org

Why did Physician Payments Lag under SGR and MACRA

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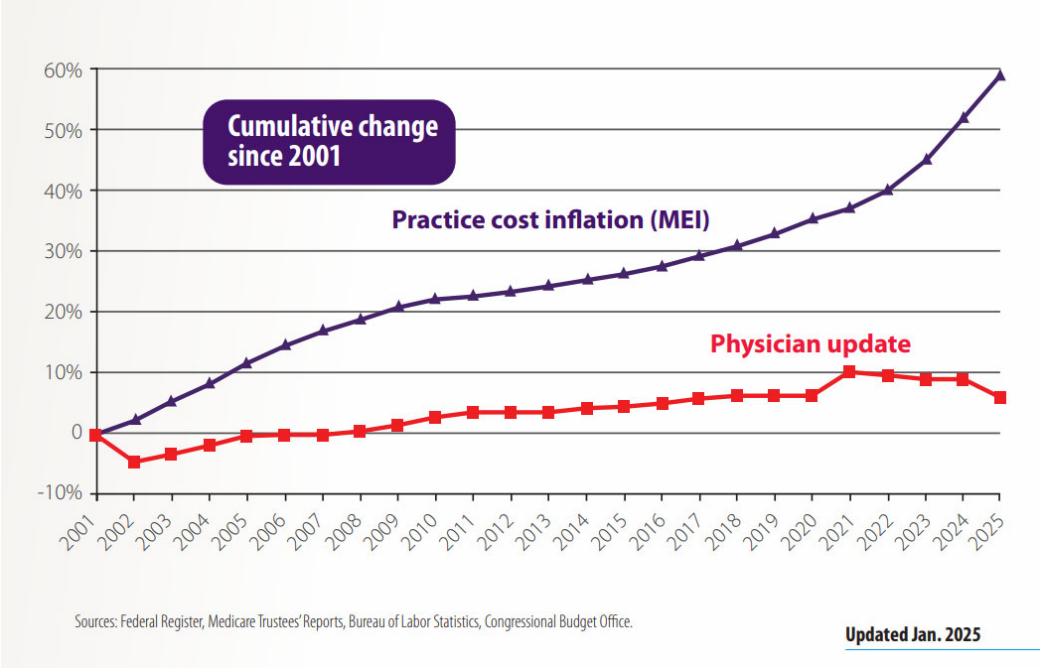
- Formulas since 1992 were designed to slow spending by
  - Budget neutrality
  - Diminished role of Medicare Economic Index (MEI) – an inflationary measure
- 6% increase from 2001 to 2024 in Conversion Factor
  - When adjusted for inflation Medicare physician payment has declined 33%



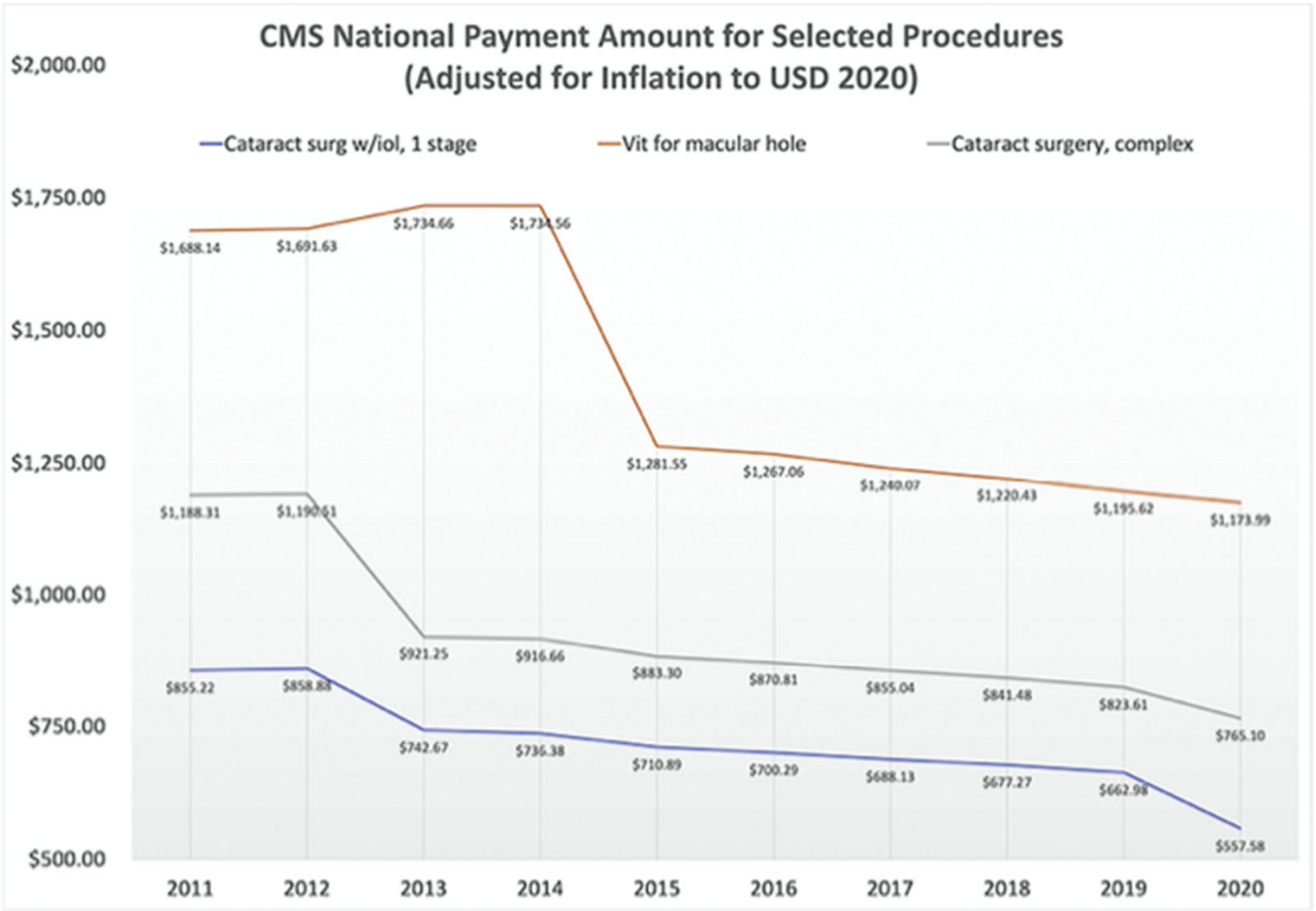


Figure 1. Line graph showing national payment amount (inflation-adjusted 2020 United States dollars) for cataract surgery (Current Procedural Terminology [CPT] code 66984), complex cataract surgery (CPT code 66982), and vitrectomy for macular hole (CPT code 67042).

Common Policy Wisdom for 30 years: Move $ To Primary Care to Save Overall Cost

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- There are too few PCPs, too many proceduralists
  - Healthcare workforce predictions since 1910 have been wrong
- PCP management is the answer to out-of-control spending
  - Has not been demonstrated outside of capitated or salaried systems
- More PCPs will improve access to care and prevent serious disease
  - Lack of insurance, high deductibles/copays are primary barriers to access
- Zero sum game: payment being shifted from specialty/surgical care
  - Last 10 years: primary care has had increases of 14-18%, specialty decreases of 1-20%
- "When there is an access issue we will do something for specialists."

Medicare Trustees - 2024

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- "Physician payment update amounts … do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases"
- "These [small] rate updates could be an issue in years when levels of inflations are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large."
- "absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

Present: Finalized 2025 MPFS

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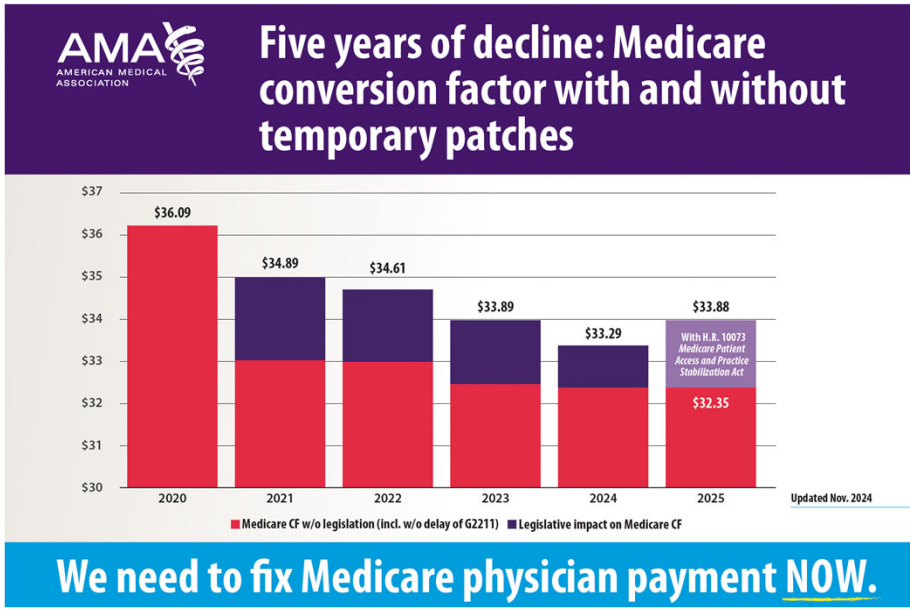
- Conversion Factor (CF) reduction of about 2.8%
  - Expiration of 2.9% Congressional boost to CF (partially mitigated 2024 cuts)
  - Small (0.02%) increase to the CF due to budget neutrality rules
  - 5th year in a row of Medicare CF cuts
- No equity for postop visits value for global surgical payments
  - Two proposed policies to collect more data will likely add some burden
- Continued delay of MEI (Medicare Economic Index) rebasing of Practice Expenses
- Ophthalmology receives about $4.7B of $91B from Part B (similar $ from Part C)



Medicare Patient Access and Practice Stabilization Act of 2024 (HR 10073)

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- 4.73% boost for 2025 over 2024
  - eliminates the 2.93% cut and provides a +1.8% MEI inflationary update
- Lame-duck session is short
- just 1 year fix

Introduced in House (10/29/2024)

118TH CONGRESS
2D SESSION

H. R. 10073

To amend title XVIII of the Social Security Act to increase support for physicians and other practitioners in adjusting to Medicare payment changes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 29, 2024

Mr. MURPHY (for himself, Mr. PANETTA, Mrs. MILLER-MEEKS, Mr. BERA, Mr. BUCSHON, Mr. RUIZ, Mr. JOYCE of Pennsylvania, and Ms. SCHRIER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to increase support for physicians and other practitioners in adjusting to Medicare payment changes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Patient Access and Practice Stabilization Act of 2024".

Long Term Reform: The Strengthening Medicare for Patients and Providers Act (H.R. 2474)

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- Bipartisan bill to add a permanent inflationary update to the Medicare Physician Fee Schedule.
- Update would be tied to the Medicare Economic Index (MEI).
- MEI measures the cost of running a practice, including increases in office rent, employee wages, and professional liability insurance premiums.
- 172 cosponsors to date
- No companion bill in the Senate

Congressman Larry Bucshon, M.D. (R-IN)

Congressman Raul Ruiz, M.D. (D-CA)

Congressman Ami Bera, M.D. (D-CA)

Congresswoman Mariannette Miller-Meeks, M.D. (R-IA)

Longer Term Reform: Fixing MPFS Budget Neutrality Requirements

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- Bipartisan House/Senate bills to address arbitrary reductions in payment due to budget neutrality by:
  - Increasing the MPFS budget neutrality threshold from $20 million to $53 million
  - Updating the Medicare Economic Index (MEI) every 5 years to keep pace with inflation

- **The Provider Reimbursement Stability Act (H.R. 6371):**
  - 37 cosponsors
  - Approved by E&C Health Subcommittee
  - Awaiting further action
- **The Physician Fee Stabilization Act (S. 4935):**
  - 8 original cosponsors
  - Introduced Aug 1, 2024

Too Many Opinions to Enumerate on Long Term Health Care Reform Principles

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- Correct misvalued services
- Establish a hybrid payment for primary care that blends fee-for-service and population-based payment.
- Congress should alter the thirty-five-year-old statutory basis for setting Medicare fees to allow CMS to consider policy priorities such as workforce shortages in refining fee levels.

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Prior Authorization

- Utilization tool requiring the payor to approve use of a device, drug or biologic before administering to the patient.
- The doctor actually needs to Know. Patients rarely know but it must be disclosed in documents signed at enrollment
- Medicare Advantage and Commercial programs
  - But also in traditional Medicare
- Medicare Electronic PA Final Rule – finalized 11/2024

The impact of prior authorization

97%

of medical groups report their patients experienced delays or denials for medically necessary care due to PA requirements.

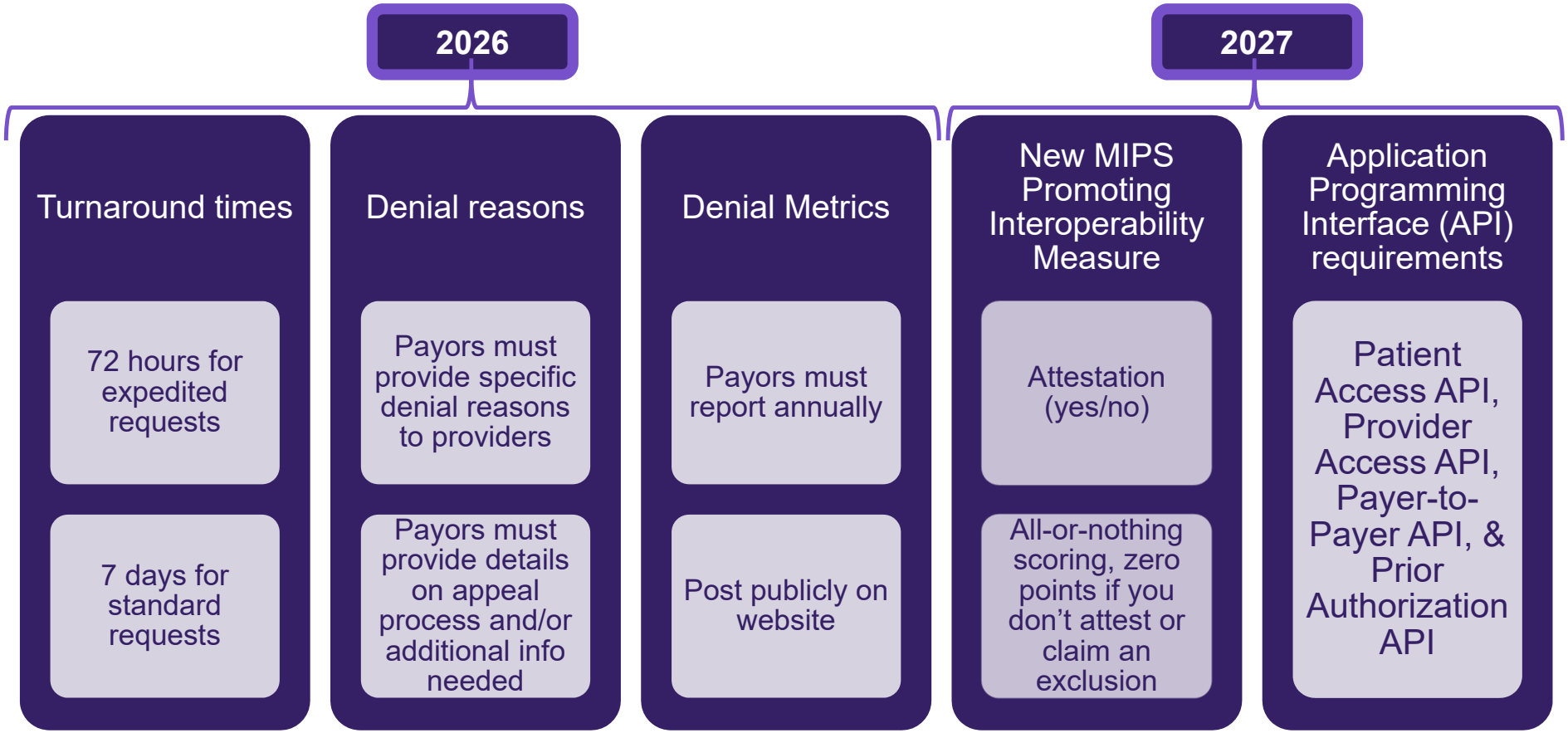
33%

of physicians report that PA has led to a serious adverse event for a patient in their care.

Source: AMA. (2023). *2022 AMA prior authorization (PA) physician survey*. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Source: MGMA. (2023). *Spotlight: Prior Authorization in Medicare Advantage*. https://www.mgma.com/getkaiasset/fa2103f5-a2f6-47a1-b467-4748b5007c7e/05.03.2023_PA-in-MA_FINAL.pdf

What will the Electronic PA final rule do?



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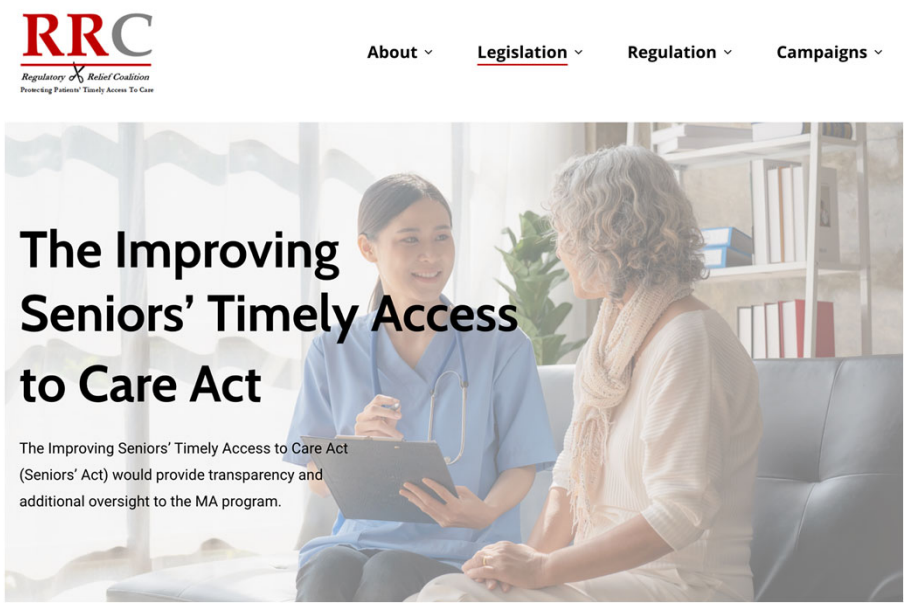
What will the Electronic PA final rule NOT fix?

- Policies do not apply to Part B & Part D drugs
- No real-time decision-making – 72 hours the quickest
- No requirement for service-level denial data

The Improving Seniors' Timely Access to Care Act

- The Academy with the Regulatory Relief Coalition led to introduction of H.R. 8702/S. 4532
  - 228 bipartisan cosponsors in the House
  - 55 bipartisan cosponsors in the Senate
  - 440+ endorsing organizations
    - AAO, AAPOS, AGS, ASCRS, ASOPRS, ASOT, ASRS, ARVO, AUPO, AUS, AVAO, EBBA, Macula Society, NANOS, NAEVR, OMIG and Vit-Buckle Society
    - AL, AR, AZ, CA, CO, FL, HI, IA, IN, KY, MA, MD, MI, MN, MO, MS, MT, NC, NE, NH, NM, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI and WY
    - Dry Eye Foundation, Prevent Blindness, Future Leaders of Sight



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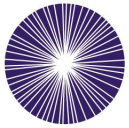
State Level Prior Authorization Activities

- States have enacted 13 prior authorization reform bills in 2024 designed variably to
  - decrease the volume of prior authorization requirements,
  - reduce patient care delays,
  - improve transparency surrounding prior authorization rules and
  - increase prior auth data reporting.
- Mississippi, Maine, Maryland, Oklahoma, Illinois, Virginia, District of Columbia, New Jersey , Vermont, Minnesota, Wyoming and Colorado

DC Update



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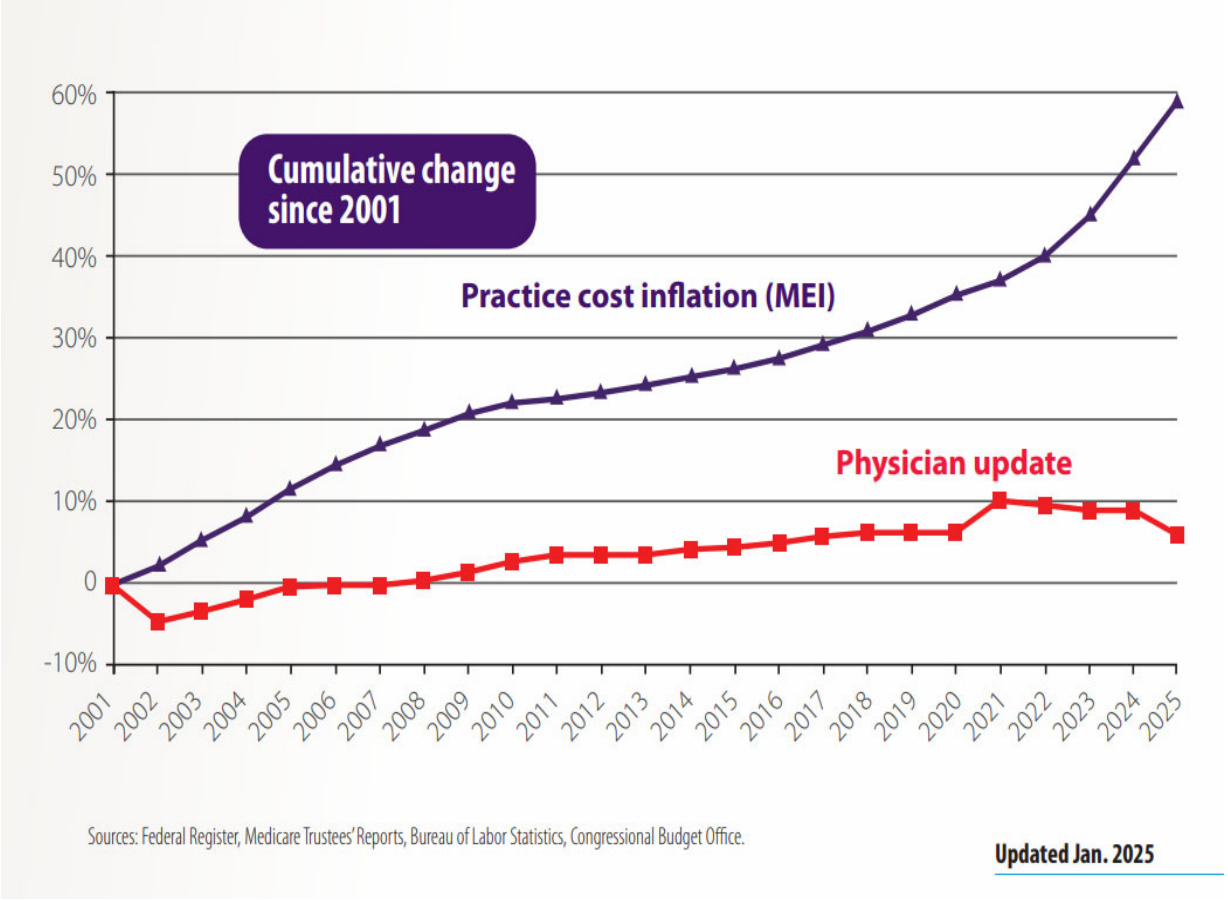
Physician Payments vs Inflation (2001-2025)

- Adjusted for inflation in practice costs, Medicare payments to physicians have decline by 33% from 2001 to 2025



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Final 2025 MPFS Concerns

- Conversion Factor (CF) reduction of about 2.8%:
  - Expiration of 2.9% Congressional boost to CF (partially mitigated 2024 cuts)
  - Nearly imperceptible (0.02%) increase to the CF due to budget neutrality rules
- No equity for postop visit value for global surgical payments
  - Two policies to collect more data instead
    - Transfer of care -54 modifier requirement
    - G0559 add-on code
- Significant ophthalmology-specific policies in MIPS:
  - Complete Ophthalmologic Care MVP
  - Revisions to the cataract surgery cost measure

Medicare Payment Activities - 2025

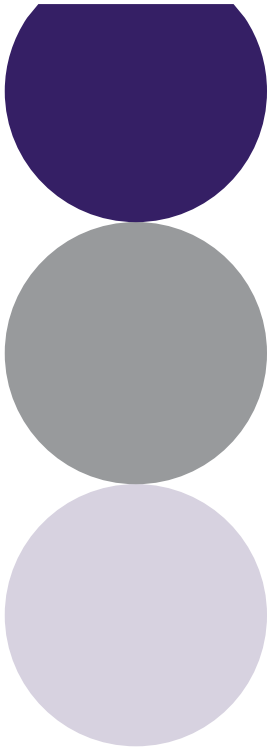
- **Renew efforts to mitigate 2025 cuts:**
  - Capitol Hill Meetings
    - AGS Congressional Advocacy Day
  - Grassroots campaigns
  - Leverage OPHTHPAC's relationships

- **Set Stage for Long-term Reform:**
  - Congressional Advocacy Day
  - Grasstops/Grassroots Campaigns
  - Reintroduce 118th Congress Bills:
    - Annual inflationary update
    - Budget neutrality reforms

- **Medicare Patient Access and Practice Stabilization Act (H.R. 879):**
  - Eliminates 2025 MPFS cuts
  - Provides inflationary update
  - Pro-rated through 2025
    - 6.62% CF boost
    - April 1- Dec 31
  - Bipartisan, messaging bill
  - No Senate bill yet

- Target: March Government Funding Bill

Budget Reconciliation/Healthcare Impacts



Budget Reconciliation Process

- Process passed in late February
  - House proposed $4.5 trillion increase in the deficit from tax cuts over 10 years if spending is cut by $2 trillion.
- Republicans looking to advance tax, energy, and immigration policies
- Allows Republicans to pass legislation in Senate by 51 votes
- Policies must affect budget
- ***Healthcare policies likely as "payfors"***

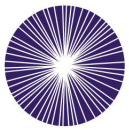
- **Challenges:**
  - Partisan exercise relying solely on Republican votes
  - Ultra-slim majority in House:
    - 3-seat majority
    - Republican vacancies
  - Intra-party fighting
  - President Trump
  - Other budget deadlines:
    - Government funding – March 14
    - Debt limit
    - March 31 for Health Extenders

Potential Healthcare Policy Solutions

- **Medicare:**
  - Implement site neutral payments
  - 340B program reforms
  - Reduce Medicare's coverage of bad debt
  - Reduce Medicare GME payments
  - Modify payments to MA plans for health risks
  - Reduce MA benchmarks
- ***Medicare Physician Payment Reforms -*** *Up to $10 billion in 10-year costs*

- **Medicaid:**
  - Caps on federal spending
  - Reduce federal matching rates
  - Establish Medicaid work requirements
  - Limit Medicaid provider taxes
- **Other Options:**
  - Reform ACA Subsidies
  - Eliminate ACA Prevention and Public Health Fund
  - Eliminate Hospital Inpatient-only List

VA Federal Supremacy Project



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VA Federal Supremacy Project

- Launched in 2021
- Establish national standards of practice (NSPs) for 50+ health professionals – including optometrists
- Could override state scope of practice laws & VA patient safety policies:
  - Restriction that only ophthalmologists will perform laser eye surgery in VA medical facilities

VA Federal Supremacy Project

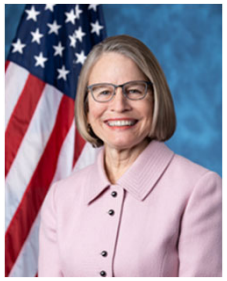
- 27 non-controversial NSPs published in the Federal Register
- 13 NSPs finalized:
  - Ophthalmology Technician
  - Blind Rehabilitation Specialist
- 27 remain “in development,” including the Optometry NSP
- Optometry NSP Workgroup:
  - VA has added Ophthalmology Exec Director, Glenn Cockerham, MD
  - Workgroup is not currently meeting/future status is unclear
- Action on Optometry NSP not expected until 2025/2026, but timing could be altered by new administration

New Administration

- Former U.S. Rep Doug Collins (R-GA) - VA Secretary:
  - Veteran- Navy and Air Force Reserve
  - Served in Congress from 2013 to 2021
  - Voted for:
    - The Choice Act of 2014
    - The VA Accountability and Whistleblower Protection Act of 2017
    - The Mission Act of 2018
  - Supported Anesthesiology on VA Nursing Handbook Modifications
- Confirmed Feb 4th by a vote of 77-23

House VA Committee – 119th Congress Returning Champions

Rep. Mariannette Miller-Meeks, MD (R-IA)



- Ophthalmologist
- Chair, Health Subcommittee
- Scope of practice champion

Rep. Greg Murphy, MD (R-NC)

- Urologist
- Health Subcommittee member
- Scope of practice champion

Rep. Julia Brownley (D-CA)

- Son is a physician
- Ranking Member, Health Subcommittee
- Scope of practice champion

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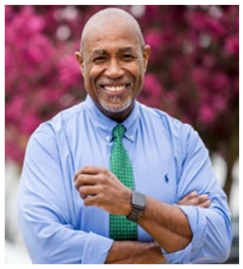
House VA Committee – 119th Congress New Champions

Herb Conaway, MD (D-NJ)



- Internal Medicine physician
- Air Force Veteran
- Supported ophthalmology on scope of practice in the NJ legislature

Maxine Dexter, MD (D-OR)

- Pulmonologist
- Supported ophthalmology in OR state legislature

Kelly Morrison, MD (D-MN)

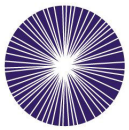
- Obstetrician-Gynecologist
- Supported ophthalmology in MN state legislature

Senate VA Committee – 119th Congress

- Senator Jerry Moran (R-KS)
  - Chairs Committee
  - States Rights Champion
  - VA Laser Surgery Fight Started in Kansas

- New Ranking Member – Senator Richard Blumenthal (D-CT)
- Lost Key Champions in 2024 Election Cycle:
  - Jon Tester (D-MT)
  - Sherrod Brown (D-OH)
  - Kyrsten Sinema (D-AZ)
  - Joe Manchin (D-WV)
- Sen. John Boozman (R-AR) - optometrist

Trump Administration 2.0



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Trump Health Care Team

Robert Kennedy, Jr.
HHS Secretary
Confirmed by a vote of 52-48

Mehmet Oz, MD
CMS Administrator

Marty Makary, MD, MPH, FACS
FDA Commissioner

Jay Bhattacharya, MD
NIH Director

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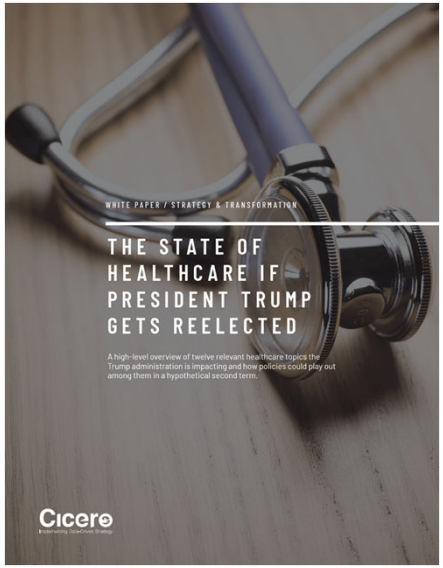
The Second Trump Administration: Possible Issues and Much Uncertainty

- Drug pricing
- Price Transparency
- Interoperability and Information Sharing/Blocking
- Medicare Advantage – more and cheaper options
- Value-based care
- Health Savings Accounts
- Medicaid – reduce open ended payments to a fixed block grant to each state
- Remove the expansion funding




The New York Times

November 14, 2024

BREAKING NEWS

Kenny Holston/The New York Times

Trump Wants Robert F. Kennedy Jr. to Lead Health and Human Services

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Current Health Care Laws Will Likely be Challenged and/or Modified

- Affordable Care Act of 2010
  - 21 million people enrolled in 2024
  - Increasing premiums in 2026
  - New Administration and Congress will suggest approaches to reduce participation, benefits or both
- Inflation Reduction Act of 2022
  - lower prescription drug costs
  - Out of pocket cap
  - Some negotiation on Part D and in the future Part B drug prices
  - $35 insulin, free vaccines
  - Premium subsidies for ACA through 2025, then ?

“Make America Healthy Again” Agenda

- Achieve “measurable” results to diminish chronic disease rates in 2 years
- Focus on obesity, diabetes, and auto-immune condition
- Remove chemicals from foods
- Reform agencies by:
  - removing “corruption” and “conflicts of interest”
  - restoring transparency

Source: November 2024 Speech@Tucker Carlson Live

- Academy/Ophthalmology:
  - Identify opportunities to incorporate eye health/vision priorities
  - Engage Administration on chronic eye diseases

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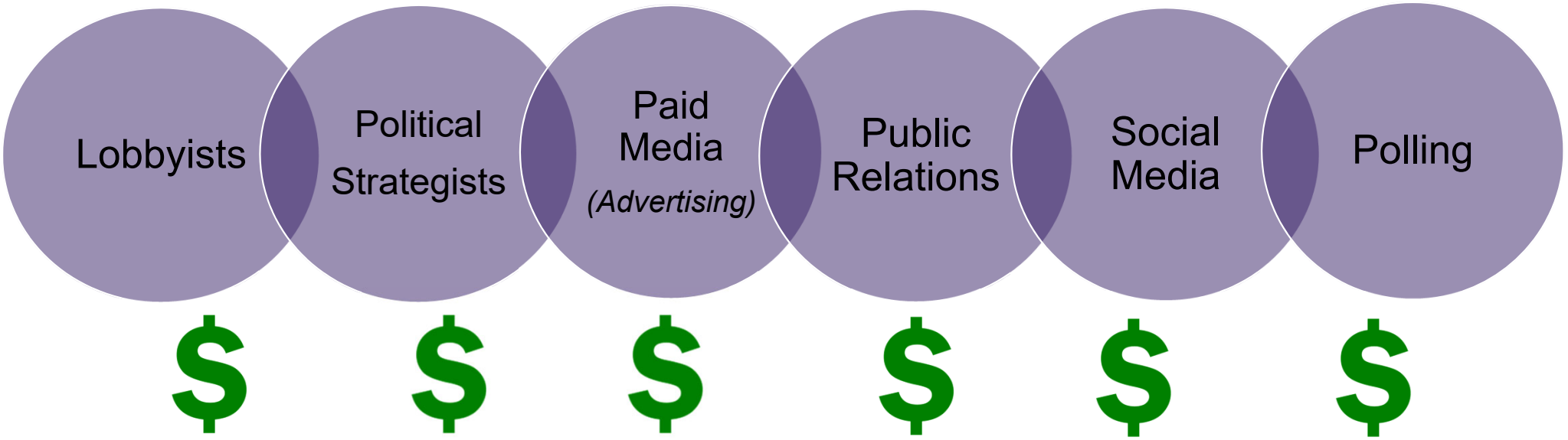
OPHTHPAC: Federal Access to Congress and Agencies

- Mitigated Medicare cuts for 2021, 2022, 2023, and 2024
  - Still working to fix 2025
- Advocated for appropriate scope of practice in VA health care facilities.
- Developed strong bipartisan congressional support on legislation to reform prior authorization and step therapy.
- Secured the extension of certain telehealth flexibilities.
- Helped secure introduction of pediatric vision screening legislation.
- Engaged with candidates on both sides of the aisle with 92% of OPHTHPAC-supported winning their elections.
- Working on Medicare Physician Payment Reform – MACRA 2.0 or other

Surgical Scope Fund:

Cost of Protecting Patient Safety? *It's not CHEAP*



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- **Go to aao.org/giveadvocacy**
- **Or scan the QR code**

Donate via Mobile:

- Text **MDEYE** to **41444** for **OPHTHPAC**
- Text **GIVESSF** to **41444** for the **Surgical Scope Fund**

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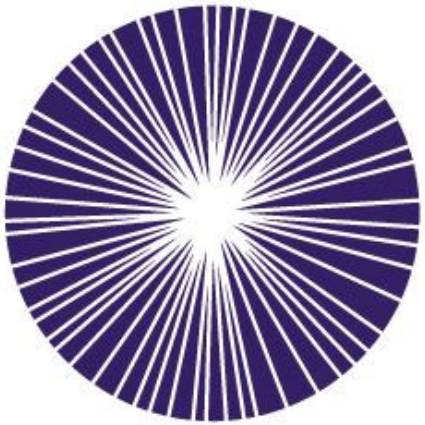

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Health Care Reform Principles: Simplicity, Relevance, Alignment, and Predictability

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- **Ensuring financial stability and predictability**
  - Provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace or revise budget neutrality requirements to allow for appropriate changes in spending growth.
  - Recognize fiscal responsibility.
- **Encourage collaboration, competition and patient choice** rather than consolidation
- **Promote value-based care**
  - Reward the value of care provided to patients, rather than administrative activities
- **Encourage innovation,** so practices and systems can be redesigned and continuously refined to provide high-value care and include historically non-covered services that improve,
- Offer a variety of payment models and incentives tailored to the distinct characteristics of different specialties and practice settings. Participation in new models must be voluntary and continue to be incentivized.
  - fee-for-service payment model must also remain a financially viable option.

Health Care Reform Principles: Simplicity, Relevance, Alignment, and Predictability

Wilmer Eye Institute
Johns Hopkins Medicine

- **Provide timely, actionable data**.
  - to identify and reduce avoidable costs.
  - Physicians should be held accountable only for the costs they control or direct.
- **Recognize the value of clinical data registries** as a tool for improving quality of care, with their outcome measures and prompt feedback on performance.
- **Safeguarding access to high-quality care**
  - Advance health equity and reduce disparities. Payment model innovations should be risk-adjusted and recognize physicians' contributions to reducing health disparities, addressing social drivers of care, and tackling health inequities. Physicians need support as they care for historically marginalized, higher risk, hard to reach or sicker populations.