

Retina in 2015: What to Expect in Government Policy

Editor's Note: Medicine is not immune to the shifts in political dynamics, and, over the course of the past year, retina specialists in particular have felt the effect of changes in federal policy.

In March 2014, the inaugural period of open enrollment for exchanges established by the Patient Protection and Affordable Care Act (ACA) ended, and patients and doctors saw the unintended consequences of the law's requirements—such as an increase in the number of high-deductible health plans—manifest themselves. In April, the Centers for Medicare and Medicaid Services (CMS) released Medicare Part B physician pay data from 2012 to the public in the name of transparency, but the lack of context explaining the data left citizens and journalists alike with a more opaque than clear understanding of what the data meant. Moreover, CMS released a list of doctors to whom it had paid more than \$3 million in 2012; of the 344 on that list, 151 were ophthalmologists. The lay press jumped on the story, and many retina specialists felt that they were suddenly on the defensive. Just recently, it was announced that the revised CMS Physician Fee Schedule would decrease reimbursement for vitrectomy, an announcement that angered many retina specialists who felt that reductions in reimbursement were a de facto penalty for efficient performance.

Retina Today invited 3 retina specialists who have their fingers on the pulse of government policy to discuss what they think sits on the horizon for retina practice in 2015. Their accounts are not meant to cover every possible topic on government policy in 2015. Rather, they offer a glimpse into the concerned minds of retina specialists who understand the impact that government policy can have on the practice of medicine.

Continued Devaluation of Ophthalmic Services Sets a Bad Precedent



By Nikolai J.S. London, MD

We commit ourselves early but start our careers late. We accept mountains of debt to pay for our training. We work harder than any of our friends—noses in books night after night throughout our education. We deprioritize our friends to the point of straining relationships. We do this because we are proud of our craft and dedicated to honing our skills as physicians, to help our patients as best we can. We do this because helping our patients to see is valuable to them, and preserving vision is valuable to society.

Or is it?

The past few years have witnessed devaluation of our services on multiple levels. Next year we will see further financial disincentives merely for the fact that we are

getting better at our jobs. Over the past decade, surgical repair of macular holes has evolved from a 90-minute surgery under general anesthesia with surgical wounds that required suturing (not to mention a week of taxing face-down postoperative positioning) to a 30-minute surgery under local anesthesia with tiny, sutureless wounds, and little to no postoperative positioning. These improvements are the result of advances in surgical technique and instrumentation, many of which were developed by the very surgeons performing the surgeries. In reward for that innovation and for making surgery safer, more effective, and easier on our patients we will receive a 42% pay cut from Medicare for macular hole repair in 2015. The rationale is that we are getting faster, so it is worth less. Where is the logic in this? Do they expect us to see a 42% increase in patient volume simply because we as a profession are better at what we do?

This scenario calls to mind a quote from 1 of my favorite novels, Ayn Rand's *Atlas Shrugged*: "Nothing can make it moral to destroy the best. One can't be punished for being good. One can't be penalized for ability."

I could say that it is not about the money, but higher quality products cost more money. I recently asked my wife how in the world she could spend \$200 on a pair of pants. Her answer was simple and brilliant (as usual): "Because that's what they cost." If Medicare want to pay Kmart prices it should not expect to purchase a Tesla.

With that off my chest, I would be remiss if I did not say that I absolutely love what I do and would not trade my job for the world. Do not tell this to the Relative Value Update Committee, but I would even do it for free. (I just might need to pick up some work at the local ice cream shop to pay the bills.) Moreover, I enjoy continuing to learn and improve my skills. We all do. This is obvious from the multiple meetings we attend every year, spending thousands of dollars out of our own pockets for the sole purposes of learning, teaching, and sharing our experiences. I am proud of our profession and my colleagues, and I know that we will do our best to retain the much-deserved respect we have from our patients.

No matter how many times we are hit we will carry on. We made an oath to do so. My only hope is that this steadfast dedication is not the noose that hangs us.

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Retina Specialists Will Face Many Challenges in the Coming Year



By Trexler M. Topping, MD

Retina specialists, and medicine in general, will face many taxing issues in the next year. I do not foresee a rainbow, but rather more thunder and lightning. We will begin the year revisiting issues surrounding the Sustainable Growth Rate, or SGR, and seeing a potentially greater than 20% cut in Medicare reimbursement. Maybe the lame duck Congress will have solved this before the end of 2014, but I doubt it. We will also face downward pressure on all of our codes from both the Relative Value Update Committee and the CMS, so we can expect reimbursement to decline. We will potentially face challenges with the availability of repackaged ranibizumab (Avastin, Genentech), and, because there is so much money at stake, I expect the lobbyists may make accessibility to the drug much more difficult, if not impossible.

Because "big data" has become such a regular part of our daily working lives, insurance carriers will all know

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how much it costs physicians to take care of patients. Do not be surprised if specialists who deal with more difficult cases or use more expensive drugs increasingly get excluded from panels. I fully expect the powers that be will, in the name of transparency, publish more and more personal financial data of physicians. It is almost certain that the driving forces of health care reform will add numerous onerous bureaucratic roadblocks to the efficient practice of medicine. I anticipate more staff time (which will not be reimbursed) to keep track of reoperation rates, visual acuity outcomes, and other data points, while we still lack any reasonable severity adjustment codes.

I personally recommend that all practices do what they can to increase efficiency. Both doctors and their administrators should be aware of all the federal incentives and penalties. For example, many physicians think the cost of electronic health records is too great in equipment and time lost, but, in several years, after all the penalties have come into play, these issues will probably have tipped the seesaw in the other direction. I do not foresee raises for services rendered, so any bonuses we qualify for will be positive, and penalties will make a gloomy picture even worse.

A 1-word summary of the future of retina practice? Bleak.

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The Law of Unintended Consequences



By John W. Kitchens, MD

In April 2008, Delta and Northwest Airlines announced a merger agreement. As a Delta frequent flyer, I was certain this would improve my travel options from the then-Delta hub Cincinnati-Northern Kentucky Airport, which is only an

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hour drive north of Lexington. Just 3 years later, the number of daily flights from Cincinnati had dropped from more than 700 to around 100 and the airport was no longer a Delta hub.

Call this an example of the law of unintended consequences: Introduce change to a complex system and you are bound to have unforeseen and perhaps unfortunate outcomes. Witness the ACA as another example.

Certainly there are many positive aspects of the ACA. First and foremost is the provision of health insurance to those less fortunate. In Kentucky, the state with the second highest uptake of the new coverage plan, we have seen a tangible difference in the number of uninsured patients. No doubt this is a positive for the more than 400 000 uninsured Kentuckians who are now able to afford insurance. It is also a positive for our practice as we are now able to care for these patients without so many reimbursement unknowns.

As with the Delta-Northwest merger, however, there are also unintended consequences. One of those consequences in our state has been the development of tiered therapy. The ACA's penchant for cost containment created a vacuum that has been filled with a for-profit managed Medicaid plan. The first initiative of this group was to create "bevacizumab-first" policy. Although the essence of such a plan is reasonable, the devil is in the details. The plan specifically states that patients must receive 6 consecutive bevacizumab injections and show fewer than 2 lines of visual improvement before the physician can request a change in therapy to a drug with a label indication for eye disease. This means that if a patient starts at 20/200 and improves to 20/80 but still has significant edema from their retinal vein occlusion, you cannot switch him or her to a therapy approved by the US Food and Drug Administration, even after 6 months. The greatest irony is that much of the cost savings from the denial of approved therapies is not passed on to the patient, but rather goes to the for-profit third party administrator of the plan.

If this is the first step, what will be next? Will insurance companies require a patient to fail a pneumatic retinopexy prior to undergoing a buckle or vitrectomy? We run the risk of having critical decision-making—the essence and art of medicine—being legislated to us in the name of profit for insurance companies.

The greatest risk we face is the loss of what makes us physicians: the ability to make clinically significant decisions for our patients. ■

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