2015 Government Policy Recap

It's time for a recap of activity in Washington that affects retina practice.

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Retina specialists often groan when they hear that the federal government has taken action that will affect their retina practices. The results of government action in the retina space are not specifically targeted at retina, per se—no member of Congress has an interest in altering the daily routine of the 3000 retina doctors practicing in the United States. Rather, changes tend to come in the form of revised policies from the Centers for Medicare and Medicaid Services (CMS), an institution through which many retina specialists receive some, if not most, of their reimbursement.

This year has already seen a number of policy changes that affect retina doctors. In the interest of offering retina specialists a quick digest of the policy changes enacted in 2015 that will likely affect their practices, I submit this update.

SGR REPEAL

This April, in what President Obama called a "milestone for physicians," Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Senate passed the bill 92 to 8, and the House passed it 392 to 37. MACRA repealed and replaced the sustainable growth rate (SGR) formula and stabilized Medicare reimbursement for services, providing annual reimbursement increases from July 2015 through 2019, and then from 2026 onward.

Starting in 2019, MACRA will combine the Physician Quality Reporting System (PQRS), electronic health records meaningful use (MU), and the value-based payment modifier (VBPM) into a single program called the Merit-based Incentive Payment System (MIPS). Based on a formula established by CMS, MIPS scores will be calculated using results from PQRS, MU, and VBPM data. A physician's MIPS score will be tied to reimbursement bonuses or penalties.

PQRS CHANGES

Although MIPS scores will be the metric of the future, the current system relying on PQRS participation is in place until 2019. After 2019, PQRS data will make up a portion of one's MIPS score. CMS announced that failure to report PQRS measures will result in a 2% penalty on all Medicare Part B drugs in 2015; in 2017, the penalty will be a 2% cut in Medicare payments in which Medicare is a secondary payer.

Another change from CMS regarding PQRS implementation concerns an increase in the number of quality measures physicians must report to CMS. Before 2015, CMS required physicians to submit data on three measures within the PQRS structure; now, CMS will require that physicians submit data on nine measures, one of which must concern cost cutting.

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KING v. BURWELL

This June, the Supreme Court of the United States voted 6 to 3 in favor of upholding the central tenets of the Patient Protection and Affordable Care Act (ACA): namely, that government subsides enabling lower-income citizens to purchase health insurance in federally run exchanges are constitutional. The Court rejected the argument brought by the law's challengers that specific language in the ACA prevented the federal government from subsidizing health insurance premiums for citizens in states using insurance marketplaces run by the federal government. The petitioners argued that only citizens in states with state-run marketplaces were eligible for subsidies, which came in the form of tax credits. The language in question concerned a section in the ACA that

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instructed the Internal Revenue Service how to grant tax credit subsidies to eligible citizens who must purchase insurance "through an exchange established by the state." The petitioners argued that this language meant that only citizens in state-run exchanges were eligible for tax credits; the government argued that federally run exchanges used in lieu of state-run exchanges were de facto state-run exchanges and that citizens in states with federally run exchanges were eligible for the same tax credits as citizens in states with state-run exchanges.

On behalf of the six-Justice majority, Chief Justice John Roberts wrote that the specific clause in question—"established by the state"—clearly contradicts the broader structure of the ACA, a law that established structures and systems which relied on citizens nationwide receiving tax credits.

Had the Court sided with the petitioners, the ACA would have collapsed. So-called death spirals of increasing prices and decreasing enrollment would have destroyed the scaffolding of state-run exchanges. Indeed, the Supreme Court, had it accepted the petitioners' argument that the ACA was designed with the specific language in question so as to coerce states into establishing their own exchanges, could have invalidated the ACA entirely on 10th Amendment grounds. (The 10th Amendment prevents the federal government from using excessively severe means of forcing states to adopt federal policy.) Instead, six justices agreed with the government's argument, and the ACA's basic structure—and, in the end, the ACA in its entirety—was preserved.

OIG REPORT ON QUESTIONABLE BILLING

The Office of the Inspector General (OIG) of the US Department of Health and Human Services released a report in September detailing rates of questionable billing for screening and treatment related to wet age-related macular degeneration (AMD) and cataract in 2012. The report found that 4% of providers billing for ophthalmology services (including ophthalmologists, optometrists, ambulatory surgery centers, and others) in 2012 fit the criteria for questionable billing practices; Medicare paid $171 million to providers engaged in questionable billing in 2012.

Questionable billing practices for AMD treatment included injecting ranibizumab (Lucentis, Genentech) more often than every 28 days or more than 13 times per year. For screening, questionable billing was considered a high number of fundus photography, ophthalmoscopy, fluorescein angiography, or indocyanine green angiography examinations per beneficiary annually; the threshold for what the OIG considered a high number was defined by the local coverage determination for that geographic region.

The OIG report recognized that there might be legitimate reasons why questionable billing practices arose—for example, a quirk in a patient's schedule might have demanded that the patient receive a ranibizumab injection 27 days after a previous injection. Still, the OIG recommended that CMS increase monitoring for ophthalmology billing and review the billing practices of providers whose billing patterns fall outside the norm.

Some retina specialists viewed the report as good news—for example, the report found that only six ophthalmologists billed Medicare for ranibizumab injections beyond the maximum annual dosing threshold. Others viewed any level of scrutiny from the OIG as an omen for increased inspection from government regulators. Regardless of perspective, it is important to note that the OIG monitors billing practices of eye care professionals, and that retina specialists need to make sure to document situations that may cause them to fall outside normal billing practices.

CONCLUSION

Retina specialists prefer to interact with patients, not government red tape. Still, given the demographics of our patient population and the reimbursement system attached to those patients, we have to understand that government regulation is a fact of practice.

Luckily, ophthalmology has a presence on Capitol Hill, and the government-relation wings of organizations such as the American Academy of Ophthalmology (AAO) and the American Society of Retina Specialists offer avenues by which retina specialists may engage government. Ophthalmology's advocacy organizations remain strong—so strong, in fact, that the AAO offered input to Congress during the drafting of the MACRA. Thus, it is important that we support organizations that give us a voice in Washington. ■

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