AMERICAN ACADEMY
OF OPHTHALMOLOGY®

MID-YEAR FORUM 2022
SESSION/HEARING REPORTS
APRIL 7-8

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Mid-Year Forum 2022: Behind the Scenes in D.C.

I. Abstract

The administration and Congress are not the only things affecting federal laws and regulations. Real-life examples of forces affecting Medicare and other policy decisions affecting ophthalmology and its patients were shared. This session provided attendees with insight into how things work in Washington, D.C., by examining some of outcomes related to ophthalmology's advocacy priorities. Attendees gained a better understanding of the important role they play in advancing our profession's legislative and regulatory agenda. The session also examined the potential impact of the 2022 midterm elections and what policy shifts ophthalmologists might see in 2023.

II. Background Information

The laws passed by the U.S. Congress and the myriad of regulations developed by federal agencies to implement those laws have far more effect on our daily lives than people realize. This is particularly true in health care where legislative and regulatory changes can affect the types of services available to patients, how physicians can treat them, how the drug and medical device industries can develop innovative products and how it is all paid for. Most policymakers do not have a health care background. Therefore, it is critical that they hear from ophthalmologists about issues that affect the practice of ophthalmology and ophthalmology patients.

III. Summary of Comments from Guest Speakers

This session, moderated by Academy Senior Secretary for Advocacy George A. Williams, MD, and Academy Medical Director for Governmental Affairs Michael X. Repka, MD, MBA, included seven panelists.

How the Pieces Fit Together
Sohail Hasan, MD, PhD, associate secretary for OPHTHPAC Committee, American Academy of Ophthalmology

Dr Hasan outlined how the care ophthalmologists provide to their patients is affected by the decisions made by lawmakers and other policymakers in Washington. He also shared his perspectives on why physician engagement is important for advancing ophthalmology's advocacy priorities. He described how the Academy uses its various resources such as the Academy's political action committee, OPHTHPAC, and its Congressional Advocacy program to secure congressional support for legislation and other initiatives. He also shared several real-life examples of how the Academy has used these resources to achieve an advocacy victory. He also discussed what the upcoming 2022 mid-term elections could mean for ophthalmology.

My Advocacy Journey to the U.S. Congress
The Honorable Mariannette Miller-Meeks, MD, member, U.S. House of Representatives

Rep. Miller-Meeks, MD, R-Iowa, outlined how her personal experiences as a practicing ophthalmologist led her to run for Iowa State Senate and the U.S. House of Representatives. She shared how her experience as the director of the Iowa Department of Public Health helped

her understand how bureaucracies work and how regulations/rules do not always follow legislative intent. She discussed the positive influence that physician members of Congress can have on health-related legislation and how that makes a difference for physicians and their patients. She encouraged attendees to be active advocates for their profession and their patients.

The Importance of Physician Advocacy: A View from Capitol Hill
The Honorable Kurt Schrader, member, U.S. House of Representatives

Rep. Kurt Schrader, D-Oregon, discussed how members of Congress still work collaboratively in a bipartisan manner to advance legislation, especially health-related bills. As a veterinarian with more than 30 years of private practice experience, he uses his experience as a small business owner to help his colleagues understand what it takes to run a medical practice. He told attendees that physician advocacy is vital because it helps their members of Congress make the case to congressional leaders for action on issues such as prior authorization reform and preventing Medicare payment cuts. He told attendees that members of Congress really do pay attention to what their constituents tell them and that is why their engagement with lawmakers is critical. He also discussed how young physicians and those still in training carry significant credibility with Congress.

The Academy presented Rep. Schrader with one of its 2022 Visionary Awards for his long-standing support of physicians and ophthalmology during the session.

Value from Building Strong Congressional Ties: A Case Study
Cathy Cohen, CAE, vice president of Governmental Affairs, American Academy of Ophthalmology

Ms. Cohen discussed how building strong congressional relationships is a critical element of the Academy's advocacy strategy. She discussed how finding a member of Congress who is passionate about our issues enhances our advocacy efforts. She provided an overview of how building a relationship with the late Rep. John Lewis, D-Georgia, led to the first blindness prevention benefit under Medicare. As a result of our joint efforts, Medicare beneficiaries at high risk for developing glaucoma are eligible for a glaucoma detection exam each year. She also described how the Academy's long-standing relationship with Rep. Lewis also resulted in his support for our campaign to derail drastic Medicare payment cuts for glaucoma and retina surgical payments in 2016.

Making an Impact for Ophthalmology and Where We are Going in 2022 and Beyond
George A. Williams, MD, senior secretary for Advocacy, American Academy of Ophthalmology

Dr Williams talked about the Academy's short-term and long-term advocacy goals. He highlighted the Academy's recent advocacy successes for averting drastic Medicare payment cuts for 2021 and 2022. He discussed the challenges physicians face in the absence of long-term reform of the Medicare payment system and the Academy's advocacy efforts to press Congress to develop a fair and stable physician payment system that includes annual positive updates that keep pace with inflation and practice costs.

The Role and Value of Coalitions to Successful Advocacy Campaigns
Peggy Tighe, JD, principal, Regulatory Relief Coalition/Powers, Pyles, Sutter & Verville PC

Ms. Tighe provided an overview of how coalitions add value to advocacy campaigns by amplifying shared messages, pooling resources, reducing duplication of effort, facilitating the exchange of information and expanding an organization's network for future advocacy

campaigns. She gave an overview of the Regulatory Relief Coalition's efforts to secure prior authorization reform in the Medicare Advantage program and highlighted the Academy's role as a founding member of the coalition. She thanked the attendees for sharing their stories of how prior authorization has affected their patients and their practices during their Congressional Advocacy Day hill visits and talked about how impactful that would be for the the coalition's efforts to pass the Improving Seniors' Timely Access to Care Act (H.R. 3173/S. 3018).

What's at Risk if Physicians Don't Get Engaged
Michael X. Repka, MD, MBA, medical director for Governmental Affairs, American Academy of Ophthalmology

Dr. Repka highlighted what is at risk for ophthalmologists, their patients and their practices if they do not get engaged in the Academy's advocacy efforts. He also explained how members of Congress can help influence the regulatory process by weighing in with key agencies on policies that are under development or need to be modified.

IV. Summary of Audience Comments

The audience had questions about why some Republican members of Congress who want to cosponsor the Improving Seniors' Timely Access to Care Act have not been added to the legislation. Ms. Tighe explained that the bill sponsors are pairing Republican and Democratic members when they add cosponsors to maintain the legislation's bipartisan balance of support. She also responded to questions about how the legislation would improve the prior authorization process in Medicare Advantage and how prior authorization requirements cost the health care system money.

Others posed questions about the underlying challenges in the Medicare payment system and what could be done to address them. Panelists responded with information on how the Academy and physician groups are working to get them addressed. They also discussed the importance of getting patients engaged in our advocacy efforts so that members of Congress are hearing how their constituents are directly affected.

V. High Priority Objectives

- Continue to educate the Academy membership on why they should be engaged in our advocacy activities.
- Continue the Academy's efforts to increase ophthalmologist engagement in our advocacy campaigns.
- Continue to highlight the Academy's advocacy successes to the Academy membership so they see the value in our advocacy programs.

Mid-Year Forum 2022: Medical Waste

I. Abstract

Eliminating medical waste in health care facilities is critical to lowering health care costs, ensuring continued access to key drugs and promoting better environmental outcomes. This session served to provide an overview of the current challenges, highlight ophthalmology leaders' success in changing state policies and provide important perspectives from ophthalmology leaders, industry stakeholders and federal policymakers.

II. Background Information

With growing concern regarding the environmental impact driven by the health care industry, the Academy is looking to educate ophthalmologists, policymakers and key stakeholders about steps that can be taken to address medical waste. In collaboration with ophthalmic societies, we seek to be a leader in reducing waste and promoting better environmental stewardship.

III. Summary of Comments from Guest Speakers

Cathleen McCabe, MD, president, Outpatient Ophthalmic Surgery Society
Dr. McCabe opened the session by thanking the audience for joining a broad discussion of this important issue. She provided a history of joint ophthalmic society engagement on important issues, like medical waste, and work on the Ophthalmic Instrument Cleaning & Sterilization (OICS) Task Force. She highlighted a recent survey of members of the Outpatient Ophthalmic Surgery Society regarding medical waste, with over 90% of respondents highlighting excessive waste and efforts that should be undertaken to reduce it. She also spoke about how 87% of the respondents to the survey wanted ophthalmic society action to address waste.

David Palmer, MD, clinical associate professor, Northwestern Medicine
Dr. Palmer focused his presentation on efforts in Illinois to change state policy that was contributing to excessive waste of topical ophthalmic drops and inability to limit waste by allowing patients to take unused drops home. Dr. Palmer outlined how he had success, via engagement with the state medical society, the American Medical Association and state legislation, and how attendees of the session could impact change in their state. He also mentioned collaboration on the recently released multi-society position statement on Reducing Topical Drug Waste in Ophthalmic Surgery.

Cassandra Thiel, PhD, assistant professor, Department of Population Health, NYU Langone Health
Dr. Thiel provided session attendees with an overview of the environmental impact of excessive waste in the health care system and examples of waste attributed to ophthalmic surgery. She highlighted that over 5% of greenhouse gases can be attributed to the health care industry. She presented examples of both the financial and environmental costs of existing policies contributing to waste and compared US surgical waste to counterparts in India.

Alex Long, vice president, Global Cataract Implantables, Alcon
Alex Long shared industry perspectives regarding the need to limit medical waste, with

specific focus on Alcon's efforts to reduce unnecessary waste linked to its packaging. The company launched its sustainability effort, GREENIST, and specific product changes to limit waste. These projects including changing the packaging to reduce waste, such as changing from Styrofoam to a more environmentally friendly foam. He concluded by highlighting that Alcon's priority remains patient safety but highlighted how these simple actions at an industry level can be impactful from an environmental standpoint.

Wiley Chambers, MD, supervisory medical officer, Office of New Drugs, Food & Drug Administration
Dr. Chambers highlighted FDA policies regarding single-use containers, multi-dose containers, and expiration dates. He addressed confusion regarding federal policies and the FDA's role on the issue of medical waste. Regarding expiration dates, he highlighted that their purpose and reason for listing on the labeling is to inform how long a product can be expected to maintain its quality, strength and purity. The labeling and expiration date is to guide the duration of maximal use.

Ruth Williams, MD, president, Wheaton Eye Clinic
Dr. Williams opened her presentation by highlighting that in her practice, everyone was not invested in addressing environmental impact of waste, but others were invested in lowering costs, and these benefits overlap. She informed attendees about activities she and her colleagues took to address waste, including limiting surgical packs to the minimum amount needed. Another step shared was using the packaging of a kit as drape and refusing to throw away anything that went unused. She said standardizing surgical sets can be an easy way for ASCs and physician practices to address waste and reduce costs. Dr. Williams thanked all the presenters for their efforts to advance medical waste reduction in ophthalmology.

IV. Summary of Audience Comments

- Attendees encouraged Dr. Chambers and the FDA to be more active in encouraging industry to make reusable products. Dr. Chambers informed attendees that the FDA's role was to be a gatekeeper and its charge was not to advocate for certain actions by industry.
- Attendees encouraged Alcon and industry to make more reusable products, as currently they are making single-use products that promote waste, such as single-use surgical blades. Alex Long responded that industry was often guided by what providers were looking for and that their engagement on this is important and can inform future decisions.
- Attendees asked panelists, specifically Dr. Theil, about green codes in New York state and whether they would be advanced elsewhere. Dr. Theil highlighted efforts in other states, mentioning Canada as well, while saying that many hospitals were opposed to efforts.
- Multiple attendees thanked the panelists for their engagement and work on this issue. They also thanked and encouraged the Academy and other ophthalmic societies to continue to advocate for reducing waste.

V. High Priority Objectives

- Attendees wanted follow-up information, including presentations from the session to be available.
- The Academy should continue to educate members about ways to reduce medical waste.

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Mid-Year Forum 2022: The Ophthalmic Office of the Future

I. Abstract

In this session, experts described how to leverage modern ophthalmic clinic design for flow and productivity and shared lessons learned from the pandemic that accelerated the evolution of our treatment practices. At the end of this interactive, fast-paced session, attendees received a toolkit containing various resources to put into practice at home.

II. Background Information

Mary Louise Collins, MD, chairwoman, Department of Ophthalmology, GBMC HealthCare; trustee-at-large, American Academy of Ophthalmology

Ravi D. Goel, MD, senior secretary for Ophthalmic Practice, American Academy of Ophthalmology

Moderators Mary Louise Collins, MD, and Ravi D. Goel, MD, introduced the hearing. Dr. Collins focused on the concept of "why" and how that related to the patient experience—satisfied patients build the practice, increase reimbursement and improve physician and staff well-being. Dr. Goel continued with the 5 Principles to Improve the Patient Experience and described the concept of the progression of economic value.

III. Summary of Comments from Guest Speakers

Jeff Pettey, MD, MBA, associate professor and vice chair of Education, University of Utah Department of Ophthalmology and Visual Sciences

Andy P. Schachat, MD, vice chairman for Clinical Affairs and director of Clinical Research. Cole Eye Institute, Cleveland Clinic

Aneesh Suneja, MBA, president, FlowOne Lean Consulting, LLC.

Alan E. Kimura, MD, MPH, president, Colorado Retina Associates

Stephen D. McLeod, MD, chief executive officer, American Academy of Ophthalmology

Dr. Pettey started the session and described assumptions for consideration. For example. there are significantly more patients per ophthalmologist, and the ratio will continue to increase with ophthalmologists being older than 55 and a decline in graduating residents. He also mentioned that patient expectations are driven by their consumer experience and that new technology will be abundant and accessible (*e.g.,* artificial intelligence and remote access to care). Dr. Petty added that financial incentives will be the dominant drivers and outlined various reimbursement models.

Dr. Schachat presented his slides on designing the lean office during the pandemic and into the future. He said it is difficult to make predictions and described considerations that some changes will be predictable and others will not, which requires a willingness to be flexible. He gave an example of flexibility by employing electronic systems to maximize efficiency, such as the MyClevelandClinic suite of applications that had self-scheduling, precheck-in appointments

and COVID-19 vaccine card integrations with future features to include onboarding and chatbots. Lastly, he provided an overview of the physical space of the Eye Institute at Cleveland Clinic Abu Dhabi.

Aneesh Suneja defined lean principles and their value in the ophthalmic practice as eliminating waste will improve value. He described the 7+1 categories of waste, the diagnosis of waste via value stream maps, examples of lean flow, differences between non-lean and lean clinic layouts and the beneficial results of redesigning the workflow.

Dr. Kimura followed with a real-life implementation of the lean principles and described outcomes (and successes). He presented a spaghetti mapping exercise and how it identified waste by movement; in addition, he described the culinary concept of *mise en place* and how it was implemented in his clinic using a "ready rack" to ensure standardization of exam rooms, greatly improving the efficiency of clinic flow. He also highlighted the success of small fixes to the existing clinic, including a centralized communication system and the transformation of a closet to a pocket office space. In essence evolution of the office space is important to meet the demands of the clinic.

Dr. McLeod pulled the concepts together and offered strategies for execution, sharing his experiences at the University of California-San Francisco. He stated the key to success is to first identify challenges starting with clear communication and work towards solutions. An inventory of the space needs, both clinically and synergistically, were outlined. From this preliminary assessment, an accounting of the overall space needs was allocated by type and reported. The workflow to inform design was prompted by user focus groups and input from the faculty and staff along with site visits. A lean consultant contributed to overall floorplan design. The final floorplan was presented, and contributions to the lean clinic flow described. Dr. McLeod emphasized that flexibility, including the use of movable cabinets in the exam lanes and equipment room, provided evolution opportunities for future redesign of the same space. Photos and a video of the real-life implementation showcased the successful project.

IV. Summary of Audience Comments

- The audience was grateful for the convenience of a physical toolkit card with an embedded QR code to allow the audience to download the hearing slides and access additional resources, such as Academy publications: *The Successful Ophthalmic ASC - Designing and Building* and *Mastering the Art of Lean Ophthalmic Practice*. Audience comments included:
    - I was glad to attend this course (I almost didn't). It was a valuable discussion that I can implement into my practice.
    - Thank you very much for the toolkit card. This is great!
    - The QR code is very helpful!
    - I'm going to bring the toolkit cards back to my office.
- The question-and-answer session included discussions on:
    - Pediatric ophthalmology practice considerations (e.g., whether it made sense to combine adult and pediatric clinic and waiting rooms).
    - The typical average size of a clinic per physician and exam lane, which the panel addressed to include satellite office considerations.
    - Practices that may not have the luxury to completely remodel their space. The panel provided suggestions for redesigning or repurposing the current layout for maximum efficiency and referenced the publications included in the toolkit that provided guidance on this subject.
    - Lessons and pearls the panel had learned during their efforts to remodel and redesign their respective offices. The panel provided recommendations for the audience to consider as well as what the panel would do differently if they had

to do it again.

V. High Priority Objective

- Attendees can download the resource toolkit listed on the cards handed out during the session at aao.info/MYF22-TOF (PDF, 25 MB). From there attendees can review relevant resources to support their practices.

Mid-Year Forum 2022: Innovation in Ophthalmology and Its Impact on Coding, Coverage and Reimbursement

I. Abstract

Innovation in ophthalmology has always been central to our culture. While offering exciting opportunities for physician growth and patient care, innovation can affect coverage, patient access and reimbursement for physicians in complex ways, both directly and indirectly.

The recent MIGS/cataract valuation highlights the challenges posed by balancing innovation, coverage and reimbursement. These require collaboration between external stakeholders, participation in coding valuations, advocacy with payers and negotiations with regulatory agencies.

II. Background Information

David B. Glasser, MD, secretary for Federal Affairs and RUC advisor, American Academy of Ophthalmology

Moderator David Glasser, MD, introduced the hearing by focusing on how innovation benefits ophthalmology: historic discoveries ranging from retinal photocoagulation to artificial intelligence have advanced the specialty practice. He explained that such innovations, however, raise practical questions of coding, coverage and reimbursement. Dr. Glasser then introduced the panel speakers and said that minimally invasive glaucoma surgery (MIGS) will be used as a case study for the intersection of these questions.

III. Summary of Comments from Guest Speakers

John McAllister, MD, Health Policy Committee member and RUC alternate member, American Academy of Ophthalmology; Northern Virginia Ophthalmology Associates
Case Study: Minimally Invasive Glaucoma Surgery (MIGS)

Dr. McAllister started the session by introducing *iStent*, one of several available device-implant options used during minimally invasive glaucoma procedures that have been brought to market in the last 10 years. He explained that iStent is a representative example of a novel device's potential impact on reimbursement for the entire family of codes associated with a procedure, as any new product must go through Food and Drug Administration (FDA) approval, Current Procedural Terminology (CPT) code creation, and RUC valuation processes to be used by physicians.

Emily P. Jones, MD, Health Policy Committee member, American Academy of Ophthalmology; American Glaucoma Society; Devers Eye Institute
MIGS Nomenclature & Clinical Practice

Dr. Jones defined the 6 subcategories of minimally invasive glaucoma surgery by presenting the differences between procedures that utilize trabecular bypass, aqueous shunting and/or take different approaches around the eye to enhance its aqueous outflow. She also covered the varied stents and devices associated with these different approaches to MIGS procedures.

Jella Angela An, MD, MBA, associate professor of ophthalmology, Johns Hopkins Wilmer Eye Institute
Study Design and FDA Approval

Dr. An detailed the path to FDA approval for new medical devices. She explained this study and approval process varies according to a product's level of medical device classification, which is determined by its complexity and risk posed to patients. As the highest-risk classification, Class III devices require premarket approval. That approval involves conducting a feasibility study and later a more-extensive pivotal study, both focused on device safety and effectiveness necessary to obtain an investigational device exemption. From first enrollment to final FDA approval, this process can take a decade or more. Dr. An then highlighted the market considerations managed by device manufacturers while navigating FDA approval and the milestones in this seven-year process for iStent, which was approved for use in conjunction with cataract surgery in June 2012. Similarly structured trials for Horizon's Hydrus Microstent followed soon after.

David B Glasser, MD, secretary for Federal Affairs, RUC advisor; Health Policy Committee member, American Academy of Ophthalmology
Impacts on the CPT Process

Dr. Glasser explained how new CPT codes are developed for the market introduction of new products such as iStent and Hydrus. A CPT code can be requested for a product before or after it's submitted for FDA approval, and the description of a CPT code later informs its recommended valuation for reimbursement. Many manufactures initially seek a Category III CPT code because it is easier to obtain than a Category I code for a new product and allows the manufacturer up to five years to collect utilization data before a code is reviewed again for Category I status. However, this comes with drawbacks. Payer coverage for Category III codes is more difficult to obtain than Category I codes, and reimbursement tends to be lower. Dr. Glasser walked through iStent's transition from Category III CPT Code 0191T to Category I codes 66989 and 66991 and Category III code 0671T, explaining that FDA approval for iStent only in combination with cataract surgery required a combination Category I CPT code. This brought the entire family of cataract surgery codes up for review by the Relative Value Scale (RVU) Update Committee, which likely would have led to devalued reimbursement for the procedures. Academy advocacy helped delay this code-family revaluation to year 2025.

Jeff P Edelstein, MD, RUC member; associate secretary of Health Policy Committee, American Academy of Ophthalmology
Physician Payment: RUC Process

Dr. Edelstein pulled these concepts together by describing the AMA/Specialty Society RVU Update Committee (RUC) process that recommends values to Centers for Medicare & Medicaid Services (CMS) for use in setting physician payment rates for new or updated CPT codes. He explained the three components of the Resource Based Relative Value Scale (RBRVS) (physician work, practice expense and professional liability insurance expense) and their component parts. He described the importance of the member-survey process and Academy collaboration with subspecialty societies that drives the RUC valuation of these components; and how this results in a total Relative Value Units (RVU) number recommended by the RUC to CMS. RVUs are then multiplied by the Medicare conversion factor to result in a physician payment allowable for a CPT code.

Sara Rapuano, MBA, CPC, COE, OCS, Eye Health America
ASC Facility Reimbursement and Access

Sara Rapuano explained how facility payment differs from physician payment for procedures delivered in the ambulatory surgical center or hospital outpatient department settings. Here instead, CPT codes are grouped into ambulatory payment classifications based on clinical intensity, resource utilization and cost. Payment for most drugs and supplies are included in the ambulatory payment classification unless they are granted pass-through status. The

number of ophthalmology-specific ambulatory payment classifications has been reduced over the last decade, making it more difficult to properly reimburse facilities for new procedures.

Ambulatory surgery center reimbursement to the facility for a given ambulatory payment classification is approximately 50% of hospital outpatient department reimbursement under Medicare. However, procedures such as MIGS, where a device accounts for more than 30% of a procedure's mean cost, use an alternative payment conversion to ensure payment covers device costs. Ms. Rapuano discussed how Academy activism in response to publication of the proposed calendar year 2022 Hospital Outpatient Department-Ambulatory Surgery Center Payment Rule helped reverse a decision that would have reduced facility reimbursement for combination cataract/MIGS procedures by 25%. CMS ultimately followed the Academy's advice to temporarily assign the codes to a new technology ambulatory payment classification and gather additional utilization and cost data for a more appropriate revaluation in the future. Ms. Rapuano closed by explaining the access challenges such a reimbursement cut would have caused, and the need for an increase in the number of ophthalmic ambulatory payment classifications to accommodate new technology.

IV. Summary of Audience Comments

Audience questions were varied, and topics ranged between:

- The purpose of the conversion factor, a tool for budget neutrality multiplied against the total RVUs for all CPT codes, and how it is determined every year
- What is asked of physicians in an average RUC survey, and what direct and indirect practice expenses are used as inputs to determine a procedure code's total RVUs
- The future of a standalone iStent CPT code (0671T, used without cataract surgery) and emerging add-on codes (including one for intensity), both still in development
- Whether the current Category III code for corneal collagen cross-linking will be converted to a Category I equivalent: Category III code recently renewed for another 5 years

There was lively discourse around:

- Criticism of the RUC survey and evaluation process's effect on physician payment from the perspective of both ophthalmologists and outside organizations:
    - RAND corporation study, noted as flawed by moderator David Glasser, MD, finds that most physicians over-estimate service times and number of post-op visits preformed on RUC surveys
    - Budget neutrality (conversion factor) applied to all RVUs can be triggered by introduction of new services and limits physician reimbursement to unsustainable levels with respect to inflation
    - Little incentive for the American Medical Association or CMS to account for pediatric sub-specialists when determining reimbursement
    - Inaccurate process to amortize equipment use for practice expense
- Near-future innovations anticipated for cataract/MIGS devices, and consequentially, procedure coding

V. High Priority Objectives

- Obtain recent evaluation and management code reimbursement increases for those same services that are part of the postoperative global period.
- Pediatric ophthalmologists would benefit from an intensity-modifier to add on to existing ophthalmology office visit (E/M) CPT codes, as well as payer-coverage for pediatric corneal collagen cross-linking.

Mid-Year Forum 2022: Changing Demography for the Practice of Ophthalmology

I. Abstract:

Single specialty private group practice remains the most popular practice model among ophthalmologists. However, across all of medicine, a recent study found that 70% of physicians are employed by hospitals or other corporate entities, and within ophthalmology, the greatest growth is occurring in practices owned by private equity companies.

On the other hand, some ophthalmologists are bucking the trend of consolidation and leaving group practice to start solo practices.

In this session we heard about options to traditional single specialty group ophthalmology private practice, including private equity, hospital/health system employment and solo practice.

At the end of this session, the ophthalmologist should understand the options that exist outside of joining a large privately owned ophthalmology group practice and the pros and cons of each model.

II. Background Information

The size and ownership of medical practices have undergone dramatic shifts in recent years, leading to a diversity of practice types. Several factors contribute to this, including practice closures, mergers and acquisitions, practice setting styles selected by younger physicians, and, most recently, the economic impact of the pandemic.

An increased number of physicians are in large practices, with 17% of physicians in practices with at least 50 physicians, according to a 2020 American Medical Association Physician Practice Benchmarks Survey. This increase has been noted since 2012 but accelerated between 2018 to 2020.

The largest proportion of all physicians, 43%, were in single specialty group practices, with surgical subspecialties having a higher proportion at 48%. Solo practitioners accounted for 14% of all respondents, and 17% of the surgical subspecialist respondents.

Physicians younger than 40 years old (41%) were less likely to work in small practices, and less likely to work in physician-owned private practice (34%) compared with physicians 55 and older (61% and 55%, respectively).

The AMA survey found that less than half of all patient care physicians were in a physician-owned private practice, the first time since performing this survey since 2012, but for surgical subspecialties, the proportion was higher at 66%.

III. Summary of Comments from Guest Speakers

Aaron Miller, MD, MBA, secretary for Member Services, American Academy of Ophthalmology; Houston Eye Associates
The Changing Demography: The Academy Member Survey

Dr. Miller described the 2021 Academy survey designed to evaluate the general health of the profession and assess current practice environment statistics. The survey was sent to 9,000 randomly selected U.S. ophthalmologist Academy members. There was a 10% response rate.

The survey found that the largest proportion, 46%, were in an ophthalmic group practice, 26% in a solo practice and 25% in an academic, hospital or multispecialty group. The average size of an ophthalmology group is 6.37 ophthalmologists, and 59% are in practices with four or fewer ophthalmologists.

Regarding practice ownership, 70% are an owner or partner in private practice, 15% are employees in a physician-owned practice, 7% are in private-equity owned practices and 6% are independent contractors.

Solo practitioners had a greater decline in net income and number of patient visits over the past three years than other practice types, and 11% of group practices sold their practice to private equity.

In terms of anticipated practice changes in the next 3 years for solo practitioners, 20% plan to retire, 14% intend to sell the practice to another ophthalmologist, and 9% intend to sell the practice to private equity and become an employee.

Robert Wiggins, MD, MHA, president, American Academy of Ophthalmology; Physician Administrator, Asheville Eye Associates
Single Specialty Physician Owned Group Practice

Dr. Wiggins described the disparateness of the single specialty group practice category, ranging from 2 to 50 or more ophthalmologists, and ranging from a single subspecialty to multiple subspecialties. The percentage of ophthalmologists in solo practice has declined over the past 15 years. The growth in physician-owned single specialty group practice has been offset in the past five years by physicians' affiliation with private equity firms.

In terms of changing demography, there are more female ophthalmologists, with 44% of current ophthalmology residents being female.

The COVID-related stress and economic repercussions has led to a potential great resignation in medicine, with one survey finding that one in five doctors plan to exit medicine in two years and one in three doctors plan to reduce work hours.

Medicare payment rates to physicians continue to trend downwards when adjusted by the consumer price index. The financial trends favor a group over a solo practice, because of ongoing overhead and equipment acquisition spread over more providers, administrative burden and paperwork spread over more staff, cross-referral among subspecialists and satellite offices for broader geographic coverage. These advantages also make group

practices generally more attractive to private equity than solo practices. At the end, it comes down to autonomy and independence vs. power in numbers.

Chris Albanis, MD, Leadership Development Program director, American Academy of Ophthalmology; president, Arbor Centers for EyeCare
Private Equity

Dr. Albanis described private equity (or co-investing) as a strategy whereby the funds and investors directly invest into businesses, and these funds are used to build acquisitions, enhance technologies and improve the financial results of the practice. She also described her practice's experience with private equity.

Reasons to partner with private equity included: growth/innovation, administrative expertise, minimize risk, exit strategy for the future and the financial resources to grow and invest.

Steps to the process of negotiating with private equity included: research, providing financial information as a source for valuation, a letter of intent, due diligence from all different aspects of the practice and legal documents.

The keys to successful co-investing include aligning vision and direction; understanding the options; exercising due diligence in finding the right partner; hiring the appropriate consultants, including attorneys, accountants and investment bankers; establishing physician governance; and creating communication channels with key shareholders and with the private equity partner.

In the end, medicine and business can work well together when their goals are aligned.

David Herman, MD, Board of Trustees member, American Academy of Ophthalmology; CEO, Essentia Health
Health System

Dr. Herman described the diversity in multi-specialty health care systems. A corporate operating company has a centralized policy with less local policy and operations, leading to less autonomy and more assistance. A corporate holding company has a central brand with more local policy and operations, resulting in more autonomy and less assistance.

Important questions to ask in any type of structure are: How are decisions made? and Who is at the table for those decisions?

Regarding corporate vs. clinical governance, is it the same table for decisions or separate tables?

Accountability should follow authority, and clinical decisions and financial decisions are firmly linked.

Advantages of multi-specialty health systems include a broad network of colleagues, including non-ophthalmologic colleagues, expertise, call coverage, access to capital, access to payer contracts and an integrated electronic health record.

Disadvantages of multi-specialty health systems are that a broader set of interests can lead to constraints, limitations on nimbleness due to large size and the fact that the revenue supports the entire mission of the organization.

To increase chances of success, your career and personal goals should be aligned with the organization's goals.

Paul Lee, MD, JD, F. Bruce Fralick professor and chair of Ophthalmology and Visual Sciences; director, W.K. Kellogg Eye Center, University of Michigan Health System
Academic Medical Center

Dr. Lee started with the why: elimination of vision loss and restoration of vision in ALL Americans.

An increased number of Academy members are in academic institutions/hospitals, with 19% reported in 2021. There is a wide spectrum of academic programs, varying by size, specialty coverage, ASCs, community offices and method of payment.

Factors vary by medical center as well, such as degree of autonomy, demand for work outside regular work week, income, on-call responsibilities, variety of work and level of infrastructure and support.

The size of the academic center will have an impact on the ability to perform clinical trials, physician and nonphysician education, capabilities outside of the medical school, the interest in population health, etc.

In terms of the future, academic medical centers are growing in size and scope, with the acquisition of hospitals and physician practices.

The changing demographics of the U.S. shows that by 2050, 30% of the population will be Hispanic and 15% will be Black, yet the status of diversity in the ophthalmology faculty members lags behind. For success, it's important to have broad experience and a diverse workforce.

The JP Morgan Healthcare conference yielded important insights: create a digital front door, drive affordability, tackle social determinants of health, create partnerships for health care innovation, become a hub for targeted services and leverage applied analytics.

Additionally, from the American Association of Medical Colleges, future trends include implementation of groupers for care, value-based contracting, and organization into service lines, and from the Robert Wood Johnson Foundation, future trends include the central role of big data, informatics and analytics.

Julia Lee, JD, board member, American Academy of Ophthalmic Executives; administrator, Lee Vision Associates
Solo Practice

Ms. Lee discussed launching a solo practice as grassroots patient care after a previous consolidation of 15 practices with 120 providers.

The important considerations in launching a solo practice were determination of location, incorporation as a new business, credentialing, confirming access to surgical facilities, selecting an EHR system and practice management system, purchasing equipment, and developing marketing.

The patient experience became more of a concierge level, community-based care with direct access to the physician without layers of bureaucracy, so that all inbound calls are answered live, with same day appointments and add-ons whenever possible, a highly cross-trained staff with the agility to execute a rapid course correction, and the referral base built from patient to patient, and providers in the community.

The future benefits are that the solo practice is a family business with full ownership and control, with a strong component of service to the community and work-life balance. Thus, solo practice should always remain a strong, viable option for ophthalmologists.

IV. Summary of Audience Comments

- There does appear to be an increasing trend toward part-time work, not only on the part of more senior ophthalmologists but also younger ophthalmologists with families. Larger practices can schedule part-time ophthalmologists more readily and cover patient care responsibilities. Contributions of part-time ophthalmologists, such as more senior ophthalmologists, are valuable, even outside of the pure patient care obligations, for mentoring, etc.
- The U.S. population is increasing in diversity, and the ophthalmologist workforce should also reflect this diversity more. The Academy's Minority Ophthalmology Mentoring Program is attracting more underrepresented minorities to the profession, and an Academy's task force has developed recommendations to evaluate and address disparities in eye care.
- For younger ophthalmologists, private equity might not be considered an opportunity. But private equity can provide more affordable investments and longer investment opportunities for young ophthalmologists that can be explored in depth.

V. High-Priority Objectives

- The Academy will continue to help ophthalmologists understand the different available practice types. Each ophthalmologist needs to determine their own career and personal goals and how these are aligned or not in prospective practice types.
- The Academy and ophthalmologists will continue to promote professionalism and advancement of the profession amidst business and other interests.

The physician's voice needs to be heard about what is important for ophthalmologists and for quality of care, particularly in non-physician owned practice types.

Mid-Year Forum 2022: On the Brighter Side

I. Abstract Time to take stock and remember all the reasons why we chose ophthalmology and how they can carry us through this pandemic and beyond.

II. Background Information

In spite of the numerous challenges brought on by the pandemic, ophthalmologists persevered and found ways to resume practice and care for their patients' safely. In this session, panelists highlighted what makes ophthalmology an incredible specialty.

III. Summary of Comments from Guest Speakers

Purnima Patel, MD, trustee at large, American Academy of Ophthalmology
Introduction
Dr. Patel introduced this session and each of the individual panelists.

William Flanary, MD, ophthalmologist, EyeHealth Northwest, Portland, Oregon
Eyes Wide Open
Dr. Flanary, aka Dr. Glaucomflecken, is well known on social media for his comedic portrayals of physicians and the health care system. He kicked off the session with a humorous take on being an ophthalmologist. For example, I chose ophthalmology because I like surgery, I like eyes, and I like to sit (during exams, during surgery). His remarks and his social media videos engendered laughter from all.

Philip Rizzuto, MD, FACS, professor of surgery, Albert Medical School, Brown University
Eye Can Do It All
Dr. Rizzuto's talk revolved around faith, family and fun. Faith in yourself and your skills will carry you through difficult times. Family enables you to learn and grow. He spoke about not only your traditional family but also your Academy family, your office family and your family of residents, fellows and colleagues. Dr. Rizzuto has fun being an ophthalmologist, an advocate and a teacher.

Jessica Shantha, MD, assistant professor, University of California, San Francisco
Globe-Trotting to Save Vision
Dr. Shantha shared highlights of her global journey, primarily to west Africa. She spoke of restoring vision to Ebola survivors, many with uveitis. She demonstrated safety and effectiveness of cataract surgery on Ebola patients. The impact of patient care has contributed to research and enabled them to build health care capacity through collaborations. Dr. Shantha also noted the upcoming Global Ophthalmology Summit in Utah Aug. 12-13.

Julia Haller, MD, ophthalmologist-in-chief, Wills Eye Hospital
Eye Can Change the World
Dr. Haller brought the spotlight to the many innovations in ophthalmology, starting with photocoagulation and the laser. She highlighted the numerous applications of the laser in treating eye disease. Next, she spoke about pharmacologic therapy, then surgical innovations focusing on the many minimally invasive surgery procedures that restore sight. Finally, she touched on ophthalmology's use of gene therapy and the use of chemotherapy for ocular

oncology.

R.V. Paul Chan, MD, MBA – secretary for Global Alliances, American Academy of Ophthalmology
Eye Will Make It Happen
Dr. Chan focused on artificial intelligence, telemedicine and digital technology in ophthalmology. He noted the Academy's committee on AI with a focus on the skyrocketing use in diabetic retinopathy and retinopathy of prematurity. Dr. Chan noted that Orbis' Cybersight has increased use of AI to augment its educational initiatives. There is growing use of virtual reality and simulation in teaching anatomy, pathophysiology, exam and surgical skills. He highlighted the opportunity to enhance patient care through AI by giving trainees an opportunity to learn surgical skills before entering the operating room on a live patient.

Daniel Briceland, MD, president-elect, American Academy of Ophthalmology
Conclusion
Dr. Briceland concluded the session with a 10-minute video highlighting 14 ophthalmologists sharing what it means to them to be an ophthalmologist.

IV. Summary of Audience Comments

- No comments

V. High Priority Objectives

- N/A

Academy, but also back at home within their respective state ophthalmology societies as well as subspecialty and specialized interest societies
- Introduce ambassadors to practice management resources available from the American Academy of Ophthalmic Executives (AAOE) and from state ophthalmology societies
- Encourage state and subspecialty and specialized interest societies to be inclusive and offer YOs an opportunity to be involved.
- Continue to educate advocacy ambassadors on the differences and the importance of contributing to three critical funds: OPHTHPAC® fund, the Surgical Scope Fund and state eye PACs.
- Inspire advocacy ambassadors to return to Mid-Year Forum and Congressional Advocacy Day as part of a committed community of advocates.

AMERICAN ACADEMY OF OPHTHALMOLOGY®

Mid-Year Forum 2022: L.E.A.P. Forward

I. Abstract

The L.E.A.P. Forward session is developed specifically for Advocacy Ambassador Program participants attending the Mid-Year Forum. It provides residents and fellowship trainees an opportunity to network and interact with active leaders in ophthalmology with panel discussions covering four major areas: Leadership, Engagement, Advocacy and Practice Management.

II. Background Information

The Academy's Advocacy Ambassador Program is a partnership with state, subspecialty and specialized interest societies, and training programs. The goals of the Advocacy Ambassador Program are to:

a) Engage and educate Academy Members in Training (residents and those undergoing fellowship training) early on as to the importance of advocating for their profession (training future advocates for patients and for the profession).

b) Help Members in Training understand the importance of membership and *active* involvement in their respective state ophthalmology and subspecialty societies.

c) Expose Members in Training to some of the critical issues in medicine being discussed by leaders in ophthalmology during the Mid-Year Forum and Academy Council sessions.

Since 2015, the Academy's Young Ophthalmologist (YO) Committee and Secretariat for State Affairs annually sponsor L.E.A.P. Forward. For the 2022 session, the following changes were instituted based on input from previous ambassadors and recommendations from the YO Committee and others:

- Increased the networking time for ambassadors with Academy and society leaders.
- Increased the number of Academy and society leaders who remained for the entire session.
- Table leaders rotated to different tables at the mid-point of the session so that ambassadors would have an opportunity to meet and network with more leaders
- Introduced the Academy's new CEO, Stephen D. McLeod, MD, who spoke to them about their ophthalmology journey.

III. Summary of Comments from Guest Speakers

Academy YO Committee members Andrea A. Tooley, MD and Lindsay De Andrade, MD, moderated the 2022 session along with YO Committee Chair Janice C. Law, MD. Moderators guided ambassadors in networking with assigned table leaders.

Each of the four topic themes began with a keynote speaker* followed by an interactive panel discussion. Keynote speakers and panelists each shared pearls and inspirational personal stories as examples of ways to become *engaged* and *involved* at the community, state society and national levels.

*Keynote speakers:

Leadership: *Tamara R. Fountain, MD* –immediate past president and graduate, Leadership Development Program (LDP) 1, Class of 1999, American Academy of Ophthalmology; past president, American Society of Ophthalmic Plastic & Reconstructive Surgery

Engagement: *Jeff H. Pettey, MD, MBA* – chair, Task Force on Academic Global Ophthalmology and graduate, LDP XIV, Class of 2012, American Academy of Ophthalmology

Advocacy: *Erin M, Shriver, MD* – councilor representing Iowa Academy of Ophthalmology and graduate LDP XIX, Class of 2017, American Academy of Ophthalmology; past president, Iowa Academy of Ophthalmology and Women in Ophthalmology

Practice Management: *Robert F. Melendez, MD, MBA* – graduate LDP X, Class of 2008, American Academy of Ophthalmology; president-elect, New Mexico Academy of Ophthalmology

IV. Summary of Audience Comments

Residents and fellows participating as advocacy ambassadors appreciate this unique opportunity to interact and network with Academy and society leaders. Follow-up to the L.E.A.P. Forward session included many positive statements by the participating ambassadors. When asked what they liked most about the session, ambassadors responded:

- *Excellent keynote speakers who were engaging and inspiring. Loved the panels following each individual section.*
- *Loved the content they (speakers) shared as well as their various approaches to public speaking. Loved each of their styles but found them all to be unique, and I hope to adopt some of these public speaking strategies moving forward. Informative.*
- *I enjoyed the opportunity to connect with new mentors and meet other residents. The format was also great to keep everyone's attention the whole time.*
- *I loved the opportunity to hear real and authentic stories from the speakers and panelists. It is so different than listening to these great leaders in their scientific talks. It makes them approachable, human and like one of us who has been there before.*

V. High-Priority Objectives

- Ensure that advocacy ambassadors fulfill the requirement to present their Mid-Year Forum experiences to their colleagues during grand rounds or other presentation opportunities. (The Academy's Ophthalmic Society Relations Department distributed a template PowerPoint to all ambassadors immediately after Mid-Year Forum 2022 on April 12 and encouraged them to personalize it based on their own experiences)
- Encourage Academy councilors to mentor advocacy ambassadors sponsored by their societies. Efforts by councilors are complemented by the YO Committee's Advocacy Ambassador Mentor Program under which 25 ambassadors are annually selected and paired with an Academy or society leader for a year-long mentoring program.
- Motivate advocacy ambassadors to engage in future state scope issues
- Continue to engage and inspire advocacy ambassadors to be involved not only in the Academy, but also back at home within their respective state ophthalmology societies as well as subspecialty and specialized interest societies

- Introduce ambassadors to practice management resources available from the American Academy of Ophthalmic Executives (AAOE) and from state ophthalmology societies
- Encourage state and subspecialty and specialized interest societies to be inclusive and offer YOs an opportunity to be involved.
- Continue to educate advocacy ambassadors on the differences and the importance of contributing to three critical funds: OPHTHPAC® fund, the Surgical Scope Fund and state eye PACs.
- Inspire advocacy ambassadors to return to Mid-Year Forum and Congressional Advocacy Day as part of a committed community of advocates.