From: Matthew Sheridan <mattsheridan34@gmail.com>
Sent: Wednesday, July 10, 2019 10:55 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: Public comment-Eye Care Emergency Department Avoidance [EyEDA]

To Whom It May Concern:

My name is Matt Sheridan and I am an optometrist that has treated hundreds of these cases and dozens of them after hours. I am a practice owner and our practice has always had a 24 hour doctor on call to help our community with eye problems. I believe that we need to change how we treat ocular emergencies. Let's take a corneal foreign body for instance. I have taken out more of these than many doctors have seen in their careers. I have never had an adverse event and we have better ways to manage the pain than the ER does ie bandage contact lenses. So if you get a corneal foreign body and go to the hospital on the weekend you will not see a eye surgeon, you will not see an eye doctor. Many times the provider is trying to take out the foreign body without a slit lamp and withoutvthe proper tools such as a spud. The provider also may be terrified of the cornea because they are not used to this procedure and because the cornea is the most sensitive surface on our body. So you are left with a less comfortable, less happy patient who paid more because they were seen at the ER. We have to fix this system and I am writing to let you know we optometrists are out here and ready to serve and ready to save the health care industry money.

Thank you,
Dr. Matthew Ryan Sheridan, O.D.

From: larry carr <eyedoccarr@hotmail.com>
Sent: Monday, July 15, 2019 3:25 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: [Eye Care Emergency Department Avoidance (EyEDA)]

Dear Sirs:

I Live and practice in a rural WV county with less than 10,000 people and have been supplying emergency eye care for 39yrs. Our nearest ED is located 15miles away and does not have biomicroscopy instrumentation which would allow greater visibility of small foreign particles. On numerous occasions we have seen patients following an ED visit that needed further intervention. Many of these visits could have been avoided had they been able to be seen at an optometrist office first. I think that the EyEDA study confirms this is a cost effective and beneficial program. I would urge continued support of this program.

Sincerely,
Larry W. Carr, O.D.

From: Brian Thamel <bthamel@visionsource.com>
Sent: Monday, July 22, 2019 5:30 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: Public Comment – [Eye Care Emergency Department Avoidance (EyEDA)]"

Dear PTAC Committee members:

This is a letter of support for the EyEDA application for a new APM for eye care. In reviewing the proposal, I am in full support of this initiative. Having been part of averting ED visits in my own practice and seeing the numbers accrue in the area of saving 30 thousand per month in seeing patients in my own practice that would have otherwise gone to the ED. This will further enhance quality of care in that the patient will be seen at the right time and in the right place. Ultimately this provides better care, better quality and at a lower cost to the system. I have seen numerous cases of non emergency visits go to the ED as well as many visits needing to be seen again after the ED costing the system duplicate visits. Optometrists have all the necessary equipment in their offices to provide the high level of care needed and to make the appropriate referral when necessary for tertiary care.

Thank you for reviewing this proposal and look forward to a positive response.

Sincerely,

Brian S. Thamel, O.D.

Brian S. Thamel, O.D.
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https://protect2.fireeye.com/url?k=d2a9a945-8efdb039-d2a9987a-0cc47adc5fa2-9671498424c79784&u=http://www.centralmassvisionsource.com/

From: David Caban <dcaban@visionsource.com>
Sent: Monday, July 22, 2019 8:18 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: Eye Care Emergency Department Avoidance (EyEDA)

Good evening PTAC committee members

This email is in support of the EyEDA application for an APM for eye care. As a Doctor of Optometry, who has practiced since 1977, I can attest to the very significant health care dollars that are wasted each year on unnecessary emergency department eye care visits. I have treated countless patients who have appeared for follow up after an ED visit who should never have been there in the first place. The savings to our health care system by avoiding unnecessary ED visits, including most eye visits, would result in billions of dollars that could be used else where to improve the health of our aging population.

Thank you.

Sincerely

DAVID J CABAN, OD
Medical Director
Director of Managed Care Initiatives-- Northeast
Senior Regional Vision Source Administrator
Northern New England

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

July 24, 2019

Jeffrey Bailet, MD
Committee Chairperson
Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Re: University of Massachusetts Medical School Eye care Emergency Department Avoidance (EyEDA) Model

Dear Dr. Bailet:

WASHINGTON, DC OFFICE
2121 K Street NW, Suite 325
Washington, DC 20037-1886

202-728-0610
800-320-0610
www.acep.org

On behalf of nearly 39,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the University of Massachusetts (UMASS) proposed physician-focused payment model (PFPM), *the Eye care Emergency Department Avoidance (EyEDA) Model*, as it affects our practice of emergency medicine and the patients we serve.

ACEP understands that the goal of the *EyEDA Model* is to reduce emergency department (ED) utilization for "ED-avoidable" eye conditions. As emergency physicians, we appreciate the importance of ensuring that patients are treated in the most appropriate care setting and recognize that patients can avoid coming to the ED for truly non-emergent conditions. However, we are concerned that incentivizing optometrists, ophthalmologists, and other providers under the model to avoid sending their patients to the ED based on an extensive list of seemingly "ED-avoidable" diagnoses could have significant patient safety implications.

The proposed model defines "non-emergent" eye conditions based on a list of over 750 ICD-10 diagnosis codes. According to the proposal, the list "has been reviewed and attested by a review committee comprised of optometrists and physicians and shared with a representative from the American Optometric Association."[1] However, we do not believe the list was reviewed by an emergency physician prior to UMASS submitting the proposal. In our internal review of the codes (after the proposal was submitted), we have determined that numerous codes may be associated with a more serious emergency medical condition. Further, although there may be some codes on the list that not correlated with an emergency medical condition, it may be impossible for a provider to know for sure that a patient does not have an emergent condition ahead of time without conducting a thorough medical screening exam.

[1] University of Massachusetts Medical School, *Eye care Emergency Department Avoidance (EyEDA) Model*, page 13, available at https://aspe.hhs.gov/system/files/pdf/261881/ProposalUMass.pdf.

The common symptom in this model is eye pain, and that can be anything from conjunctivitis, to abrasion, to a vision-threatening herpetic infection, to vision-threatening acute glaucoma. Patients with symptoms consistent with a possible emergency health condition should NEVER be expected to self-diagnose before deciding as to whether to come to the ED. As emergency physicians, we often ourselves cannot differentiate just based on presenting symptoms when a patient first comes to our ED, whether they are experiencing an emergent or non-emergent condition. Many conditions share very similar symptoms, and we frequently must do a full work-up and exam, sometimes with additional diagnostic tools, before it becomes clear what the ultimate diagnosis is. In fact, a 2013 peer-reviewed study published in JAMA of over 34,000 ED visits found that for those discharge diagnoses which could be considered primary care–treatable, the chief complaints reported for these visits were identical to those reported for 88.7 percent of all of the studied ED visits, many of which ended up requiring admission to the hospital, triaged at the highest/most urgent level, or went directly to the operating room.[2] As the authors of the JAMA paper note:

"For example, a 65-year-old patient with diabetes may be discharged with the nonemergency diagnosis of gastroesophageal reflux after presenting with a chief complaint of chest pain; however, that patient still required an emergency evaluation to rule out acute coronary syndrome."

The extremely limited concordance between presenting complaints and ED discharge diagnoses in this study demonstrates that using lists of diagnostic categories as a means for basing payment and incentives is a flawed and inaccurate practice.

In light of our concerns with the model, we offer the following suggestions:

- ***Limit the Number of "ED-avoidable" Eye Conditions:*** ACEP **strongly recommends** that UMASS narrow the list of "ED-avoidable" eye conditions that are currently included in the model proposal. Concentrating on a select few eye conditions, and perhaps expanding the list over time, would allow models participants to focus on particular cases where there is overwhelming evidence that a patient most likely does not have an emergency medical condition.

- ***Concentrate on Symptoms Rather than Diagnoses:*** As UMASS considers which eye conditions and specific codes to include in this shorter list, ACEP **strongly recommends** that UMASS only include symptom-based codes and not codes that are based on patients' final diagnoses.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org

Sincerely,

Vidor E. Friedman, MD, FACEP
ACEP President

[2] Raven MC, Lowe RA, Maselli J, Hsia RY. Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits. JAMA. 2013;309(11):1145-1153. doi:10.1001/jama.2013.1948.

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July 29, 2019

Designated Federal Officer
Sarah Selenich
Office of Health Policy, ASPE
Sarah.Selenich@hhs.gov

The American Academy of Ophthalmology appreciates the opportunity to comment on the proposed Alternative Payment Model – Eye Care Emergency Department Avoidance (EyEDA) put forth by the University of Massachusetts Medical School. The Academy is the largest association of eye physicians and surgeons in the United States. A nationwide community of nearly 20,000 medical doctors, we protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public.

The Academy has significant concerns regarding this proposal and does not support it as proposed. While we certainly agree with ensuring appropriate ER visits, it should be conducted in a manner that does not put patients at risk. Our primary concern is that we find no evidence that ophthalmologists were included in or consulted regarding this alternative payment model or its development. The Academy has additional concerns regarding patient care as outlined in the application. There are many eye conditions and diseases that present to the ER that require an immediate medical assessment and/or prescription, many of which have even been included on the list of diagnosis codes for ED avoidable eye conditions. Delaying treatment for these conditions can cause loss of vision and patient harm. Additionally, the Academy believes that the savings estimated in this proposal are substantially overestimated.

Without performing an onsite physical examination, it can be difficult to assess the extent of damage or the nature of symptoms a patient experiences to appropriately categorize them as emergent vs. urgent or non-urgent, and surgical vs. non-surgical. One example of such a diagnosis in this category is a perforated corneal ulcer. Corneal ulcers vary widely in their management. Without direct examination it is difficult to determine whether the patient is presenting with a perforated ulcer requiring emergency surgical intervention. This would reasonably justify a visit to an emergency department for evaluation and management. The same could also be said regarding any issues related to retinal injury, vascular event or detachment. Diversion to third-party triage instead of the ER can cause a delay in treatment which increases the risk of permanent vision loss and downstream costs.

The Academy appreciates the opportunity to comment and provide any further discussion or review.

Sincerely,

Michael X. Repka, M.D., MBA
Medical Director for Government Affairs

AMERICAN OPTOMETRIC ASSOCIATION

July 29, 2019

Sarah Selenich
Office of Health Policy
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Selenich,

The American Optometric Association (AOA) appreciates the opportunity to provide comment on the University of Massachusetts Medical School Eye care Emergency Department Avoidance (EyEDA) Model. The AOA represents approximately 39,000 doctors of optometry, optometry students and paraoptometric assistants and technicians. Doctors of optometry serve more than 10,000 communities across the country, and counties that account for 99 percent of the U.S. population.[1] Recognized as Medicare physicians for more than 30 years, doctors of optometry provide medical eye care to more than six million Medicare beneficiaries annually. In support of evidence based health care and to serve the needs of the American public, the AOA develops Clinical Practice Guidelines that meet the National Academies of Sciences, Engineering, and Medicine - Health and Medicine Division (NASEM) evidence-based standards.[2]

The AOA appreciates the work of the University of Massachusetts Medical School in developing the Eye care Emergency Department Avoidance Model. Doctors of optometry provide high quality, cost-effective care. Eye and vision disorders have broad implications in health care because of their potential for negatively impacting activities of daily living resulting in decreased quality of life. They are associated with loss of independence and difficulty maintaining employment. Many eye and vision disorders are chronic conditions that can affect individuals for their entire lives. The burden of these conditions is projected to continue to increase as the aging population expands.[3] It is estimated that at least 40 percent of vision loss in the United States is either preventable or treatable with timely intervention, yet many people are undiagnosed and untreated.[4] The diagnosis and treatment of eye diseases and vision problems can result in improved visual function and health-related quality of life for adults of all ages.

Recent analyses have shown that an estimated $8.3 billion is spent each year on emergency department (ED) care that could be provided in another location.[5] Additionally, nearly 40% of all ED visits were for nonurgent medical conditions according to a 2013 study.[6] Unfortunately, many patients are seeking care in EDs for ocular conditions that could be treated in an office-based setting. A 2017 study found that "Nearly one-quarter of enrollees who visited the ED for an ocular problem received a diagnosis of a

[1] https://www.aoa.org/documents/HPI/HPI%20Uniform%20Edit%20Format%20ACCESS%20TO%20EYE%20CARE.pdf
[2] https://www.aoa.org/optometrists/tools-and-resources/evidence-based-optometry/evidence-based-clinical-practice-guidlines
[3] Wittenborn J, Rein D. Presented to Prevent Blindness America. Cost of vision problems: the economic burden of vision loss and eye disorders in the United States. 2013, Chicago, IL.
[4] Rowe S, MacLean CH, Shekelle PG. Preventing vision loss from chronic eye disease in primary care: scientific review. JAMA 2004; 291:1487-95.
[5] https://www.hfma.org/topics/news/2019/02/63247.html
[6] Uscher-Pines L, Pines J, Kellermann A, et al. Emergency department visits for nonurgent conditions: systematic literature review. Am J Manag Care. 2013;19(1):47-59.

nonurgent condition. Better educating and incentivizing patients to seek care for nonurgent ocular diseases in an office-based setting could yield considerable cost savings without adversely affecting health outcomes and could allow EDs to better serve patients with more severe conditions."[7] Further, a JAMA Ophthalmology 2019 analysis of data from an electronic record system found that a patient with a nonemergency eye concern would save $782 in charges and 5.75 hours in visit duration by choosing same-day outpatient care rather than an emergency department visit.[8] It is clear that doctors of optometry can play a key role in achieving these types of cost-savings.

While we fully agree that patients are better suited to seek care for ocular diseases and conditions in an outpatient, office-based setting with a doctor of optometry, we have concerns with certain aspects of the proposal. We fully recognize that as part of Alternative Payment Models (APMs), physicians must take on some financial risk. However, we are concerned that doctors participating in the model are required to take a discount of at least 8% applied to all fee for service rates on the emergency care related visits. We know from previous research that there are significant cost savings when patients seek same-day outpatient care rather than an emergency department visit. We believe a more equitable model would require doctors to pay an 8% payment penalty on pertinent visits in the year following the performance year, if savings were not truly realized. The care that doctors of optometry provide is valuable care and we believe an upfront payment discount devalues that care.

We are also concerned that the list of diagnosis codes meant to assist in identification of visits that would be considered in the EyEDA model is too broad. The 2019 JAMA Ophthalmology study indicated that the top 4 ophthalmic diagnoses for ED patients were conjunctivitis, cornea abrasion, iritis, and visual loss. We recommend that the pertinent diagnosis code list for the proposed payment model be further revised and limited. Now having the full details of the proposed model, we believe our organization could better assist in the creation of an accurate and appropriate diagnosis code listing for the purpose of the model.

Under the proposed model, doctors that meet or exceed the target number of qualifying ED-avoidable visits and demonstrate maintained or improved quality performance will receive shared savings payments from payer savings achieved through the reduction in utilization and payments to EDs. We believe for this payment model to be successful and equitable, there would need to be additional policy incentives in place. The policy proposal authors have rightly noted that "Patients lack awareness of the existence of alternatives to the ED for urgent eye conditions. Hospitals lack incentives to dissuade or redirect patients with nonemergent conditions away from the ED." To address these issues, payers participating in the model should be required to commit to dedicating resources to educating beneficiaries on the care that doctors of optometry provide and that our doctors can care for the majority of conditions that lead patients to seek ocular care in an ED. Payers that have 24-hour phone line support services to help answer beneficiary health care questions should also be required to commit to patient education related to ocular health. Additionally, we believe that EDs themselves should commit to assist in public education efforts as the EDs have the incentive to reduce the number of nonurgent ocular care provided so that the EDs can focus on more urgent care needs. We are concerned that placing the burden of public awareness solely on doctors of optometry would have limiting effects. Without the engagement of other players in the heath care system, the payment model would, in practice, target a single health care provider type which we believe may not meet the goals of the PTAC.

The EyEDA model would require that physicians administer a survey of patients to assess practice quality. The proposal authors note, "The practice will administer the survey by emailing a survey invitation with the online link to each patient who meets the survey criteria – that is, to each patient who

[7] https://www.aaojournal.org/article/S0161-6420(16)31631-1/fulltext

[8] https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2731881?guestAccessKey=727cd553-b35c-43ee-aef5-79420d038b28&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jamaophthalmology&utm_content=etoc&utm_term=071119

visits the practice to obtain treatment for any of the qualifying 6 eye conditions. The survey invitation should be emailed to the patient following the visit, on the day of the visit if possible, and followed by a reminder email approximately a week later." If the proposal were finalized, doctors of optometry would be required to administer the surveys, however the draft survey language has confusing language that creates an inappropriate distinction between "doctors" and "optometrists." The initial survey question indicates, "Our records show that you saw an eye doctor or optometrist at this practice recently. Is that right?" We believe this language should be updated to include appropriate terminology and should indicate, "Our records show that you saw a doctor of optometry or ophthalmologist at this practice recently." That language better describes the potential physician types that would be engaged in the payment model.

The AOA appreciates the opportunity to provide this feedback. We stand ready to assist the Physician-Focused Payment Model Technical Advisory Committee (PTAC) if any questions arise or if more information is needed regarding doctors of optometry and the care they provide. Please contact Kara Webb, Director of Coding and Regulatory Policy, at kcwebb@aoa.org or 703.837.1018 for any assistance.

Sincerely,

Barbara L. Horn, O.D.
President, American Optometric Association