A SPECIAL REPORT
BY THE EDITORS OF
Review of Optometric Business

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SIGNATURE EYE CARE

APRIL 2014

Navigation Guide to HEALTH CARE REFORM for *Independent Optometrists*

A Time of Opportunity

This is a time of seismic shifts in the health care marketplace, and there is widespread anxiety among independent optometrists about how these changes will impact practice viability in the years ahead. This anxiety is understandable and has diverse roots. Many ODs worry that third-party reimbursements will be squeezed to such an extent that either quality of care or net income must suffer. ODs also fear being overwhelmed by new bureaucratic requirements that steal time from patient care and reduce efficiency. Further, there is concern about maintaining access to patients, as the insurance industry evolves.

Optometrists occupy a distinctive position in health care, rendering both clinical services and retailing vision correction devices. Despite their unique dual role as medical professionals and retailers, ODs are impacted by the same market and regulatory dynamics affecting all health care providers. To remain economically viable, independent ODs must proactively adapt to the changes taking place in health care delivery.

As of early 2014, the ultimate impact of the Affordable Care Act of 2010 (ACA) is unclear. The initial rollout has been plagued with delays and missed forecasts, and it is not certain that all of the ACA provisions will survive Congressional scrutiny. The highly politicized media discussions of health care reform make it hard to separate fact from partisan opinion. For ODs, this makes it difficult to devise a strategy to adapt to the new world of health care.

Despite the uncertainties, some reliable assessments about the impact of health care reform can be made, based on longer term trends in health care, which form a useful foundation for planning. This report, commissioned by Vision Source and developed by Jobson Medical Information, examines the major long-term developments in health care delivery that are impacting optometry. It assesses the probable impacts of health care reform on optometric practice and suggests an appropriate plan of action for independent ODs to deal with the emerging realities.

Vision Source, which commissioned this report by Review of Optometric Business, believes that the disruptive changes unfolding in American health care delivery open up vital opportunity for ODs to gain access to new patients and expand the range of services provided. It is actively re-structuring its organization and service portfolio to assure that its membership is well positioned in the emerging health care landscape. It is convinced that its expanding OD network will offer a cost effective solution to new health organizations, which are being formed to respond to the evolving environment.

Vision Source membership will open-up access to new provider networks and enable members to extend primary care services to a larger population. Vision Source brings expertise and the resources of a large organization to bear to assist independent ODs in creating access to patients, in dealing with the new administrative complexities and in assuring continued financial viability.

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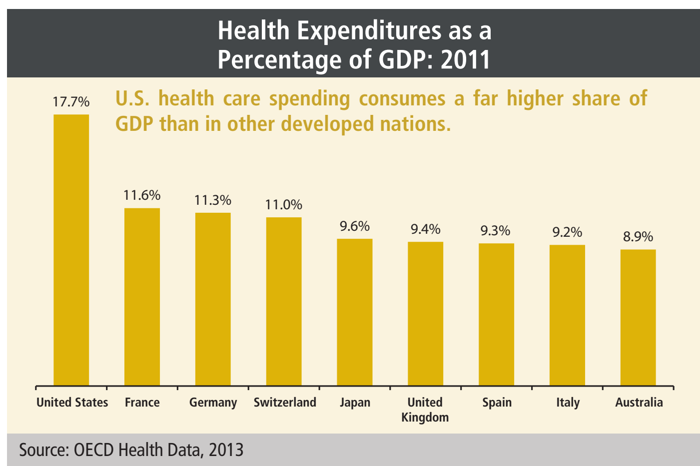
The Evolution of U.S. Health Care: Major Trends

The U.S. health care system is being fundamentally reformed. Despite its many successes, the U.S. health system is structurally deficient in a way that makes medical care increasingly less affordable, limits access for millions of people, and produces less than optimal outcomes.

Health Care Trend:
Health care demand is rapidly expanding.

Health care consumes an increasing share of American income. Sixty years ago, health care spending accounted for 4 percent of U.S. gross domestic product. Twenty years ago, health care spending reached 14 percent of GDP. Today it accounts for 18 percent, a ratio more than 50 percent higher than that of other developed nations. Ultimately, continued growth of health care's share of spending is economically unsustainable. This troublesome trend has prompted the federal and state governments and managed care companies to attempt to rein-in costs.

Health Expenditures as a Percentage of GDP: 2011



Source: OECD Health Data, 2013

A number of structural problems in the U.S. health care system reduce efficiency:

- Payments that reward providers for inputs not outcomes
- High administrative costs (approximately one-fourth of total health care cost)
- Preventable medical error rates higher than other developed nations
- Inadequate focus on prevention

Beyond the structural inefficiencies that have caused costs to escalate, U.S. health care spending has outpaced expenditures for other goods and services. This is a result of the aging of the population and a dramatic acceleration of the obesity epidemic that brings with a host of medical conditions, as well as the introduction of new technologies that raise standards of care and extend lives.

Mature people require more medical care, including vision care. In 2012, 13 percent of the U.S. population was 65 years of age or older. By 2035, nearly 21 percent of the population will be 65 or older. As the number of seniors grows faster than the younger population, health care demand will also continue to grow faster than either overall population or economic growth.

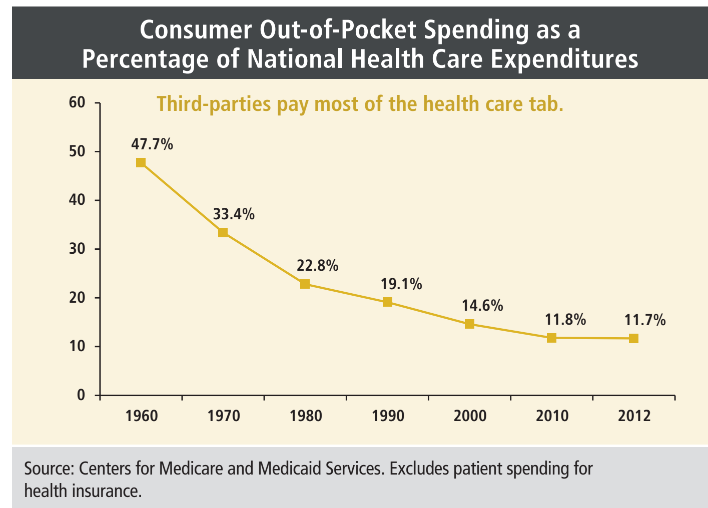
The other major driver to health care demand is the escalation of technology advances, and this trend will continue. It is highly unlikely that the rate of technological innovation in health care, or eyecare, will slow. People will pay more for advances that improve or lengthen their lives, providing strong incentive to companies to invest in R&D and keep the stream of new products flowing.

Health Care Trend:
Managed care increasingly dominates health care delivery.

As demand for medical care has steadily grown, control over the purse strings of health care spending has shifted dramatically. Over the past half century, the proportion of health care spending paid for directly by patients has steadily declined, and third-party payers have become the dominant source of revenue for health care providers. In 1960, patient out-of-pocket payments accounted for nearly half of national health care spending. Today, direct patient payments account for just 12 percent of spending.

As third-party payers have come to dominate health care, independent medical practitioners have become less independent, losing control over fees and becoming subject to new administrative rules and requirements. The same patterns are evident in eyecare.

Consumer Out-of-Pocket Spending as a Percentage of National Health Care Expenditures

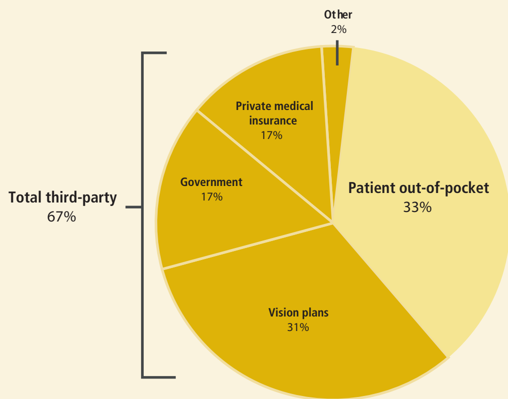


Source: Centers for Medicare and Medicaid Services. Excludes patient spending for health insurance.

In the vision care marketplace, the most important third-party payer group has become vision insurance companies. Vision insurance plans were widely adopted by employers over the past few decades. Currently about half of U.S. adults are enrolled in one of these plans – an enrollment ratio that has stabilized in recent years. Most of the plans are standalone, unbundled with other medical benefits. In the future, as Medicare Advantage plans and Medicaid enrollment grow, it is likely that vision benefits more often will be included in medical insurance plans.

Sources of OD Revenue: 2011

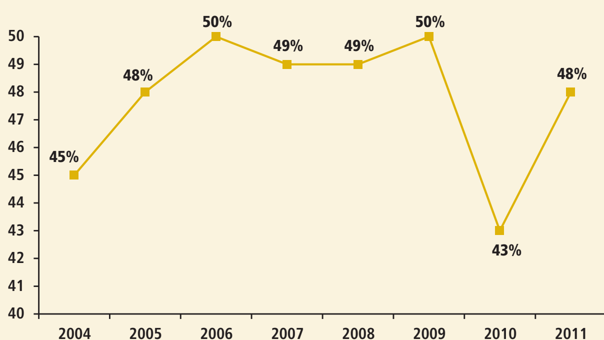
Most OD revenue comes from third-party payers.



Source: American Optometric Association, 2012 Survey of Optometric Practice

Percent of U.S. Adults with Vision Plans

Half of adults are covered by vision insurance.



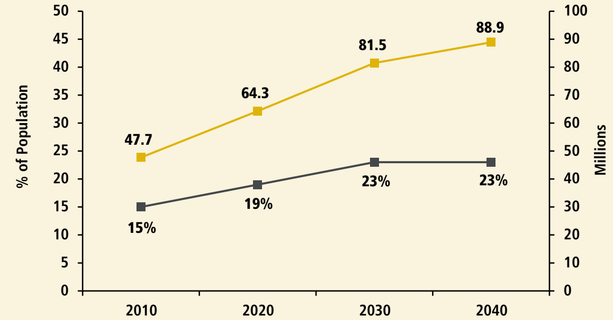
Source: Jobson Optical Research, 2008 and 2012: "Consumer Perceptions of Managed Vision Care"

The U.S. government has become a major third-party payer for medical care. Primarily through the Medicare and Medicaid programs, federal and state governments now account for 44 percent of the national health care spending and an increasing share of vision care spending as well.

The aging Baby Boomer generation is producing rapid growth in Medicare enrollment. Currently there are 51 million Medicare beneficiaries (16 percent of the total population). In 2020 medicare beneficiaries will rise to 64.3 million (19 percent of population) and in 2030 to 81.5 million (23 percent of population). Medicare payments have accounted for an increasing share of total OD revenue over the past decade — a trend highly likely to continue. During 2013, Medicare disbursed $1.1 billion to ODs. That represents an increase of 74 percent compared to 2004, and a compound annual growth rate of 6.3 percent. Over the same time period, Medicare payments to ophthalmologists increased 32 percent, or 3.1 percent annually. During 2011, ODs served 5.7 million Medicare patients – about 12 percent of all Medicare beneficiaries.

Medicare Enrollment

Medicare enrollment is growing.



Source: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

Medicare Payments to Eyecare Professionals: 2004-2013 ($ million)

Medicare payments to ODs have grown 6% annually since 2004.

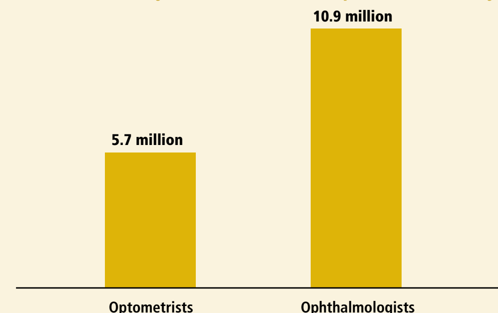
	2004	2013	% Change	CAGR
Optometrists	$611	$1,061	+73.6%	+6.3%
Ophthalmologists	$4,291	$5,645	+31.6%	+3.1%

Source: Centers for Medicare and Medicaid Services

As of late 2013, 15 million Medicare beneficiaries, or 29 percent of the total beneficiaries, were enrolled in Medicare Advantage programs, providing a supplement to their Medicare coverage. Enrollment is increasing 10 percent annually. These programs are run by large insurers including United Healthcare, Blue Cross/Blue Shield, Humana, Kaiser Permanente, Aetna, Wellpoint and others. Most of the plans offer a vision benefit — usually a set amount to pay a portion of the cost of a pair of eyeglasses — which is an attractive feature of the plans to the over-65 population.

Medicare Beneficiaries Served By Eyecare Professionals: 2011

ODs serve nearly 6 million Medicare patients annually.

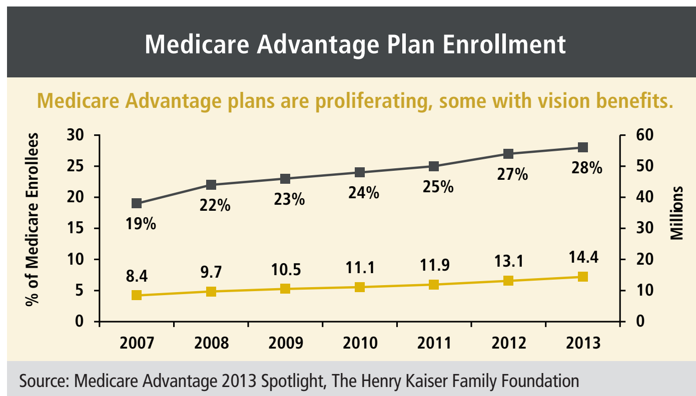


Source: Centers for Medicare and Medicaid Services

Under the Affordable Care Act, Medicare Advantage plans must spend at least 85 percent of the money they take in on medical care, limiting profit and administrative expense to no more than 15 percent of income. It is likely that the federal government will exert continuing pressure on Medicare Advantage programs to control outlays.

Medicare Advantage plans construct restricted provider panels and dictate reimbursements. They rigorously seek to improve helath outcomes plus contain costs to maintain profitability.

Medicare Advantage Plan Enrollment



Source: Medicare Advantage 2013 Spotlight, The Henry Kaiser Family Foundation

Medicare Advantage plans are rated by Medicare based on 75 quality measures, including the percentage of diabetic patients receiving annual dilated eye exams. Highly rated insurers receive higher per capita payments and are able to market their programs for periods beyond the normal end-of-year enrollment cycle. So there is strong economic motivation for insurers to achieve high ratings and to build cost-effective networks of providers to deliver mandated services.

As Medicare Advantage plans expand enrollment, they will become a more important source of OD revenue. ODs are ideally positioned to monitor diabetics and partner with physicians to improve population health, in addition to providing the refractive services that many of these plans will provide.

Health Care Trend: *Physician roles are changing as the MD supply stagnates.*

The economics of medical practice have encouraged a steady consolidation of provider organizations and an increasing institutionalization of primary medical care. The critical mass of revenue necessary to sustain an independent medical practice has increased, under managed care reimbursement limits and reporting requirements. Larger organizations can achieve economies of scale unavailable to smaller practices. Larger groups can devote more manpower resources to planning and management than a solo practitioner can marshal.

Although there is not unanimous agreement among physician workforce studies, there appears to be a growing shortage of primary care physicians, as demand for health care grows faster than the supply of doctors. The supply of physicians has been growing at only about half the rate of demand growth. The shortage is particularly acute among primary care physicians, which includes those specializing in family and internal medicine and pediatrics. Fewer medical students are choosing family and internal medicine because the income potential of these specialties is lower, and increasing amounts of time are spent on unrewarding administrative chores. The Affordable Care Act may make a primary care specialty even less attractive by increasing the number of people with access to primary care givers.

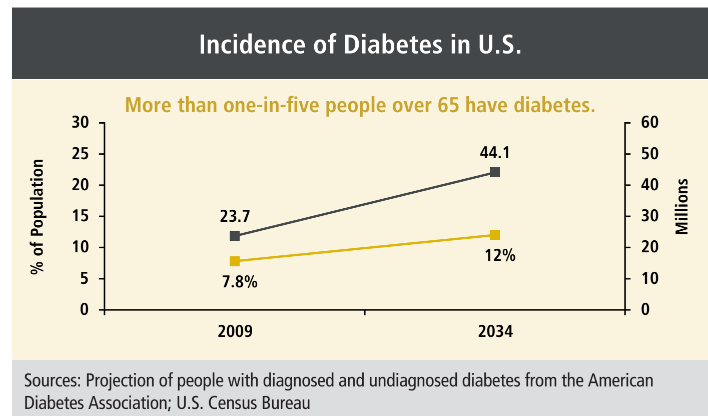
As of 2012, there were 18,000 ophthalmologists practicing in the U.S., many providing the same range of services as optometrists, in addition to ocular surgery. Through 2020, no change is anticipated in the number of practicing ophthalmologists, who are dealing with many of the same challenges facing primary care physicians. As the population ages and demand for surgical services and other treatments of chronic ocular disease grows, and as the supply of ophthalmologists remains stable, MDs will spend a greater share of patient care hours providing the services only they are trained to provide. In this climate, it is unlikely that ophthalmologists will become more active retailers of vision correction devices. Nor is it likely that insurers or ACOs will select MDs to be primary providers of pediatric or Medicaid vision care or to monitor diabetics.

Health Care Trend: *The population with age-related chronic conditions is growing.*

Population aging will increase the incidence of many age-related chronic diseases, including diabetes and glaucoma.

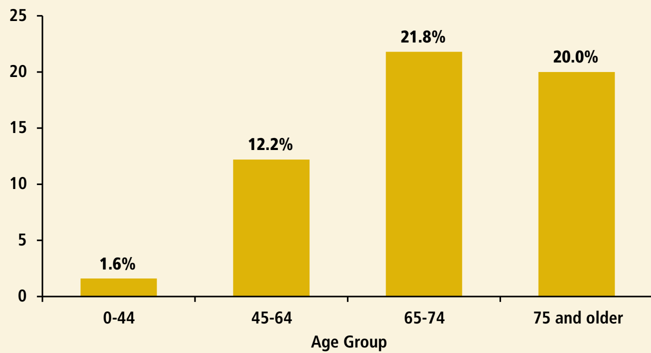
By 2034, the American Diabetes Association estimates that 12 percent of the U.S. population, or 44 million people, will suffer from diabetes. In an OD or physician office with 5,000 active patients, that translates to 600 diabetics. ODs are well positioned to monitor the ocular symptoms of the growing diabetic population. Medicare offers incentives to insurers to assure that each diabetic patient has an annual dilated comprehensive eye exam.

Incidence of Diabetes in U.S.



Sources: Projection of people with diagnosed and undiagnosed diabetes from the American Diabetes Association; U.S. Census Bureau

Incidence of Diagnosed Diabetes by Age: 2011



Source: Centers for Disease Control and Prevention

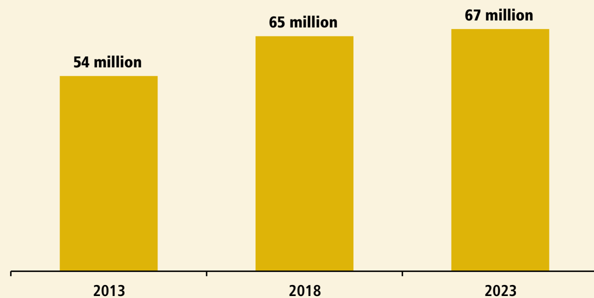
The incidence of glaucoma also is projected to rise over the next decades. Medicare covers an annual glaucoma screening exam for people at high risk.

Health Care Trend: ***The Affordable Care Act is expanding the population with health care access.***

The largest immediate impact of the ACA is to expand access to medical care for the under-served, low-income population through the Medicaid program. By 2023, an additional 13 million people are projected to become enrolled in Medicaid programs as a result of the relaxation of eligibility requirements under the ACA. People with income at or below 138 percent of the federally defined poverty level are now eligible. Many Medicaid patients will have vision benefits.

Projected Average Monthly Medicaid Enrollment (million)

The Affordable Care Act expands Medicaid eligibility



Source: Amerigroup Corporation

Beyond extending Medicaid benefits to low-income people, the Affordable Care Act was designed to increase the number of Americans with health insurance through a combination of subsidies and penalties. A key mechanism to make this a reality was creation of insurance exchanges, at both state and federal levels, to offer a range of insurance options to people without employer coverage. As of early 2014, it is unclear how many additional Americans will enroll in health insurance plans as a result of the new law. The most important impact of expansion of insurance coverage will be an increase in the numbers with a pediatric vision benefit, which includes youth through age 18.

Fifty-eight percent of the U.S. population under 65 years of age has health insurance paid for in part by a current or former employer, including the dependents of employees. The percentage of Americans covered by employer insurance has gradually declined. Beginning in 2016, companies with 50 or more employees will face the choice of continuing current health benefits or discontinuing benefits and paying a penalty to the federal government for each uncovered employee. When an employer discontinues coverage, an employee will be able to purchase their own coverage via a newly created insurance exchange in their home state or through private insurance. Estimates of the percentage of the currently insured population who will lose employer funded coverage range from 8 to 20 percent, or between 12 and 30 million people.

In 2015, it is likely that employers will face substantially higher insurance premiums, in order to fund the ACA-mandated elimination of lifetime coverage limits, acceptance of patients with pre-existing conditions, and the addition of new benefits such as expanded mental health coverage. This will stimulate greater effort by large employers to find new solutions to insure employees at a lower cost and will likely accelerate formation of ACOs (see sidebar at right). As some employers choose to drop medical insurance benefits, they are likely to simultaneously drop vision benefits. Other companies may choose to retain medical insurance but eliminate less essential benefits, such as dental and vision insurance.

As health care organizations evolve, advances in digital communication technology continue to transform medical practice. The new technology facilitates accurate and detailed record-keeping and makes possible superior measurement of treatment outcomes. The technology makes effective and efficient coordination of care among specialist providers much easier, because it removes barriers to information sharing. Recognizing the potential of digital technology to improve outcomes and reduce costs, government and insurers have begun to mandate information technology adoption by providers. Adoption of the technology will soon be a requirement for all providers.

Employers and ACOs look to provider groups and ask, “Have your patient experiences been measured, and can you show improvement?” They need to see improvements in patient satisfaction over time, which includes improvements in the quality of the patient experience. One method that health care providers can measure this is with the use of a net promoter score (NPS). Being able to present a high NPS, and demonstrating an ongoing commitment to measuring and improving the patient experience, are critical factors when working with ACOs and other organizations.

The Medical Home Model and the Rise of Accountable Care Organizations

Under the traditional U.S. health care delivery system, patients selected their own doctors, and when a specific ailment occurred, they made an office visit and paid for the services rendered, either with their insurance or cash.

Under this model, little attention was paid to a patient's total lifetime health care needs or to prevention. Physicians operated in specialized silos and communicated little with other providers. There were few incentives to control costs by eliminating redundancy, and little evidence-based decision making in selecting treatment protocols. Consequences of the traditional system included waste, inefficiency and less than optimal outcomes.

Patient-Centered Medical Home

To respond to the deficiencies of the traditional system, a new health care delivery model is emerging: the medical home model, sometimes called the "patient-centered medical home" (PCMH). This is a team-based model involving coordination among medical specialists to provide comprehensive care for all of a patient's health care needs. Under the medical home model, each patient has a personal primary care physician, who serves as the quarterback of the care team. Provider team members are linked by information technology, enabling each provider to access all details of a patient's medical history. Providers are compensated on an annual per capita basis, not by the traditional fees-for-service method. This new method of compensation provides a strong incentive for medical homes to control costs.

Accountable Care Organization (ACO)

An Accountable Care Organization, or ACO, is an emerging example of the medical home model. An ACO is a group of doctors, hospitals, and other health care providers, who come together voluntarily to deliver coordinated high-quality care to Medicare patients or to groups of privately insured people. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services, and preventing medical errors.

Reduce Costs, Eliminate Duplication

There is a strong financial incentive for an ACO to reduce costs through elimination of unnecessary or redundant services. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it shares in the savings it achieves for the Medicare program or enjoys increased profitability. It also increases the value of its services to insurers and employers.

ACOs are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients. Payments to these organizations are linked to quality improvements that also reduce overall costs. Payments involve reliable and sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care.

Medicare Shared Savings Program (MSSP)

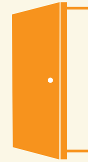
As defined under the Affordable Care Act, the Medicare Shared Savings Program (MSSP) is a three-year program in which ACOs accept responsibility for the overall quality, cost and care of a defined group of Medicare fee-for-service beneficiaries. Under the program, ACOs are accountable for a minimum of 5,000 beneficiaries. The provider network is required to include sufficient primary care physicians to serve its beneficiary population. The ACO must define processes to promote evidence-based medicine and patient engagement, monitor and evaluate quality and cost measures, meet patient-centeredness criteria and coordinate care across the care continuum.

Medicare ACOs operate under one of two payment models, one-sided or two-sided, based on the degree of risk and potential savings they prefer. Under a one-sided model, ACOs share in the cost savings they achieve (above a 2 percent minimum threshold) for the first three years, with no risk of loss if costs rise. Under a two-sided plan, ACOs assume some financial risk if their costs increase, but must meet no 2 percent threshold before sharing in savings.

As of early 2014, approximately 500 ACOs were in operation in the U.S. Some 75-80 percent of ACOs are currently Medicare-affiliated. Most are located in large metro areas and serve enrolled populations of 10,000 or less.

Currently, many ACOs are being organized by hospitals and are marketing their services to large employers in their geographic areas. In effect, they are becoming insurers themselves.

Meeting the Goals of Health Care Reform



GOAL	Expand access to care	Produce better outcomes
OPTOMETRY'S OPPORTUNITY	Provide more exams, expanded care	Diagnose disease, co-manage chronic conditions
ACTION POINTS	Enroll in ACOs, MC Marketplace panels, Medicare, Medicaid	Track outcomes, employ diagnostic tools, measure patient experience

Strategy Imperatives & Action Plans

Many ODs are taking a "wait and see" approach to the Affordable Care Act. The risk of this approach is that passive ODs may be left on the outside as new clinically integrated health care delivery organizations are formed — wanting to participate, but lacking critical office processes or credentials. The potential impact of health care reform is too sweeping for ODs to take a "wait and see" approach.

The emerging health care landscape described in the previous section suggests four major strategy imperatives for ODs to embrace to assure continued financial success in the years ahead:

1. Comply with new government regulations and insurer requirements.
2. Seize opportunities to expand services.
3. Realign office processes to capture efficiencies, deliver expanded services.
4. Maintain and expand patient access.

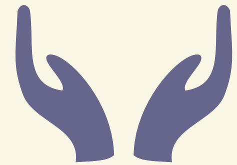
This section of the report summarizes the most significant implications of health care reform for independent ODs, from which the four strategy imperatives are derived. It also identifies the action steps ODs must take to respond to the four strategy imperatives.

OD Strategy Imperative:
Comply with new government regulations and insurer requirements.

Major Implications of Health Care Reform for ODs

Increased government regulation of health care
A major consequence of the Affordable Care Act will inevitably be greater government control of health care delivery. The federal government will enforce a standardization of services provided to insured patients and through a combination of penalties and incentives will dictate administrative procedures and standards of care that providers must adopt.

It will become imperative for independents to keep current on the administrative requirements mandated by government to maintain accreditation and patient access, assure rapid reimbursement and to reduce audit risk.

			
Lower cost of care	Compensation for good patient outcomes	Electronic health records	Inter-connectivity
Provide good value, efficiency	Moving away from fee for service	Continue to lead in conversions to EHR	Expand co-management, e-communication
Install efficient systems, delegate & streamline office processes	Track $/outcomes, evaluate treatment protocols	Total EHR, meaningful use, HIPAA compliance, ICD-10	E-records, HIPAA compliance, collaborative health care delivery

Consolidation of medical insurance companies

The federal government's increasing role in health care is likely to stimulate consolidation within the insurance industry. The Affordable Care Act defines national standards for health insurance plans, which has the effect of making insurance a commodity. In commodity markets, larger firms are better able to reduce costs through economies of scale and thus gain market share. Commodity markets tend to be dominated by a few large companies.

Larger insurers have greater capacity and expertise to manage risks and to deal with government agencies. Larger companies can be more effective in organizing and maintaining provider networks and in marketing plans to employers and consumers. Larger insurers have greater bargaining power with hospitals and providers. Government is likely to consider larger insurers "too big to fail" and provide financial protection against unforeseen negative consequences of healthcare regulation.

A result of consolidation is to increase the leverage of the large companies over both providers and consumers. It will become increasingly difficult for independent OD practices to negotiate successfully with large insurers. To maintain access to patients, it will be necessary for ODs to comply with insurer credentialing and administrative requirements.

Universal adoption of digital record-keeping and electronic connectivity with other providers.

Very soon no health care provider will be able to rely on paper records or be incapable of electronic sharing of patient records and imaging with other providers. Failure to adopt EHR and to achieve meaningful use standards will result in financial penalties, loss of accreditation, loss of access to insured patients and reduction in the market value of a medical practice.

Action Plan

Adopt EHR and satisfy meaningful use requirements.

This should be the first priority for an optometric practice because the financial consequences of non-adoption will soon be debilitating. There are many continuing education programs outlining the steps toward EHR adoption and meaningful use. As EHR systems are selected, it is critical that a system enables automatic data transmission from testing instrumentation to patient records and permits effortless data sharing with other providers. . Access a Review of Optometric Business articles on Meaningful Use: www.ReviewOB.com.

Make the office HIPAA compliant.
Access AOA HIPAA compliance information: http://www.aoa.org/optometrists/tools-and-resources/hipaa-compliance

Manage/co-manage medical eyecare patients to the full measure of licensure.
Under the ACA, insurers and health organizations will narrow, not expand, provider panels. If a practice is not providing full scope care, managed care organizations are unlikely to accredit the practice, because it costs more to have two doctors see the same patient rather than just one.

Achieve full compliance with PQRS (Physician Quality Reporting System) coding.
Access the AOA PQRS compliance data: http://www.aoa.org/news/practice-management/how-one-pqrs-amd-code-can-save-you-future-penalties

Be ready to implement of ICD-10 coding in October 2014.
Access the new coding requirements from Centers for Medicare & Medicare Services:
http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10

Make systems compliant with government regulations to avoid reimbursement penalties.
Starting in 2012, CMS began lowering reimbursement to practices that did not comply with government initiatives such as e-prescribing. In 2015, more practices will incur penalties if they fail to show meaningful use with electronic health records and reporting PQRS.

Focus on service quality.
Third parties want happy patients. Practices with large numbers of unhappy patients are not attractive to third parties. A practice can assess its current level of service quality by visiting doctor rating websites such as Yelp, HealthGrades and Angie's List. A practice must keep current on what patients are saying because that is what the third parties will do.

On HealthGrades, a practice is rated on a scale of 1- 5 for the following areas:

- Ease of scheduling urgent appointments
- Office environment: cleanliness, comfort
- Staff friendliness and courtesy
- Total wait time
- Level of trust in provider's decisions
- How well provider explains medical conditions
- How well provider listens and answers questions
- Spends appropriate amount of time with patients
- Likelihood of recommending the doctor to family and friends

If deficiencies are noted, the problem areas should be addressed now.

Medicare patients will be directed by the Centers for Medicare and Medicaid Services to visit the Physician Compare Website as they choose medical and eyecare providers. At this time it is possible to compare group practices on Physician Compare, and in the future, to compare individual physicians and other health care professionals. ODs should check their current listing on the site. OD practices will soon be listed according to board certification, participation in meaningful use and your PQRS data.

Optometry's Expanding Opportunity in Early Detection and Ongoing Monitoring of Disease

The increased focus on containing health care costs is likely to expand the role of ODs in early detection and ongoing monitoring of chronic disease.

An estimated 40,000 ODs practicing in the U.S. have approximately 100 million patient encounters annually, mostly to perform comprehensive eye exams. That is roughly equivalent to seeing one-third of the U.S. population annually – a very broad interaction with the public. Unlike most other health care specialties, ODs routinely see healthy patients, conducting eye exams for patients that are not triggered by disease symptoms. These facts make ODs ideal gatekeepers for patients' overall health.

In the course of conducting a comprehensive eye exam, ODs are able to detect a range of chronic conditions including the prevalent hypertension, high cholesterol and diabetes, as well as lower incidence conditions such as multiple sclerosis, rheumatoid arthritis, Crohn's disease, Graves disease and others.

Optometrists are well positioned to detect chronic disease and direct patients to primary care physicians and other specialists for treatment. Beyond the breadth of the population optometry serves, access to ODs is often easier than with other medical providers and the patient experience at an OD's office is often more satisfying. This makes ODs attractive to insurers who are compensated in part based on quality of care.

ODs also will play an expanded role in ongoing monitoring of patients' disease states. The benefits of regular monitoring for insurers is earlier intervention, increased patient compliance and fewer complications -- all of which can reduce long term costs.

Based on a sound economic rationale, insurers are likely to increasingly rely on ODs for early disease detection and on-going monitoring. ODs will extend activities traditionally performed by primary care physicians.

OD Strategy Imperative:
Seize opportunities to expand services.

Major Implications of Health Care Reform for ODs

Consolidation and institutionalization of primary care physicians
The Affordable Care Act is likely to accelerate consolidation, and the independent practice physician will gradually disappear. The economics of medical practice in an environment dominated by third-party payers favor larger medical groups able to negotiate reimbursements, manage information technology and keep current with regulations and rules. This will erode many long-standing referral arrangements between individual PCPs and ODs, as large MD groups seek arrangements with OD provider panels which can service a wide geographic area with consistently high standards.

The same forces causing consolidation among physicians will make the financial well-being of solo optometric practices increasingly precarious and will encourage more formation of group practices and membership in OD alliances, such as Vision Source.

Growing shortage of primary care physicians
A major consequence of a physician shortage is that primary care physicians will use a greater portion of their workday seeing patients with more acute and complex conditions, and less time tending to patients with uncomplicated chronic diseases, minor disorders, prevention and counseling. Increasingly, these less complicated medical tasks and responsibilities will be delegated to non-MD clinicians, including physician assistants, and potentially, to optometrists.

For optometrists, the primary care physician shortage is likely to mean that insurance companies will increasingly direct patients to optometrists to monitor diabetes and glaucoma, for regular eye exams and to provide other medical eyecare services. Primary care physicians will also be more likely to refer patients to ODs for routine testing. The effect will be to expand the role of optometrists in American health care.

Action Plan

Refine office processes to serve diabetic and glaucoma patients.
Each optometric office will need to be equipped with instrumentation to monitor diabetes and glaucoma, including retinal imaging, OCT and visual fields.

OD offices will need to establish methods to pre-appoint diabetics and patients with high glaucoma risk to assure that annual exams are performed and insurer standards are met.

Procedures must be developed to issue succinct reports to primary care physicians on the day patients are examined. Staff must be trained to educate patients about compliance with annual exams and about chronic diseases. Procedures must be put in place to remind patients of scheduled exams.

Reorient practice to provide pediatric vision benefits.
Most medical plans are expected to include a pediatric vision benefit. Procedures should be put in place to educate parents about these benefits. In many practices it will be necessary to educate the doctor and staff to communicate effectively with youth and to demonstrate the practice's enthusiasm for treating young patients.

If not currently a Medicaid provider, reconsider participation.
Medicaid expansion should trigger reconsideration of Medicaid participation. Because Medicaid now covers people up to 133 percent of the federal poverty level, it may now cover a larger portion of a practice's population. For example, under the new law for a family of five, Medicaid expansion covers up to a family income of $36,668.

To view resources on expanded Medicaid coverage:
http://obamacarefacts.com/federal-poverty-level.php.
www.medicaid.gov

If the practice is already a Medicaid provider, prepare the office for more Medicaid patients filling your schedule.

OD Strategy Imperative:
Realign office processes to capture efficiencies and deliver expanded services.

Major Implications of Health Care Reform for ODs

Increased patient visits
Rapid growth of the senior population, greater access to care by previously uninsured patients, and greater OD involvement in extending primary care monitoring of chronic disease will increase the number of patient visits to OD offices in the years ahead. The largest increases in patient counts are likely to be in Medicare and Medicaid populations and in youth using the new pediatric benefit. Higher patient counts will increase the need to serve patients efficiently, with no reduction in personalization of care.

Reimbursement squeeze
As third-party payers account for a growing share of health care spending, it is inevitable that they exert an increasing influence on fee reimbursements, treatment options, claims filing procedures and outcomes reporting requirements.

In an environment with increased emphasis on cost containment, independent ODs can expect that fee reimbursement amounts paid by third- parties will lag behind the overall inflation rate, putting pressure on net income. Third-party payers are also likely to limit allowances for eyewear and contact lenses, covering only the most basic requirements and not keeping pace with the steady rise in the average cost of corrective devices, caused by new technologies.

An increasing number of patient visits per OD hour, coupled with stagnant reimbursement rates, will increase the importance of maximizing the amount of patient care delivered per OD hour.

Over time, OD reimbursement by third-parties are likely to be based less on compensation for individual services rendered and more on measures of outcomes for large populations, patient satisfaction ratings and other measures of quality of care.

Spread of coordinated care model
Government, insurers and large employers will increasingly support the coordinated care model of health care delivery, by which a local population is cost-effectively provided comprehensive care through a team of providers. For ODs, the new delivery model has the potential to expand access to patients, but at rigorously controlled levels of compensation. Coordinated care places new burdens on ODs to rapidly and succinctly communicate with other network providers.

Action Plan

Refine office processes to optimize revenue from managed care patients.
Professional fees from routine eye exams are likely to be a shrinking revenue source in the years ahead, as third-party payers limit reimbursements. Practice profitability will increasingly depend on expanding medical eyecare services and increasing sales of high technology vision correction devices. Most third-party payers limit reimbursement on eyewear and contact lenses to cover only the most basic types. It will become increasingly important that ODs position managed care allowances to patients as important contributions to eyecare costs, not as full payment for the high performance products that patients expect. Effective patient education about managed care benefits will become more critical to the financial health of the practice.

Each practice needs a scripted process to handle patients who state they only want what their plan covers. The scripts must help patients understand the value of multiple pairs of glasses, back-up eyewear with contact lenses, sunglasses with contact lenses, glare free lenses with cataracts, glare free lenses with dry eye syndrome, blue blocking lenses with macular degeneration and other advanced technology products.

Improve patient care efficiency.
As the number of patient visits grows, ODs must pay greater attention to maximizing the value delivered for each minute the office spends in patient care. That will mean increased delegation of testing and administrative duties to staff and reconfiguring office processes to maximize patient flow.

Each practice should evaluate the current efficiency of its office systems. Questions that can reveal current efficiency include:

- Do you run behind constantly?
- Do you have a lot of patient down-time in the office?
- Does the practice need to reschedule patients because the office wasn't ready to deliver care today?

Whatever problems are discovered should be immediately addressed.

Develop medical eyecare protocols for common conditions.
Access the AOA medical eyecare protocols and implement them:
http://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines

Upgrade co-management communications.
In the new world of integrated health care, quality of care will increasingly depend on thorough and clear communication of clinical findings, diagnoses and treatment plans within provider networks. ODs will need to communicate efficiently and effectively with general practitioners and specialists on most patients seen, so that all physicians involved in caring for the same patient are fully informed of ODs' evaluations and management. ODs need to consider the outcomes of the specialists to whom they refer patients. The result will be greater recognition by physicians of the value of patient care delivered by ODs.

Train staff to educate managed care patients.
As new health organizations emerge and as ODs affiliate with them, new rules and requirements will appear, making the tasks of patient education and administration more complex. This will place new demands on staff to understand and comply with the new ground rules of third-party payers.

Be prepared for a family of three to come into the office with Mom having coverage from her employer, Dad having been thrown into one of the plans on the Marketplace, and the 12-year-old child having coverage from a completely different third party. Your staff must be prepared to explain the differences in deductibles and coverage that occurs among the plans.

The staff must be prepared to deal with patients having higher out-of-pocket expenses than in the past. There must be a system in place to calculate immediately (that is, while the patient is in front of staff) what the patient owes. It is also helpful to have systems in place to help patients pay for out-of-pocket expenses, beyond typical credit cards. These include options such as PayPal and CareCredit.

Upgrade medical record keeping skills.
To achieve this goal, implement the Office of Inspector General (OIG's) Compliance Program for Individual and Small Group Physician Practices. Details: http://oig.hhs.gov/authorities/docs/physician.pdf.

Improve recall processes.
Effective management of diabetic and glaucoma patients and other patient with chronic conditions will require rigorous recall methodologies. This will assure that insurer that HEDIS scores are maximized.

To the extent that an OD's patients are examined on an annual basis through recall activity, ODs will be more effective gatekeepers of patients' overall health and will be more effective at helping third-party payers control costs and improve outcomes.

OD Strategy Imperative:
Maintain and expand patient access.

Major Implications of Health Care Reform for ODs

Expansion of ACOs and Medicare Advantage plans

Expanding patient access is a central goal of the Affordable Care Act. The narrow networks that ACOs and Medicare Advantage plans will create will restrict patient access to providers. Soon, in the worst case scenario, patients going to doctors who do not actively engage in the evolving landscape will find there is no medical eyecare coverage for the majority of patients in the practice.

Although the cost reduction benefits of ACOs are not yet fully demonstrated, it is likely that the concept of comprehensive, coordinated care of each patient's total health care needs by a network of local providers will spread. Large physician groups, affiliated with hospitals, are likely to pioneer local ACOs and contract with local employers to provide comprehensive healthcare to employees. They are likely to seek collaborative care arrangements with ODs.

The spread of ACOs will result in a decline in the traditional fee-for-service payment model. There are no clear cut precedents guiding ACOs as they establish formulas to compensate ODs on their panels. Different payment structures are likely to be used by different organizations. The most common formula in the near term is likely to be for an ACO to pay a percentage of the Medicare allowable service reimbursement to specialist providers such as ODs for each patient served. Over time, ODs may become eligible for bonus payments based on the overall performance of the ACO.

Initially many of the patients ODs will serve as ACO panel members will be patients already regularly seen, the overall health of which ODs will now evaluate and refer those with chronic conditions to appropriate specialists for treatment. Over time, navigators affiliated with the ACOs may direct patients to ODs for general health monitoring and assessment.

A major risk posed by the spread of the ACO model is exclusion of ODs and other providers from serving patients enrolled with an ACO.

The continued growth in Medicare Advantage enrollment also poses a risk of exclusion from insurer panels, many of which limit the number of accredited providers to improve quality and contain costs.

For ODs these developments pose the risk of loss of access to patients. ODs will need to market their services effectively to ACOs and gain membership in ACO provider panels.

Stagnant or declining enrollment in standalone vision plans

The continuing rise in insurance premiums employers pay, perhaps accelerated by the Affordable Care Act, will increase pressure on employers to contain outlays. This will cause many companies to shift more of the insurance burden to employees and may cause some companies to eliminate vision benefits. The effect may be that fewer employees will enroll in vision plans. It is also likely that employers will seek to reduce the amounts they pay for vision coverage, causing the insurers to reduce reimbursements to eye care providers.

Vision insurance companies are currently expanding efforts to market vision plans directly to consumers. But it is unclear how effective these marketing investments will be. Unlike other forms of medical insurance, the primary motivation to buy vision insurance is not to avoid an unlikely, catastrophic, bankrupting medical expense. The benefits provided by vision plans offered to individuals and families are often not substantially greater than the annual premiums.

For independent ODs, a consequence of lower enrollment in standalone vision plans may be a lengthening of the interval between exams for some patients. A segment of patients may choose to seek a lower cost provider to contain their vision care outlay. Independent ODs can also expect a continuing squeeze on reimbursements from vision plans.

Action Plan

Identify managed care companies enrolling patients in health care exchanges in your local area.

Practices that want to continue to provide medical eyecare to patients must take steps to assure that they maintain access. Soon only accredited providers will be able to be reimbursed for medical eyecare. Practices on the outside once the third parties close their provider panels will have a very difficult time. On the inside, a practice has choices.

Go to the healthcare.gov website and find out which third-party companies are signing up patients for coverage within the boundaries of the practice area.

- For third-party companies for which the practice is already a provider, contact each company to make sure the practice is an accredited provider to patients within the Marketplace. The trend is to limit provider panels for the delivery of care so it is essential to verify the practice is on the Marketplace panel.
- For third-party companies for which the practice is not a provider, contact each company and become a provider. This may take 3 to 6 months to complete the process, so don't delay.

For ODs in smaller communities and rural areas, identify the ACOs serving the local population and gain accreditation.

There are likely to be several ACOs in your area. ACOs encompass both governmental programs and private carrier programs. ACOs are closed panels. In some areas of the country, ACOs have completed their panels and have closed the panel already. In other areas of the country, ACOs are being formed right now. And in still other areas of the country, ACOs have not yet been formed. The best way to get into an ACO is to get in as they are being formed.

Find out which ACOs are being formed in the practice area. There are four major ways to approach this:

- Contact the executive director of your state optometric association to find out which ACOs are being formed in your practice area.
- Contact the ophthalmologists with whom you co-manage patients. Tell them you want to be in the same ACOs they are in so that you can continue to co-manage patients together. Ask them to put in a good word for you with the medical director of the ACOs.
- Contact Vision Source to see if they are involved in negotiating with ACOs in your practice area.
- Initiate and strengthen relationships with PCPs who practice near you.

Make sure your practice is attractive to an ACO.

Ask the following questions, and immediately fix any problems:

- Is your equipment and furniture up-to-date?
- Do you have an OCT, visual fields, blood pressure monitor and retinal imaging to manage diabetic and glaucoma patients?
- Is your staff trained to help you efficiently see patients?
- Is your facility clean and updated?
- Are systems in place for accurate billing, coding and collections?
- Do you use electronic medical records, and are you attesting for meaningful use?
- Do you measure the perceived patient experience after a patient visit?

Contact the Director of each ACO in the practice area. Ask for a face-to-face meeting. Prepare a compelling case why the practice should be a part of the ACO.

Tips for Presentations to Integrated Health Organization Decision Makers

- If you are a Vision Source member, provide professionally printed copy of Vision Source Fact Sheet
- Building Relationships with PCPs in your area
  - » If a Vision Source member, order at the member portal the Customized PCP Relationship Building Kit to team with PCPs in your area through this vast, plug and play referral system
- If a Vision Source member, map Vision Source locations and ACO’s physicians and other care facilities to provide a visual coverage overview of the Vision Source network
- Focus on diabetic examinations – the cornerstone service ACO’s seek
- Explain shared goal of improving HEDIS measurements
- Share your patient experience score
- Explain key benefits of OD services
  - » Superior quality examinations
  - » Availability of advanced instrumentation
  - » Convenient patient access (appointment within one week, evening/weekend hours)
  - » Knowledgeable staff who assure patients know directions to office
  - » Rapid, succinct communication of exam results to PCPs
  - » Optometric Physicians are the primary eye health gatekeepers who provide prompt patient access at affordable cost.

Vision Source® Response to Health Care Reform

Vision Source® is acutely aware of the challenges and opportunities posed by health care reform and is dedicated to assisting its membership to prosper in the new environment. Vision Source® management is optimistic that its members will be able to expand the services provided in their local communities and be financially rewarded for doing so.

Recognizing the significant implications of health care reform for its members, in 2013 Vision Source® named Jim Greenwood as its new CEO. Mr. Greenwood is an executive with deep experience in health care with a 20 year career with Concentra, a physician practice management company. Since his appointment, he and his staff have launched a series of initiatives to prepare the membership for change in health care delivery.

Mr. Greenwood is convinced that the emergence of new integrated health care delivery systems opens up a unique opportunity for Vision Source® members to gain a distinct competitive advantage, as the organization leverages its large member base, national branding, local leaders, managed care expertise and extensive communication channels with members. Vision Source® is gearing up to help members to identify emerging integrated health organizations and to provide members with a toolkit to facilitate early stage discussions with ACOs, insurers and physician groups to assure inclusion in the new networks.

Vision Source® has recently announced contracts with several integrated health organizations and is engaged in negotiations with dozens of others throughout the U.S. These prototype contracts serve as useful templates for establishing relationships in other markets.

Recognizing that insurers and ACOs will favor OD groups offering broad geographic coverage, Vision Source® is aggressively expanding its member base. The clinical leaders of Vision Source® are convinced that the well-being of all its members will be best advanced with expanded coverage.

Vision Source® is developing educational tools and programs to help members adapt to the new environment, including:

- Vision Source® Customized PCP Relationship Business Kit
- Vision Source® Managed Care Preparedness Kit to assist members in networking, contracting and credentialing with ACOs
- Vision Source® Resource Guides for managed care
- Gold Standard Book – a pocket guide to enhance the patient experience
- Seminars on health care reform
- EHR implementation
- Piloting technology tools designed to enable enhanced levels of connectivity between different software systems

Vision Source® Benefits for Independent ODs

From its inception in 1991, the mission of Vision Source® has been to strengthen the position of independent ODs. Vision Source® now has 2,800+ member practices in the U.S. and Canada, including 3,500+ independent ODs with a member retention ratio of 98 percent. As the largest OD network in the world with the broadest range of consultative services and practice-building tools, Vision Source® offers industry-leading value to its members. The major benefits of membership include:

- **Enhanced Buying Power.** The 2,800+ member practices produce more than $2 billion in annual revenue. This gives Vision Source® a strong negotiating position with leading optical manufacturers.
- **Exclusive Vision Source® Brands.** Vision Source® has a full line of exclusively branded contact lenses, ophthalmic lenses and frames, unavailable outside the Vision Source® network.
- **Local Leaders/Mentors.** Local leadership is a difference maker for ACOs. Our local leaders also serve as coaches and mentors.
- **Marketing Services.** Vision Source® offers a wide range of marketing services including an online marketing toolkit, marketing materials templates, exterior and interior signage designs, and next generation websites for members, reputation management, SEO and SCO. Monthly webinars on marketing and social media are available to members. Vision Source® also provides marketing consulting services to OD members and staff.
- **On-going Professional Education.** Walt West, OD, Vision Source® VP of Practice Development and noted practice management expert, conducts more than 40 seminars annually throughout the U.S. The seminars focus on business-building topics, including incorporation of new technologies.
- **Vision Source® Website.** A rich resource of educational programs for both ODs and staff members.
- **Health Care Reform Guidance.** Vision Source® provides materials and specialized training and material for ICD-10, HIPAA and meaningful use guidance.
- **Member Publications.** Vision Source® publishes Vision Source OD, a quarterly magazine mailed to each member, and Vision Source Gazette, published every two weeks. Both are designed to keep members current on industry developments, new Vision Source® initiatives and cutting edge products.
- **The Exchange Annual Meeting.** The Exchange has become one of the premier optometric meetings in the U.S. with best-in-class education and exhibits.
- **Local Meetings.** Each year, Vision Source® conducts more than 1,300 local meetings, enabling members to share ideas and learn best practices.
- **National Branding.** National branding leverages the power of Vision Source® and its growing national reputation among eye care consumers and third-party providers. It is the only independent OD alliance sponsoring national TV advertising to attract new patients for its membership

“Enriching lives by enabling independent optometrists to reach their full potential”

Vision Source®

For more information and to see our plan:
www.visionsourceplan.com