The Eye Care Professional And Emerging Models in the Reform of Healthcare

A White Paper by KDD Health Solutions
EXECUTIVE SUMMARY

On March 23, 2010, President Obama signed into law comprehensive health reform promulgated under the Patient Protection and Affordable Care Act (ACA). The legislation is designed to enhance consumer access to affordable health care, decrease cost, improve quality, expand use of electronic health records and promote better coordination of care among providers.

Supporting the tenets of the ACA are two widely-endorsed care delivery models - the Patient-Centered Medical Home (PCMH) and the Accountable Care Organization (ACO). The ACA also mandates the development of public health benefit exchanges at the state level designed to create a competitive market for individual consumers and small businesses to select health insurance plans that offer the best value.

Essentially:
- Public exchanges are intended to serve as a marketplace for health plans to feature their benefits and related services,
- ACO models serve to support care coordination among a group of providers collectively assuming responsibility for the clinical and financial outcomes of a given population, and
- The PCMH model is a mode of practice in which a team of health professionals, coordinated by a primary care physician, works in collaboration to provide high levels of care.

The purpose of this paper is to present a review of the two emerging delivery care models, address the significance of health insurance exchanges and assess opportunities available to eye care professionals choosing to embrace new concepts of accountability, payment reform and service in the marketplace.

HEALTH INSURANCE EXCHANGES

Beginning in 2014, individual consumers and small businesses may access public health exchanges for the evaluation and purchase of health insurance. Individual consumers may gain access to health plans via American Health Benefit Exchanges while small businesses may evaluate and purchase health insurance offered under the Small Business Health Options Program (SHOP). The Congressional Budget Office (CBO) estimates some 24 million individual consumers will purchase health insurance via American Health Benefit Exchanges by 2019. Estimates for individual employees participating in SHOP exchanges are significantly less at approximately 4 million.

In addition to the public exchanges, employers may opt to purchase health insurance benefits via private health exchanges. Employers may select a single-carrier exchange in which benefits are supplied by a single carrier or a multi-carrier exchange providing a broad range of insurers and design options. In either case, private exchanges are helping expedite a transition from defined benefit plans to defined contribution plans. Defined contribution plans provide employees with greater flexibility in the selection of those benefits best suited to their needs. Proliferation of public and private exchanges represents opportunity for the eye care professional in this shift to consumerism within the health insurance market.
THE EMERGING MODELS OF CARE DELIVERY

The PCMH and ACO models serve not only to facilitate broad and sweeping change associated with payment methodologies, but also support a change in responsibility for the provision of care. No longer will there be a reliance on insurance plans to provide accountability for care as these new models shift such responsibility to the providers of care. Payment methods will transition from a volume driven fee-for-service system to reimbursement methods based in part on financial incentives rewarded for quality improvement. See Appendix 1 for greater detail regarding quality measures and performance related to vision care.

Both the ACO and PCMH models are complimentary to each other as both promote the use of electronic health records, patient registries, patient education on chronic disease management, and more responsive scheduling. See Appendix 2 for a consolidation of the essential components for both models. The models differ by two main premises in that the PCMH does not require the primary care practice to accept accountability for population-level outcomes nor the responsibility for the total cost of care for such patients.¹

INTRODUCTION TO HEALTH REFORM

The scope of the Patient Protection and Affordable Care Act is quite broad and will affect the means by which millions of individual consumers and small businesses access health care coverage.

Through the ACA, the Centers for Medicare and Medicaid Services (CMS) is attempting to strengthen Medicare, in part, by correlating payment to quality standards. CMS is offering incentives to providers for delivering high value, coordinated care which are expected to create better health outcomes and reduce overall health care costs.

In part, the ACA:

- Requires that each state have fully functional health benefit exchanges – an American Health Benefit Exchange for individuals and a Small Business Health Options Program (SHOP) for small businesses - in place by January 1, 2014, to serve as a marketplace for consumers and small businesses to acquire health coverage from qualified health plans,
- Creates an individual mandate requiring U.S. citizens and legal residents purchase health insurance or face financial penalties for not doing so,
- Bans medical underwriting for all individuals by January 1, 2014 as insurance companies will be required to issue a health plan to any applicant regardless of their health status or other factors,
- Expands Medicaid to include all individuals under the age of sixty-five (65) with incomes of less than 133% of the federal poverty level,
- Establishes the Pre-Existing Condition Insurance Plan (PCIP) making health coverage available to U.S. citizens (or those residing here legally) having been denied health insurance because of a pre-existing condition and have been uninsured for at least six months, and
- Requires qualified health plans to include vision care as an essential health benefit for pediatric services.

"Paying for value is an incentive. It is a motivation toward improvement. The underlying idea of improvement is that American health care, historically built in fragments, often cannot achieve for patients what it really wants to achieve. No one really wants that. Health delivery system reform refers to really reconfiguring care into much more seamless coordinated-care operations so that people, especially those with chronic illnesses, experience continuity of care over time and space."

- CMS Administrator, Donald Berwick, MD²
ADAPTING TO HEALTH REFORM AND CALL TO ACTION

Health care reform is inevitable and, with change, comes opportunity. Judicial review of the ACA by the Supreme Court rendered the legislation constitutional thus removing much of the uncertainty surrounding its implementation. An uncertain political climate somewhat complicates adoption of strategy and execution, however, a total repeal of the ACA could not happen until 2013 by which time a significant number of the health benefit exchanges designed for individual consumers and small businesses would be certified and operational. Further, the broad and early commercial acceptance of the ACO and PCMH models and emergence of private health benefit exchanges suggests employers, hospitals, large physician groups, insurance plans and other stakeholders are betting favorably the models and related concepts are here to stay.

Health benefit exchanges are intended to serve as an internet-based marketplace for interactively serving consumers and small businesses in evaluating and purchasing health benefits offered by qualified health insurance plans. The exchanges also serve as an entry point for individuals to determine their eligibility for Medicaid benefits. Individuals may use their federal tax credits for the purchase of health insurance on the exchanges.

Providers of care wishing to embrace change, including eye care professionals, must adopt strategies to favorably effect both care coordination and health outcomes in order to realize associated financial incentives made available through health reform. Such strategies should recognize and embrace emerging trends and models of care including the Accountable Care Organization and the Patient-Centered Medical Home. Application of these emerging models hold great promise to meet expectations for quality care as defined by the federal Agency for Healthcare Research and Quality as “doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”

In a recent white paper and survey conducted on behalf of The Physicians Foundation, its Advisory Panel projected that the independent, private practice physician setting will largely, though not uniformly, be replaced, mostly as a result of the ACA. Physicians will be compelled to consolidate with other practitioners, become hospital employees, or align with large hospitals and health systems for capital, administrative and technical resources. The Panel also predicts reform will drastically increase physician legal compliance obligations and potential liability under federal fraud and abuse statutes.

Eye care professionals should undertake a proactive approach in the evolution of health reform adapting a series of changes within their respective practice settings that parallel and emulate, where feasible, characteristics of the ACO and PCMH models.

From a marketing perspective, one option for consideration includes establishing a separate High-Performance Eye Care Professional Network consisting of an adequate number of optometrists and ophthalmologists within a given locale for the purpose of providing vision care for defined population(s). As a specialist, the eye care professional may participate in multiple ACOs in sub-sharing revenue agreements. The High-Performance ECP Network would market its optometric products and services to ACOs serving defined populations featuring eye care professional members in its provider directory. The ACO may market its provider network to insurance plans, employers or government sponsors.

Table 1 lists features, characteristics and objectives the High-Performance ECP Network should assume similar to those of the ACO it serves (more detail regarding each characteristic is provided later in this document).
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Rationale</th>
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<tr>
<td>Assumes responsibility for quality of care, patient care experiences,</td>
<td>Accountability for clinical and financial performance transitions from insurer to providers of care</td>
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<td>population outcomes and total costs for vision care</td>
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<tr>
<td>Adopt and demonstrate a strong primary vision care foundation</td>
<td>Eye care professionals are uniquely positioned to efficiently deliver primary, secondary and tertiary vision care</td>
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<td>Engage and Inform Patients</td>
<td>Eye care professionals and patients must work together in developing a clear understanding of mutual expectations and responsibilities</td>
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<td>Commitment to Serving the Community</td>
<td>Enhances access to care delivering appropriate services in the right setting and at the right time</td>
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<td>Criteria for Entry and Continued Participation that Emphasize Accountability</td>
<td>Establishes an appropriate legal structure with defined leadership bound by governance, infrastructure and technology to achieve common goals</td>
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<td>and Performance</td>
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<td>Multi-payer Alignment to Provide Appropriate and Consistent Incentives</td>
<td>Adoption of strategies consistent across multiple payer classes in negotiating performance incentives</td>
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<td>Payment that Reinforces and Rewards High Performance</td>
<td>Apply reliable and predictable cost trends should in determining savings achieved by the IPA</td>
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<td>Innovative Payment Methods and Organizational Models</td>
<td>Recognition that diverse patient populations may require flexibility in developing appropriate reimbursement models</td>
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<td>Balanced Physician Compensation Incentives</td>
<td>Deliver evidenced-based care with means to ensure care is not withheld</td>
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<td>Timely Monitoring, Data Feedback and Technical Support for Improvement</td>
<td>Deploy health information technology including use of an electronic exchange to bridge disparate data sources all designed to share patient data, enhance care-coordination efforts and report clinical and financial performance</td>
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<td>Develop and Adopt Principles Similar to those Joint Principles for the PCMH</td>
<td>Supports care coordination, improved access to care with the objectives of improving quality and safety</td>
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<td>put forth by the Patient-Centered Care Collaborative</td>
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*Adapted from: S. Guterman, S.C. Schoenbaum, K. Davis, et. al. High Performance Accountable Care: Building on Success and Learning from Experience.
THE EMERGING BUSINESS MODELS

The Patient-Centered Medical Home

The Patient-Centered Medical Home is a model of practice in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety. Further, the concept facilitates partnerships between individual patients and their personal physicians, and, when appropriate, the patient’s family. In order to accomplish these objectives, care providers must undergo practice reorganization, create collaborative relationships for team-based care and implement a process for continuous quality improvement and reporting of outcomes.

In February 2007, four primary care societies—American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association—developed the Joint Principles for the PCMH, summarized in these points:

- Each patient has an ongoing relationship with a personal physician
- Physician-directed medical practice
- Whole-person orientation
- Care is coordinated and/or integrated
- Quality and safety as hallmarks
- Enhanced access to care, and
- Payment appropriately recognizes the added value

Components of the Patient-Centered Medical Home

Patient-Centered Medical Home team members are involved not only in the delivery of primary care in a coordinated way, but should evaluate and work consistently to improve process. Such approach requires a “think-out-of-the-box” mentality to reorganize the practice setting and enhance delivery of care based upon evidence and personalized needs of the patient.

The PCMH is described as consisting of:

- The fundamental tenets of primary care: access, comprehensiveness, integration and relationship
- New ways of organizing practice
- Development of practices’ internal capabilities
- Health care system and reimbursement changes

Primary Care-Driven Opportunities

- Improved access to care
- Improved prevention and early diagnosis
- Reductions in unnecessary testing, referrals and medications
- Use of lower cost treatment options
- Reductions in preventable emergency room visits and hospitalizations

TRANSFORMATION OF PRIMARY CARE

In addition to the basic tenants of improving quality, reducing cost and enhancing care coordination, the Affordable Care Act embraces concepts put forth by the Patient-Centered Medical Home model in other meaningful ways including provisions that:

- Allow states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home,
- Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation the purpose of which will be to research, develop, test, and expand innovative payment and delivery arrangements to innovative business models including medical homes,
- Provide grants to develop and operate training and faculty, and to establish, maintain, and improve academic units in primary care including the patient-centered medical home, and
- Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years.

Further emphasis on the importance of primary care is demonstrated by the fact many private insurers have adopted policies designed to increase reimbursement for primary care services.
THE ACCOUNTABLE CARE ORGANIZATION

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to a defined patient population. 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. Within the ACO, providers essentially share responsibility for both the quality and cost of care provided to patients within the defined population.

The ACO has emerged as a center-piece of the Patient Protection and Affordable Care Act and Medicare Shared Savings Program. The Shared Savings Program, effective January, 2012, promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

To qualify as a Medicare ACO, entities must have certain fundamental characteristics and requirements that include:

- A formal legal structure assuming responsibility for the overall management, cost and coordination of care for beneficiaries,
- Acceptance of responsibility for the receipt and disbursement of payments for shared savings to providers,
- Defined processes for governance including the ability to promote evidence-based medicine, coordinate care, capture data and report upon quality measures related to clinical and financial outcomes,
- A leadership and management structure that includes systems for both clinical and administrative services,
- A commitment by the ACO to participate for a minimum of three years,
- Participation by an adequate number of providers including primary care physicians and specialists to manage a minimum of 5,000 beneficiaries,
- The ability to demonstrate the organization meets patient-centered criteria as mandated, and
- A governing body that is at least 75% controlled by ACO participants (providers and suppliers) and include a Medicare beneficiary representative.

Increased interest in the ACO model among both payers and providers of care is evidenced in part by the rapid proliferation of over 160 ACOs formed across the United States since the 2010 passage of the ACA. Such rapid scale prior to the January, 2012, launch of the Medicare Shared Savings Program suggests initial wide-spread commercial acceptance of the ACO model. Sponsoring entities include health systems, physician groups and insurers with a market presence in 41 states.

The performance of an ACO-like system indicates the importance of the eye care professional in helping achieve improved quality of care and the awarding of millions of dollars in shared savings and Physician Quality Reporting System (PQRS) incentives. Eye care professionals participating within a network of over 600 physicians in a 2005 Physician Group Practice Demonstration Project involving Medicare fee-for-service beneficiaries at St. John’s Health System (now Mercy Clinic) in Springfield, MO, identified early symptoms of diabetic retinopathy and other disease in otherwise asymptomatic patients. The organization did not achieve its threshold for savings in the first two years of service but did record 100% of its quality measures in the same period. Since then it has achieved millions in CMS shared savings each year while significantly improving patient satisfaction scores.
DESIGN FEATURES OF THE ACCOUNTABLE CARE ORGANIZATION

The Commonwealth Fund Commission on a High-Performance Health System offers the following series of recommendations intended as a set of design features of sufficient importance to help ensure ACOs achieve the goals of health reform – the Triple Aim of better care, better health and lower costs.11

1. Strong Primary Care Foundation
ACA statutes require the participation of a sufficient number of providers, including primary care and specialists, to serve Medicare beneficiaries. A strong primary care foundation is necessary to achieve the goals of improving access to well-coordinated care, reduced cost and improved clinical outcomes.

In contracting with the ACO, integrated health system or other delivery model, the High-Performance ECP Network should strive to deliver vision care services using guidelines similar in scope to the ACO model including defined processes of governance, leadership, management, patient-centered mandates, and governing body. As a member of the ACO, the High-Performance ECP Network should promote optometric products and services by ensuring they are prominently featured on all relevant health benefit exchanges.

2. Accountability for Quality of Care, Patient Care Experiences, Population Outcomes and Total Costs
ACOs must be accountable to those stakeholders they serve – beneficiaries, payers and providers with whom they enjoy relationships with. Payments to ACOs will be tied to achievement of performance standards reinforcing accountability for health care quality, patient satisfaction and favorable clinical and financial outcomes.

Optometrists are uniquely positioned to deliver primary care vision services to a defined population. Some 32,000 optometrists are practicing in the United States serving more than 7,000 communities – optometrists serve as the sole primary eye care provider in 4,300 of these communities.12

According to the American Medical Association, there were over 18,000 active ophthalmologists engaged in practice in the United States as of December 31, 2009. Given the broad scope of the ophthalmic practice which includes medicine and surgery coupled with the wide prevalence of eye disease, the ophthalmologist is an exceptionally important and long-serving member of a patient’s care team.

Optometrists and ophthalmologists working in unison bound by appropriate measures of governance within the High-Performance ECP Network help achieve the goals of improving access to well-coordinated care, reduced cost and improved outcomes.

3. Informed and Engaged Patients
Complete transparency should exist between the provider and patient with full disclosure of the fact the provider is a part of an ACO and what that means in terms of enhancing the patient-provider relationship and the objectives of well-coordinated care. Both provider and patient should strive to achieve agreement on their mutual expectations and responsibilities.

According to surveys conducted by the American Medical Association, patients are often confused in their understanding of the level of training and education of some key health care providers. The demand for and access to health services is expected to grow significantly under the ACA. Further, the introduction of H.R. 451, Healthcare Truth and Transparency Act of 2011, is designed to ensure patients receive accurate health information by prohibiting misleading and deceptive advertising or representation in the provision of health services.

Organizational Competencies for the ACO13

• Leadership
• Organizational culture of leadership
• Relationships with other providers
• IT infrastructure to support population management and care coordination
• Infrastructure for monitoring, managing, and reporting quality
• Ability to manage financial risk
• Ability to receive and distribute payments or savings
• Resources for patient education and support
4. Commitment to Serving the Community
The HMO market and managed care experience of the 1990s led to significant patient dissatisfaction given its shift of focus from delivery of care to paying for care. HMOs were perceived as more concerned with lowering costs and denying necessary care rather than improving outcomes and enhancing access to services. The Commission recommends that ACOs focus on providing access to the most appropriate care and a mission of serving the community particularly for those of low-income, uninsured or other vulnerable populations.

Providers within the High-Performance ECP Network should maintain a focus of providing access to the most appropriate vision care in the right setting and right time with a mission of serving the community especially for those of low-income, uninsured or other vulnerable populations. This is especially important given that the 2011 National Healthcare Quality and Disparities Reports prepared by the Agency for Healthcare Quality and Research indicates that access to health care did not improve for most racial and ethnic groups.

5. Criteria for Entry and Continued Participation That Emphasize Accountability and Performance
Compliance requirements within the ACA mandate a number of essential features including an appropriate legal structure, leadership and management, governance, processes for promoting evidence-based medicine and care coordination, continuous quality improvement initiatives, collection and analysis of data and the reporting of outcomes. Efficient operational execution is paramount to success and sustainability of the High-Performance ECP Network.

6. Multi-payer Alignment to Provide Appropriate and Consistent Incentives
Most physicians provide care for both Medicare patients and individuals privately insured. If the respective payers deploy different payment methodologies, the incentives prescribed for quality improvement and cost reduction may be less effective than a scenario in which payment methods are similar in design and scope. Further, the greater scale derived from increased participation will drive efficiency and reduce risk. It is important to consider negotiating incentives consistent for both Medicare and privately insured patients.

7. Payment That Reinforces and Rewards High Performance
Savings attributed to the ACO should be correlated to predictable and reliable cost trends for each individual organization and should protect against anomalies in year-to-year costs all the while rewarding the entity for performance. Determination of shared savings and resulting payments should be made without delay. Savings attributed to the ACO and High-Performance ECP Network should be correlated to predictable and reliable cost trends.

8. Innovative Payment Methods and Organizational Models
Where appropriate, different and suitable payment models should be considered for diverse configurations of ACOs with respect to geography and circumstances associated with the patient population.

9. Balanced Physician Compensation Incentives
Experience of the 1990s suggests that payment for incentives for improved care and efficient operation made to individual physicians or small groups of physicians could have an adverse financial impact. Provider compensation, including members of the High-Performance ECP Network should include incentives to deliver evidence-based care coupled with means to ensure that appropriate care is not withheld.

10. Timely Monitoring, Data Feedback and Technical Support for Improvement
Financial incentives alone are not sufficient to ensure success of the ACO. Electronic health information systems designed to collect, share, analyze and report data are paramount in efforts to improve care coordination, reduce cost and deliver favorable clinical and financial outcomes. Disparate sources of data should be bridged via an electronic health information exchange to facilitate sharing of patient data and support of care coordination. Creation of disease registries coupled with effective interventions and best practices that health organizations have found to be effective should be deployed. These initiatives, coupled with an infrastructure of effective leadership and governance, will help ensure success and sustainability.
CONCLUSION

The Patient Protection and Affordable Care Act is the driving influence behind formation of numerous pilot programs for expanding the scope of the Accountable Care Organization and Patient-Centered Medical Home models. Most experts conclude that health reform is inevitable and new, emerging models designed to transition the accountability for the provision of care from insurance plans to providers coupled with payment methods that reward quality and performance will slow the overall growth of the cost of health care.

Eye Care Professionals are uniquely positioned to help shape and influence strategies designed to achieve the Triple Aim of better care, better health and lower costs. ECPs assume greater risk in a “wait and do nothing” approach in anticipation of legislative change associated with a changing political climate or judicial review. Consider involvement at a local level and promote participation in pilot programs designed to demonstrate value of your professional abilities and services through deployment of concepts defined within the emerging PCMH and ACO models and proliferation of health insurance exchanges.
APPENDIX 1

Quality Measures

The ACA adds greater specificity in defining a "quality measure" as a "standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services. Under the ACA, the Secretary of the U.S. Health and Human Services through its Centers for Medicare and Medicaid Services (CMS), is charged with the responsibility of identifying gaps where no quality measures exist and evaluate existing quality measures for improvement - all designed to support federally-funded health care programs.** Priority must be given in the development of new measures that assess outcomes, care coordination, use of health information technology, functional status of the patient, the patient experience, shared decision-making and efficiency.

The Secretary is required to develop standards for outcome measures for use by physicians, hospitals and other providers as appropriate. Measures for the five most prevalent and intensive acute and chronic conditions are to be addressed as well as measures for specific populations including children, elderly and chronically ill adults.

National Quality Forum

The entity selected by the Secretary to develop quality measures is required to convene stakeholders to provide input in support of the development process. Such process must be transparent. Presently the entity charged with the development of quality measures is the National Quality Forum (NQF). NQF’s Measure Applications Partnership provides multi-stakeholder input to the Department of Health and Human Services on the selection of performance measures for public reporting and payment reform programs. A sister group formed by NQF’s National Priorities Partnership offers consultative support to the Department of Health and Human Services on setting national priorities and goals for the HHS National Quality Strategy.

Related NQF quality measures for ECPs include:

**Diabetes**

- Eye Examination
  
  Percentage of diabetes patients 18-75 years of age with diabetes who had a dilated or retinal eye exam during the measurement year or a negative retinal eye exam during the prior year.

Eye Care

- Primary Open Angle Glaucoma: Optic Nerve Evaluation
  
  Percentage of patients aged 18 years and older with a diagnosis of primary open angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.

- Age-Related Macular Degeneration: Antioxidant Supplement Prescribed/Recommended
  
  Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration with at least one antioxidant vitamin or mineral supplement prescribed/recommended within 12 months

- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
  
  Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
  
  Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Formed in 1990, the NCQA has been at the forefront of driving improvement throughout the health care system. Its vision statement is simple: "to transform health care quality through measurement, transparency and accountability."

NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. HEDIS consists of 76 measures across 5 domains of care with specifically-designed...
measures making it possible to compare the performance of health plans on an “apples-to-apples” basis. Glaucoma screening for older adults is a component of the HEDIS measurement set.

**Medicare Advantage Star Ratings**

The quality scores for Medicare Advantage plans in 2011 are based on 53 performance measures that are derived from plan and beneficiary information collected in three surveys – HEDIS, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Medicare Health Outcome Survey (HOS) – and administrative data. Based on these surveys, Medicare Advantage Plans are rating on a scale of 1 to 5 stars with 1 being poor performance, 3 average performance and 5 representing performance excellence.

Beginning in 2012, Medicare Advantage Plans will be eligible to receive bonus payments predicated on quality ratings. Given these financial incentives, it is important that ECPs evaluate their potential to favorably influence such ratings and negotiate to receive a share of the bonus payments achieved.

## APPENDIX II

**The Eye Care Professional And Adapting Essential Components Of The PCMH and ACO Models**

### Provider Network
- Appropriate mix and scale
  - Optometrists
  - Ophthalmologists

### Organizational competencies
- Leadership
- Organization culture of teamwork
- Relationships with other providers
- IT infrastructure for population management and care coordination
- Ability to manage financial risk
- Ability to receive and distribute payments or savings
- Resources for patient education and support

### Clinical care management
- Evidence-based clinical protocols
- Decision support
- Coordinated care
- Enhanced patient access to services
- Integrated, multi-disciplinary team approach

### Contracting Strategies
- Pilot initiatives for assessment
- Minimization of risk
- Benchmarking
- Risk adjustment
- Supplier relationships
- Employer relationships

### Cost Management
- Operational efficiency
- Scale
- Utilization management

### Integration
- Health information exchange
- Hospitals
- Physicians
- Other providers
- Outcomes measurement and reporting of key metrics
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Mr. Barnwell serves as President and Founder of KDD Health Solutions, LLC. As an early innovator, he helped pioneer the development of community-based networks of physicians and hospitals bound by an infrastructure of technology and measures of governance which successfully improved clinical and financial performance - characteristics seen in today’s Accountable Care Organizations.

His work in disease management and wellness has been distinguished as a Best Practice for Chronic Disease Management Systems by the American Accreditation Health Care Commission, URAC; Selected by Models of Care: Case Studies in Healthcare Innovation, Best Practice in the Administrative and Clinical Realm; and Nominated for the American Hospital Association, Nova Award for Innovation in Healthcare. In addition, his work is featured in Harvard Business School’s Master of Business Administration, Case Study Program, Boston, MA.

Mr. Barnwell’s past experience includes serving as a Senior Vice president of Cardinal Health, a Fortune 18 diversified health services company. A previous publication by Mr. Barnwell on the value of vision care - “Comprehensive Eye and Vision Examinations – A Path to Wellness” – is widely distributed.

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