

A SPECIAL REPORT
BY THE EDITORS OF

Review
of Optometric
Business

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APRIL 2015

Navigation Guide to **HEALTH CARE REFORM** *for Independent Optometrists*



Table of Contents

Introduction: A Time to Grasp Opportunity.....	3
The Evolution of U.S. Health Care Reform: Major Trends	4
Medicare and Medicaid Enrollment.....	5
Accountable Care Organizations: Current Trends.....	6
Implications of Health Care Reform for Independent ODs	7
Optometry’s Expanding Opportunity in Early Detection and Ongoing Monitoring of Disease.....	8
The Medical Home Model and the Rise of Accountable Care Organizations.....	9
Meeting the Goals of Health Care Reform.....	10
Strategic Imperatives and Action Plans	12
Vision Source® Health Care Reform Initiatives	17
Vision Source® Benefits for Independent ODs	18

Navigation Guide to **HEALTH CARE REFORM**

for **Independent Optometrists**

Review
of Optometric
Business

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Mark Wright, OD, FCOVD, Professional Editor

Carole Burns, OD, FCOVD, Professional Editor

Thomas Steiner, Research Director

Al Greco, Publisher

Roger Mummert, Executive Editor

Margery Weinstein, Managing Editor



A Time to Grasp Opportunity

This is a challenging time in the fast-changing health care marketplace. For independent optometrists, it also is a critical time to seize opportunities to grow and flourish.

Optometrists occupy a distinctive dual role within the health care marketplace. ODs are medical professionals who render clinical services, and as such they are buffeted by legislative and regulatory changes. In addition, ODs are retailers of vision correction devices in a highly competitive arena.

To remain economically viable, independent ODs must proactively adapt to fundamental changes taking place in health care delivery and in consumer buying patterns.

ODs who are nimble and prepared for change can grasp emerging opportunities to expand patient bases and the range of services offered. Optometrists who fail to adapt to the changing landscape risk loss of patients and face the prospect of lower practice profitability.

Vision Source® has a vital interest in the changes occurring in health care delivery, recognizing that these changes represent both threats and opportunities for a broad-based membership.

The presence of Vision Source® in health care delivery is strong and growing. In 2014, Vision Source® optometrists, who number nearly 4,000, provided care to 12.5 million Americans, and forecasts are to reach 20 million Americans within the next few years. Of the 12.5 million patients seen in 2014, it is notable that:

- 41 percent or 5.1 million have a chronic condition or health risk, such as hypertension, diabetes or metabolic syndrome
- 33 percent or 4.1 million are seniors
- 12 percent or 1.5 million are diabetic

Vision Source® has commissioned Review of Optometric Business to develop this extensive report, updated yearly, on the ongoing impacts of health care reform on independent ODs. Outlined herein are the critical strategic imperatives and action steps that ODs must embrace to position themselves well in the changing environment.

Vision Source® believes that the advantages of affiliation with its large alliance of independent ODs becomes more significant as health care reform unfolds. In the changing environment, the decision-making latitude of independents will inevitably shrink as large organizations gain greater control of patient care and treatment protocols.

As part of a large organization, Vision Source® members will offer an engaged and high performing network for the organizations that will bring disruptive innovation to health care delivery systems. With its experienced staff and resources, Vision Source® is able to assist its members in negotiations and accreditation processes with the new managed care entities and to educate ODs about the new rules and procedures mandated by the government and insurers.

Vision Source® is honored to be your partner in this challenging and exciting time of health care reform.



Glenn D. Ellisor, OD



Jim Greenwood

*Glenn D. Ellisor, OD
Founder & Executive Chairman
Vision Source®*

*Jim Greenwood
President & CEO
Vision Source®*

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

The Affordable Care Act of 2010 (ACA), while much debated, has had only a modest impact on eyecare businesses to date, according to optical industry leaders. At the same time, health care reform in general holds the potential to transform daily operations in optometric practices. OD-owners and their staff must be vigilant in keeping on top of these changes.

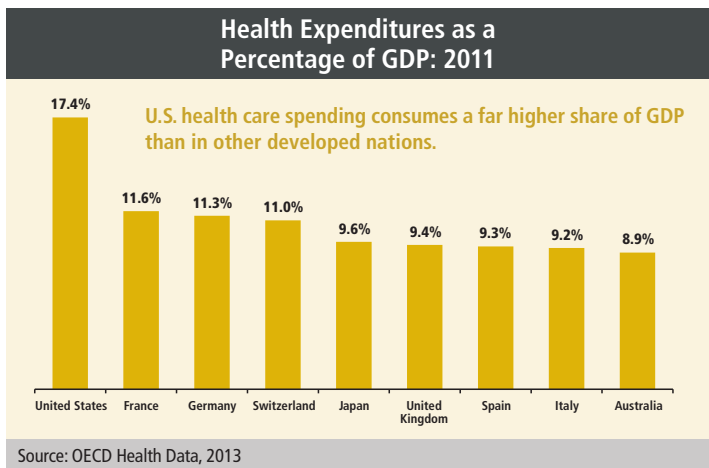
In the present environment, it is challenging to assess precisely how federal legislation will change health care delivery in the years ahead. As of the first half of 2015, it remains unclear which provisions of the ACA will survive modification by a Republican controlled Congress, against the veto power of a president who is intent on preserving intact his major legislative achievement. It is uncertain if employer mandates and taxpayer penalties for citizens who choose not to buy insurance will continue. How the Supreme Court will rule on the legality of subsidies to people in states without insurance exchanges is likewise uncertain.

Regardless of the final shape of federal regulation, the underlying issues driving health care reform remain. These issues are problematic and will force change in medical care delivery regardless of which party controls the White House.

Changes are coming to the traditional system of payment for service. The spread of tightly managed coordinated care networks appears inevitable. The long-term trend toward dominance of managed care in health care is unlikely to be reversed, and independent medical providers will not regain control of their fee schedules or restore freedom to choose treatment protocols. It's likely that a higher proportion of the population will have insurance, but that consumer choice of providers will be more restricted. Across all medical specialties, professionals will increasingly seek affiliation with larger organizations to better manage more complex administrative requirements and preserve patient access.

Health Care Trend
Health care spending accounts for an increasing share of U.S. GDP.

Health care spending in the U.S. totals \$3 trillion annually, accounting for 17.4 percent of GDP during 2013 — a much higher share of GDP



than in other developed countries.

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

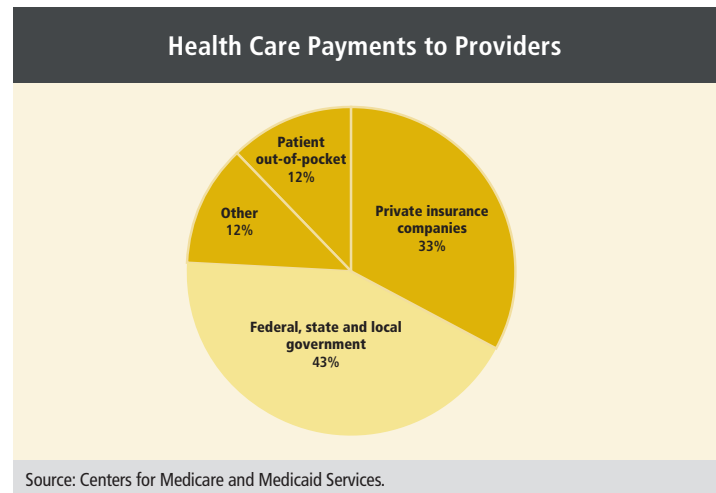
- Payments that reward providers for inputs, not outcomes
- High administrative costs (approximately one-fourth of total health care cost)
- Preventable medical error rates higher than other developed nations
- Inadequate focus on prevention

Although the steady rise in health care's share of GDP abated during the recent recession, it is expected to resume its climb over the next 10 years. The Congressional Budget Office projects that health care spending will grow 5.7 percent annually between 2013 and 2023, much faster than overall economic growth, and will reach 19.3 percent of GDP by 2023. Continued growth in health care's share of the national economy is unsustainable over the long term. The current system needs to change to improve health, control costs and reduce inefficiencies.

Growth in demand for health care is being fueled by the aging of the population, an obesity epidemic, introduction of new, more expensive treatment options, increase in the insured population and unnecessary treatments provided by the delivery system. A recent Institute of Medicine study estimated that excess costs in U.S. healthcare delivery totaled \$765 billion annually, with delivery of unnecessary services and excess administrative costs being the major contributors.

Health Care Trend
Managed care accounts for a growing share of health care spending.

Over many decades, government has expanded medical benefits, and insurance program enrollment has increased. For all medical care, patient out-of-pocket payments now account for just 12 percent of spending; for optometrists direct patient payments now account for just one-third of revenue. As third-party payers have become increasingly dominant in health care, independent providers have lost much of their control over fees and treatment options.

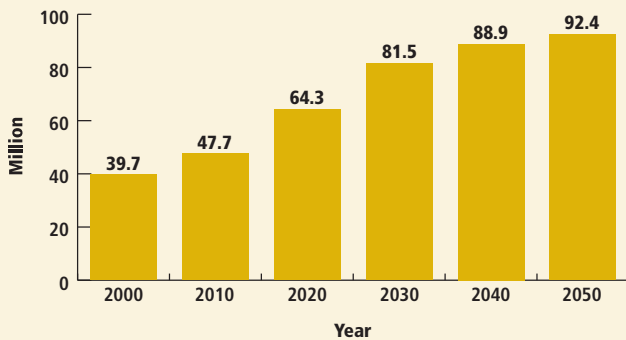


Health Care Trend

Medicare enrollment is expanding.

As the Baby Boom generation reaches retirement, Medicare rolls are expanding rapidly. Currently 54 million people, or 17 percent of the U.S. population, are Medicare beneficiaries. The number of enrollees will grow annually through 2030, when 81.5 million will receive Medicare benefits, or 23 percent of total population. For ODs, Medicare will account for an increasing share of revenue, and its rules will increasingly impact daily operations.

Medicare Enrollment

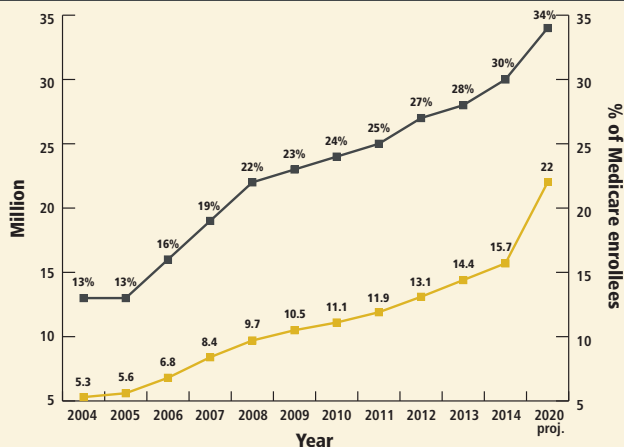


Source: Kaiser Family Foundation

Medicare Advantage programs, many providing vision benefits, have been increasingly popular among Medicare enrollees. These plans are offered by many of the largest health insurers. Currently, 30 percent of Medicare beneficiaries have Medicare Advantage coverage. This ratio is expected to grow steadily over the next six years, and by 2020, there are expected to be 22 million people enrolled in Medicare Advantage plans.

To control costs, the Advantage plans establish provider panels, which generally restrict patient choice. The plans receive financial incentives from the federal government based on 81 quality measures, including the percentage of diabetic patients who receive annual dilated eye exams. Providers on the panels of these plans are required to meet the government quality standards.

Medicare Advantage Program Enrollment



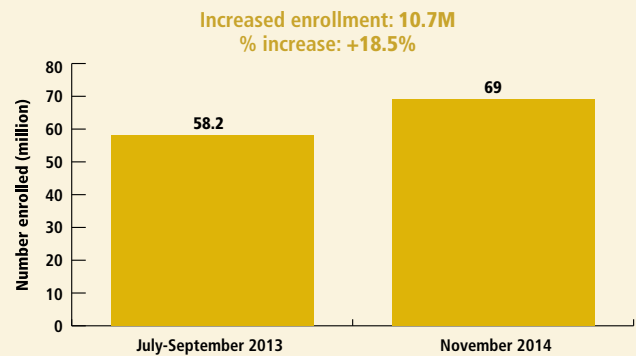
Source: Kaiser Family Foundation; Centers for Medicare and Medicaid Services

Health Care Trend

Medicaid enrollment is expanding.

Medicaid eligibility requirements have been relaxed under the Affordable Care Act. Since enrollment began under the new eligibility rules, Medicaid enrollment has surged by 18.5 percent, bringing the number of enrollees to 69 million in late 2014, or 22 percent of the U.S. population. An additional 8.5 million Medicaid enrollees are anticipated by 2016. The increase in Medicaid-covered patients is by far the largest source of newly insured patients under the Affordable Care Act. It seems highly unlikely that Medicaid benefits will be withdrawn by any future Congressional action.

Medicaid Enrollment Expansion Under the Affordable Care Act



Source: Centers for Medicare and Medicaid Services

It seems likely that many of the effects of the Affordable Care Act will continue, even if the law is amended. It's likely that the subsidized insured population will grow (through payments or tax credits). The range of covered services required under insurance plans will increase. Lifetime coverage limits will remain out of favor. Mandated coverage of people with pre-existing conditions will continue, and youth will continue to be covered by their parents' insurance plans until age 26. All of these additional benefits cost money and will result in increased insurance premiums and increased fringe benefit expense of employers. Pressure on employers to transfer some of the cost burden to their employees and to find creative ways to reduce waste in the delivery system will only grow.

One result is that consumers are likely to pay higher premiums and have higher co-pays and deductibles. A likely long-term result will be growing consumer focus on the cost of health care and pressure on providers to offer competitive fees. It may also result in less demand for elective services that enhance the quality of life, rather than preserve life.

Another result is that large employers are searching for innovative solutions from the rapidly proliferating coordinated care networks. Some 94 million Americans are provided medical coverage via their employers' self-funded health care plans. Employers who utilize such plans are at risk for escalating costs. Employees, in turn, shoulder about 30 percent of the costs of their self-funded plans and are hard-pressed to pay for more. Given those pressures, there is increased call for narrow networks that can be disruptive in providing high-quality care for low cost.

Accountable Care Organizations: Current Trends

One of the major transformative developments in U.S. health care since the Affordable Care Act was passed is the growth of Accountable Care Organizations (ACOs).

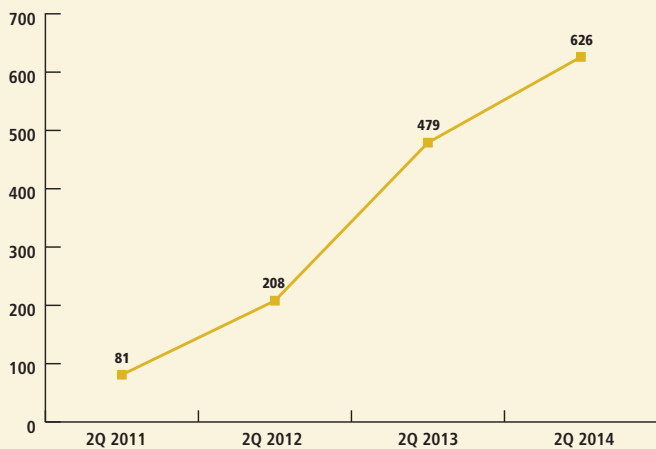
An ACO is a group of health care providers who come together to provide coordinated, comprehensive care to a defined population within a geographic area. Some serve Medicare or Medicaid patients; others serve the total population within an insurance program.

The goal of ACOs is to coordinate care among providers to assure timely, appropriate treatment, to eliminate duplication of and unnecessary services, to prevent errors, to encourage prevention and to optimize the patient experience. The result can be lower per capita medical costs, improved outcomes and increased patient satisfaction. Compensation to ACO providers is based in part on quality of care measurements and cost reduction goals.

The number of ACOs has grown dramatically. As of May 2014, there were 626 ACOs operating in the U.S., covering 20.5 million lives. Most operate in large metropolitan areas. Penetration of ACOs varies widely by geographic region, but is growing everywhere. In nine states (Alaska, Iowa, Massachusetts, Maine, New Hampshire, Oregon, Rhode Island, Utah and Vermont) more than 10 percent of the population is enrolled in an ACO.

Continued growth of ACOs will depend on many factors, including their effectiveness in delivering a higher quality of care while containing costs, on government regulation and on patient response. At present, it appears likely that the rapid spread of the ACO model will continue.

U.S. Accountable Care Organizations

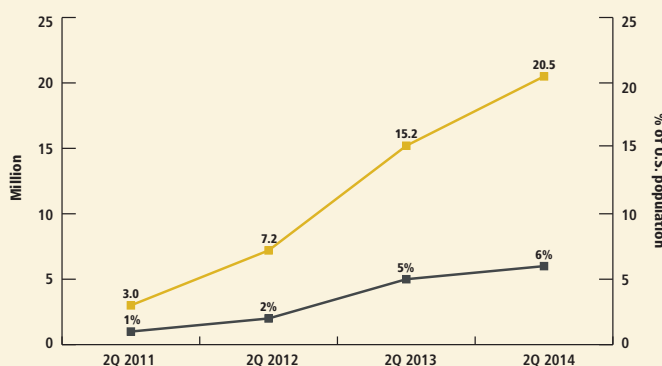


Health Care Trend

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 patients 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.

U.S. Accountable Care Organization Covered Lives (million)



Source: Human Affairs Blog, January 2014; American Hospital Association; Leavitt Partners Center for Accountable Care Intelligence

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 these clinicians.

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.

Implications of Health Care Reform for Independent ODs

The implications of health care trends and health care reform legislation for independent optometrists include:

- **New barriers to patient access will develop.**

New health care organizations are forming, which will provide services to large populations in specific geographic areas and will limit access of patients to a small group of providers, who they have screened and accredited and who are willing to accept the organizations payment schedule and procedures. Similarly, Medicare Advantage plans may limit access to a small network of ECPs in specific geographic areas. For non-accredited ECPs, the result could be the severing of relationships with existing patients and difficulty in attracting new patients.

ECPs must be aware of local changes in the managed care universe, be able to present their services effectively to the new health organizations and be prepared to meet accreditation standards. These standards are likely to include availability of instrumentation to monitor diabetes and glaucoma effectively. They are also likely to include the availability of ongoing patient satisfaction measures, such as the net promoter score.

- **Demand for optometric services will grow.**

It's likely that the number of daily patient visits that ODs will experience will steadily increase. This will occur as the number of insured patients increases, as ODs' role in monitoring chronic conditions such as diabetes and glaucoma expands, as medical eyecare services expand, as more children seek eyecare to take advantage of pediatric benefits and as insurers increasingly look to ODs to monitor the health of covered lives cost-effectively. The increase in the number of patient visits will make office efficiency even more critical in the years ahead.

- **Government influence on eyecare will increase.**

As the federal government seeks to increase access to care, to improve the efficiency and outcomes of health care delivery and to contain cost increases, its regulation of providers is likely to grow. ODs will need to remain current on government requirements to assure compliance.

- **Insurer leverage over eyecare providers will increase.**

Consolidation within the insurance industry is a likely consequence of health care reform. Larger insurers enjoy economies of scale, are better able to manage risks and to institute more robust methods to assure compliance with government standards. They have greater ability to market their services to employers and consumers.

Individual ECPs will have little ability to contest reimbursement schedules set by the large insurers, to avoid procedural mandates or to opt out of the managed care world. They will struggle to devote sufficient time and resources to learn about and deal with the complex and changing administrative procedures and accreditation processes of the large insurers.

- **ECPs will be required to maintain digital records and have electronic connectivity with other health care providers.**

In the new world of coordinated health care, mandatory requirements will be to make meaningful use of EHR and have an efficient system for electronic sharing of diagnoses and treatment plans with other providers in care networks.

- **Medicaid patients will account for an increased share of people seeking eyecare.**

The largest increase in the insured patient population in the near term will be Medicaid patients. In the past, many ODs chose not to accept Medicaid patients, but, for some, this will no longer be a practical option.

- **Medicare patients will be an increasing source of OD revenue.**

As Medicare enrollment grows and Medicare Advantage plans become more popular, an increasing proportion of OD patient bases will be enrolled in these plans and have vision benefits. It will be necessary for ODs to be accredited by these plans to gain access to this rapidly growing population.

More than 25 percent of the population over 65 years of age has been diagnosed with diabetes and is eligible for an annual dilated eye exam, covered by Medicare. The number of Medicare patients at risk for developing glaucoma will also grow, and they will be eligible for a Medicare-covered annual exam.

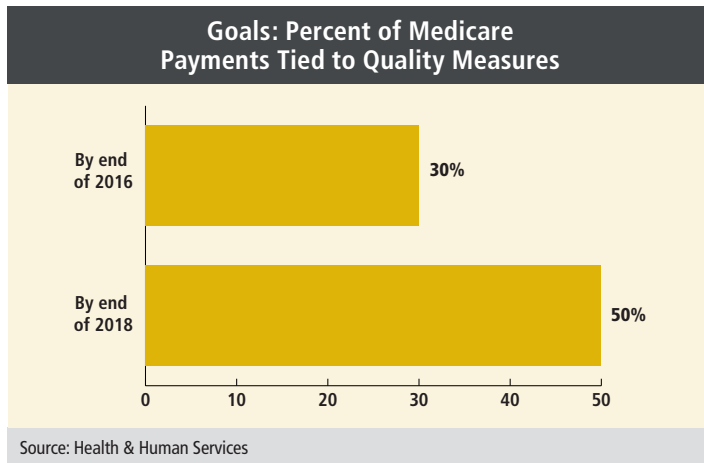
- **Professional fees will be squeezed by third-party payers.**

Insurers and government have few attractive ways to contain mounting health care outlays. One of the least painful methods to control costs is to stabilize or reduce reimbursements to providers. Individual ECPs have little clout to negotiate reimbursements with third-party payers. So it's likely that managed care reimbursement rates to ODs will grow at a rate slower than overall inflation in the years ahead, threatening practice profitability. This will increase the need for efficient patient management during office visits and for maximizing revenue from managed care patients through effective recall and product presentation processes.

Medicare Reimbursements Tied to Quality of Care

In early 2015, U.S. Health & Human Services (HHS) outlined explicit goals for moving Medicare reimbursement to quality rather than quantity of care given to patients.

HHS set a goal of tying 30 percent of traditional (fee-for-service) Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements by the end of 2016. That goal expands to 50 percent by the end of 2018.



Further, HHS set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016, and 90 percent by 2018, through programs such as Hospital Value Based Purchasing and the Hospital Readmissions Reductions Programs, all according to HHS.

“Whether you are a patient, a provider, a business, a health plan, or a

taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people,” stated HHS Secretary Sylvia M. Burwell.

What This Means for Optometrists

“This recent event will likely serve as a catalyst for an accelerated pace of change for America’s healthcare delivery landscape,” says Jim Greenwood, President & CEO of Vision Source®.

With respect to your practice, Vision Source® recommends that optometrists implement the following:

- Use the Vision Source® Eye Exam Report for all patients with diabetes to communicate your findings with their primary care physician.
- Measure the patient experience using the net promoter score.
- Utilize the resources Vision Source® offers to build new relationships and strengthen existing ones with primary care physicians in your community.
- Comply with instructions and requests from your administrator when new relationships are forged with local health systems and medical groups.
- Complete the newly designed Vision Source® C.E. course “Diabetes Mellitus Protocols.” This program provides member practices with a common set of ophthalmic, evidence-based clinical care standards derived from research and practice experience.
- Most importantly, never lose focus on the excellent clinical outcomes that your practice is known for.

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 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 ongoing monitoring. ODs will extend activities traditionally performed by primary care physicians.

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.

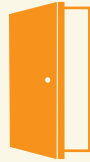
Medicare ACOs operate under one of two payment models, one-sided or two-sided, based on the degree of risk and potential savings they prefer. Under a one-sided model, ACOs share in the cost savings they achieve (above a 2 percent minimum threshold) for the first three years, with no risk of loss if costs 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 mid-2014, approximately 626 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

GOAL



Expand access to care



Produce better outcomes



Lower cost of care



Compensation for good patient outcomes



Electronic health records



Inter-connectivity

Health Care Reform

OPTOMETRY'S OPPORTUNITY

ACTION POINTS

Provide more exams,
expanded care

Participate in new narrow networks,
ACOs, Medicare, Medicaid

Diagnose disease,
co-manage chronic conditions

Track outcomes, employ diagnostic
tools, measure patient experience

Provide good value, efficiency

Install efficient systems, delegate
& streamline office processes

Moving away from fee
for service

Track \$/outcomes, evaluate
treatment protocols

Continue to lead in
conversions to EHR

Total EHR, Meaningful Use,
HIPAA compliance, ICD-10

Expand co-management,
e-communication

E-records, HIPAA compliance,
collaborative health care delivery

Strategic Imperatives and Action Plans

OD Strategy Imperative

Capture pediatric vision benefits.

Under the Affordable Care Act, beginning in January 2014, millions of children 18 years of age and younger became eligible, under their parents' health insurance plans, for coverage of an annual eye exam and a vision device subsidy. The new pediatric vision benefit was enumerated as one of the 10 essential benefits required in all plans sold by state and federal insurance exchanges, as well as by non-grandfathered individual and small group plans. Optometrists who are accredited by the insurers are able to be reimbursed for this care.

Research has shown that only 7 percent of children entering first grade had received an eye exam and that undiagnosed vision problems among youth can lead to reduced academic performance. Analysis also indicated that simple screenings were insufficient to detect many vision issues.

Nearly 25 percent of the U.S. population, or 78 million people, are 18 years old or younger. AOA surveys suggest that less than 20 percent of OD patient visits are made by people in this age group. Most youth visit an eye doctor when they suspect or have been diagnosed with a vision problem. Thus, the new law has the potential to increase the number of youths who visit ODs, as well as the frequency of their visits. It's likely that many parents remain unaware of the pediatric vision benefit offered by their health insurer. A 2014 AOA survey indicated that two-thirds of adults did not know that the Affordable Care Act mandated pediatric vision coverage.

Action Plan

1. Determine the insurance companies covering patients in your area who are participating in the state exchange or offer pediatric vision benefits.
 - Determine the benefits and allowances offered by each plan
2. Educate parents about the risks of undetected vision problems among children and about pediatric vision benefits.
 - Develop a section on the practice website explaining the importance of early detection of vision deficiencies and the availability of pediatric benefits.
 - Develop a brochure about pediatric eyecare benefits and give to parents with children under 19.
 - Conduct a mailing to parents during back-to-school period encouraging youth exams.
 - Issue press releases about pediatric care benefits.
3. Inform parents of any out-of-pocket costs involved in pediatric care.
 - Different insurers may offer different reimbursements for pediatric care. These variables must be understood and relevant information communicated to patients.

- Materials subsidy may not cover full cost. A script should be developed encouraging purchase of higher performance eyewear offering safety and glare reduction benefits.
 - Some health insurance plans may reimburse for pediatric vision services only after annual deductibles have been paid. Patients should be advised of the terms before service is provided.
4. Make the practice child friendly.
 - Dedicate space in the reception area for youth under 7 years of age and decorate to make children comfortable.
 - Train staff to educate youth about eyecare and make children feel welcome at the practice.
 5. Establish a recall program for pediatric patients.
 - Schedule an annual exam for patients with refractive error or with vision problems.
 - Schedule bi-annual exam for all others.

OD Strategy Imperative

Convert to ICD 10 coding.

As of press time, plans are that all health professionals will be required to use a new set of codes when filing reimbursement claims. By October 1, 2015, codes carry the acronym ICD 10 (International Classification of Diseases – 10th revision). The ICD 9 codes currently in use will no longer be valid, and electronic or paper claims filed using these codes will not be paid after September 30, 2015. The new codes only deal with medical diagnoses and do not change or replace the CPT procedure codes.

The new ICD 10 codes are considerably more complex than the ICD 9 set, with 68,000 codes compared to 13,000 ICD 9 codes, adding additional specificity on disease diagnosis, severity and treatment stages. A major change is that the ICD 10 codes require a practitioner to specify the laterality or bi-laterality of a condition, as appropriate. Each ICD 10 code has three to seven characters in the following sequence:

- Category (letter)
- Etiology (number)
- Anatomic site (letter or number)
- Severity (letter or number)
- Extender (letter or number)

Action Plan

1. Confirm that your practice management software system has been or will be updated to support the new codes.
2. Train doctor and staff on the structure of the new coding system and

differences from the ICD 9 structure.

3. Review documentation from Medicare and major insurers on the conversion, administrative procedures and compliance standards.
4. Establish a process for how ICD 10 codes will be selected (manual, look-up program).
5. Practice ICD 10 code selection beginning July 1, 2015.
6. Create a new fee ticket structure for all procedures based on ICD 10 codes.

Resource:

AOA 2015 Codes for Optometry Book and Express Mapping Reference Card

OD Strategy Imperative *Achieve Meaningful Use of EHR.*

Electronic Health Records and Meaningful Use

The universal adoption of electronic health records (EHR) by medical professionals is a key goal of health care reform. Indications are that optometry may be ahead of other medical specialties in this adoption.

Transferring existing patient data from paper to EHR and recording new data in this manner streamlines the exam process and potentially raises the level of care that ODs provide. Further, the goals for all medical professionals, ODs included, are to leverage this electronic platform to share information (in a secure environment, as defined by HIPAA) with other medical professionals for treatment and research, as well as with patients to encourage engagement and better outcomes.

U.S. Department of Health & Human Services (HHS), through its information website (www.HealthIT.gov) defines meaningful use:

- Improve quality, safety, efficiency and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

HealthIT.gov further defines objectives of meaningful use:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Meaningful Use Incentives

Medical professionals are incentivized to achieve these stated goals through meaningful use of EHR. This is laid out in three stages. As

of mid-2015, medical professionals are in Stage 2, with Stage 3 commencing in 2016.

The Centers of Medicare & Medicaid Services (www.CMS.gov) provides criteria for eligibility for EHR Incentive Programs, as well as steps to be taken and a timeline tool for meeting objectives. The criteria for EHR Incentive Program Stage 3 were posted March 2015.

Stages of Meaningful Use		
Stage 1	Stage 2	Stage 3
2011-2012	2014	2016
Data capture and sharing	Advance clinical processes	Improved outcomes

Source: HealthIT.gov

There are two programs:

Medicare EHR Incentive Program	Maximum incentive amount \$44,000
Medicaid EHR Incentive Program	Maximum incentive amount \$63,750

Registration for these programs remains open, though medical providers who began their participation by 2011, when payments began, are positioned to gain the most in reimbursements.

Action Plan

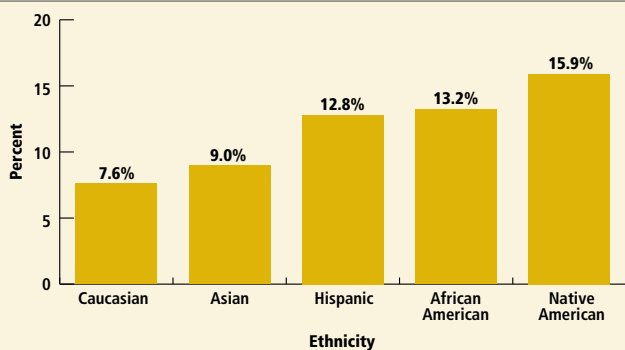
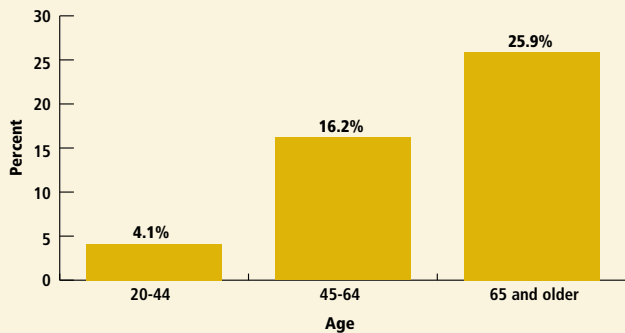
1. Visit www.HealthIT.gov and read EHR Incentives & Certifications.
2. Follow steps for "getting started" and "Payment Timetable."
3. Analyze EHR system for compatibility in achieving meaningful use criteria

OD Strategy Imperative *Manage diabetic patients.*

In 2014, The Centers for Disease Control estimated that 29.1 million Americans had diabetes, including 21 million diagnosed cases and 8.1 million undiagnosed people. Overall incidence in the population was 9.3 percent, with incidence rates much higher among older people and African Americans, Hispanics and Native Americans. The number of diabetics is increasing rapidly as the population ages and with the growing prevalence of obesity.

Recognizing the high rate of diabetes among people 65 and older and the high cost of caring for patients with vision loss, Medicare Part B covers a yearly eye exam for its beneficiaries with diabetes, paying 20 percent of the Medicare approved amount after the yearly Part B deductible has been met.

Incidence of Diabetes



Source: Centers for Disease Control

Many health insurance plans also will cover retinal exams for diabetics of all ages, providing coverage of an annual exam for diabetics with retinopathy and every other year for diabetics without retinopathy. In providing this coverage, the insurers satisfy one of 81 HEDIS measures (Healthcare Effectiveness Data and Information Set), which are widely used to monitor the quality of health care within the managed care industry. Medicare requires that companies offering Medicare Advantage plans report HEDIS scores annually.

Optometrists are well positioned to perform the eye exams needed by diabetics. A recent United Health care study, "Impact of Eye Exams in Identifying Chronic Conditions," revealed that diabetes was diagnosed as the result of an eye exam in 15 percent of the cases studied in 2011-2012. ODs perform comprehensive eye exams on millions of diabetic patients every year. In a typical optometric practice with 5,000 active patients, there are likely to be 450-500 diabetics.

Action Plan

1. Establish a pre-appointed recall system for diabetic patients.
 - The goal is to achieve 100 percent compliance with the annual exam standard for diabetics with retinopathy and Medicare beneficiaries and every other year for other diabetics. To achieve this goal will require pre-appointment and a rigorous system of follow-up reminders.

- Diabetics should be educated about their insurance or Medicare benefits related to eyecare. This will increase compliance with exam schedules.
2. Educate diabetics about lifestyle and diet changes that will help control the disease.
 - Diabetics fear vision loss and may be open to changes in habits to reduce the likelihood of blindness.
 - Patient education of diabetics enhances an ODs role as a member of a coordinated health care team.
 3. Apply proper coding to claims.
 - This is important to insurers whose HEDIS scores are lowered if improper coding is used.
 - Improper coding will delay reimbursement.
 4. Communicate exam findings to primary care physicians.
 - A reporting system should be developed to enable consistent electronic communications of exam findings to primary care physicians and other specialists, in a concise, readily understood format, within three days of each diabetic exam.
 - Vision Source® provides its members standardized reporting templates.
 5. Refer previously undiagnosed diabetics to primary care physicians.
 - For each insurer, identify local primary care physicians who are accredited.
 - Contact accredited PCPs to create a referral relationship.

OD Strategy Imperative

Manage glaucoma patients and patients at high risk of developing glaucoma.

Some 2.2 million Americans have open angle glaucoma, a number projected to reach 3 million by 2020.

Medicare Part B covers an annual glaucoma test for patients considered at high risk of developing the disease, including:

- Diabetics
- People with a family history of the disease
- African Americans 50 years of age and older
- Hispanics 65 and older

A glaucoma screening includes:

- A dilated eye exam with intraocular pressure measurement
- A direct ophthalmoscopy exam or a slit lamp bio microscopic exam

Action Plan

1. Develop a list of all patients diagnosed with glaucoma or who are in the high risk demographic groups specified by Medicare.
2. Conduct a mailing to patients who are diagnosed with glaucoma or at high risk of developing it, explaining the vision loss risks of the disease, the importance of annual eye exams and the availability of Medicare benefits.
3. Apply proper coding to claims.

OD Strategy Imperative

Upgrade the patient experience and monitor patient satisfaction.

Gaining accreditation with insurers and new coordinated care networks will increasingly require that ODs document the quality of care they provide. This requirement will become more prevalent as the compensation health networks receive will be based in part on standardized quality scores. It will also be needed because consumers will have access to information on the quality of care at different providers as they choose insurance plans and individual professionals.

To the extent that the patient experience at an OD's office is superior to that of other health providers, an OD becomes a more highly valued member of a network and will attract more referrals.

Action Plan

1. 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.
2. Rate your practice with a net promoter score. A net promoter score provides ODs with an objective measure that reflects the high quality of care and outstanding level of service they provide.

A net promoter score (NPS), developed by Fred Reichheld, Bain & Company and Satmetrix, is a measure of how loyal a patient is to your practice, based on their experience. Beyond measuring levels of patient satisfaction, the NPS shows, in particular, how readily a patient would recommend your practice to a friend, colleague or family member.

Regularly measuring your NPS with your patients provides two benefits: It focuses OD and staff on providing outstanding care and service, and it can transform satisfied patients into practice advocates/recommenders who can expand your patient base.

3. Rate your practice by HealthGrades, 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

4. Rate your practice from a patient's perspective. Along with your staff, conduct a "fresh eyes" tour of your practice by entering the front door and taking the "patient's journey" from reception through final billing and rescheduling. Write down what you notice, as if you were a patient—from a stain on the ceiling, to old magazines in the waiting room, to the decor of the waiting area between pre-test and seeing the doctor. Then discuss and make changes.
5. Address deficiencies. 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.

Resources: For more information on net promoter scores: *The Ultimate Question* by Fred Reichheld, www.netpromotersystem.com.

OD Strategy Imperative

Create relationships with large groups of primary care clinicians.

Steps to create relationships:

1. Identify leading medical groups in your community.
2. Identify the leadership of each organization and the person responsible for assembling the specialist network.
3. Contact the organization, outlining benefits of ODs providing care and the advantages of the Vision Source® network. Key information to be provided in letter of introduction:
 - Location map
 - Number of doctors with Medicare certification
 - Diagnostic equipment available
 - Weekly appointment availability

- Office hours
- Patient experience management processes (satisfaction surveys, conveniences, etc.)

4. Make a presentation to decision makers. Presentation contents:

- Probe to understand the organizations' goals, problems.
- Describe Vision Source® network advantages:
 - Broad scope of care provided (list conditions)
 - Broad geographic coverage
 - Vision Source® quality assurance programs (member screening, training, standardized reporting forms, etc.)
 - Local administrator to facilitate communications
 - Single call center capability
- Specify next steps, additional information needs, timetable.

Vision Source® Health Care Reform Initiatives

The advance of health care reform has caused a major reorientation of the Vision Source® corporate mission. Recognizing the threats and opportunities posed by reform, Vision Source® has dedicated itself to assist its members to provide a broad scope of high quality care to patients and to serve as gatekeeper of patients' overall health in emerging coordinated care networks. In so doing, it is building a provider organization with extensive geographic coverage, which will be attractive to integrated health care entities.

Vision Source® believes its members are particularly well positioned to serve on panels in coordinated care networks:

- Its member ODs meet the high standards Vision Source® establishes for membership.
- The organization provides deep training and administrative resources to members to assure the best patient experience and compliance with managed care procedures.

PCP Awareness Kit - Large

www.VisionSourceGear.com

For questions please contact:
Kristen Cornick
ks@vactx.com
or call (972) 242-6332, x 14

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10	\$12.50	\$125.00
25	\$12.50	\$312.50
50	\$12.50	\$625.00
100	\$12.50	\$1250.00

Quantity:

Enriching lives by enabling independent optometrists to reach their full potential

- Vision Source® helps its members communicate benefits to large networks.

Recognizing the unfolding changes in health care delivery, in 2013 Vision Source® hired Jim Greenwood as its new CEO, an executive with 20 years experience with Concentra, a physician practice management company. Jim has launched dozens of initiatives to position Vision Source® members to take advantage of the opportunities presented by health care reform. As of mid-2015, active relationships have been formed with dozens of organizations in virtually every region of the country. Many additional relationships are under negotiation.

“It is clear that, in this fast-changing environment of health care reform, no one can afford to stand still,” says Jim Greenwood, President and CEO of Vision Source®. “ODs need to be informed, be positioned, and have a strong partner and advocate. We believe that being part of Vision Source® provides those essential tools for practice success.”

IDENTIFYING AND RESOLVING CARE GAPS

OUTSTANDING PATIENT EXPERIENCE

FULL CIRCLE INFORMATION EXCHANGE

IMPROVED HEDIS MEASURES

EASE OF PATIENT ACCESS

How can we help you?

When hospitals and physician-based health plans need optometry help, they turn to Vision Source®. Our optometrists are equipped and trained to help your organization manage eye-related diseases, like diabetes, and ensure positive patient outcomes.

With 3,000+ locations and 3,700+ practitioners, Vision Source® can help close the care gap by connecting your primary care physicians, patients, and organization to the nation's largest network of independent eye care professionals, with high quality eye exams, and trackable reporting systems.

If you need help enhancing your managed care organization's health care delivery, we have a plan for you. Learn more about our entire scope of services designed for your industry at VisionSource4PCPs.com

VISION SOURCE®. At your service.

- Smaller OD alliances lack the local clinical leadership that Vision Source® enjoys and have difficulty offering such extensive education and materials.
- In many geographic areas, the Vision Source® network offers broad coverage of the local population – coverage that is expanding as membership rolls grow.
- Vision Source® understands that ODs are able to detect, manage and monitor many chronic conditions more cost-effectively and with greater patient satisfaction than are other medical specialties. It promotes broad scope of care to its members.

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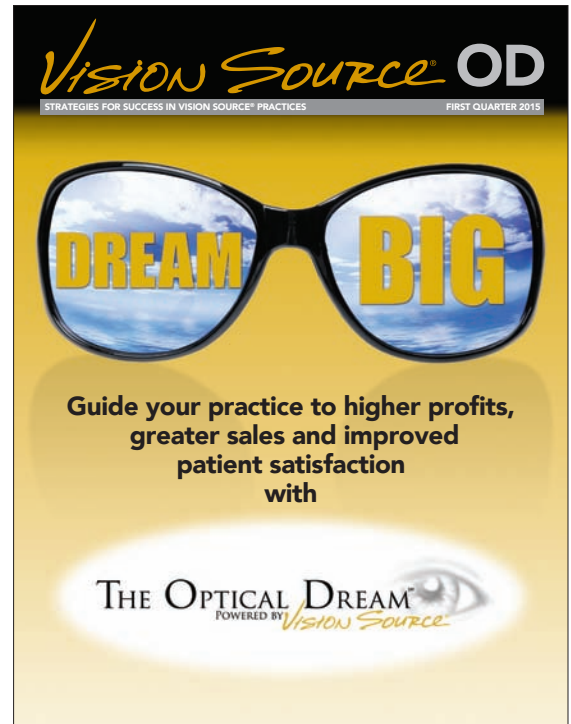
Managed Care Preparation Kit 2.0
2015

Vision Source

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 3,100+ member practices in the U.S., including nearly 4,000 independent ODs, with an unrivaled member retention ratio. 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:

- **Health Care Reform Guidance.** Vision Source® provides materials and specialized training and material for ICD-10, HIPAA and meaningful use guidance.
- **The Optical DreamSM,** which is offered to all Vision Source® member practices, is a practice development initiative designed to provide both enhanced awareness and unique sales training to each member of the staff. The program is comprised of state-of-the-art audio, written instruction, video role play demonstrations and is reinforced with engaging questionnaires, and edu-tainment. Staff and doctors are eligible to win prizes. Focus is on selling contact lens annual supplies, multiple-pair sales, upgrades to AR, and selling back-up pairs of sunwear.
- **Enhanced Buying Power.** The 3,100+ member practices produce more than \$2 billion in annual revenue. This gives Vision Source® a strong negotiating position with leading optical manufacturers and service providers.
- **Local Leaders/Mentors.** Local leadership is a difference maker for ACOs. Our local leaders also serve as coaches and mentors.
- **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.
- **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.
- **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.
- **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.
- **Vision Source® Website.** A rich resource of educational programs for both ODs and staff members.
- **National Branding.** National branding leverages the power of Vision Source® and its growing national reputation among eyecare consumers and third-party providers. It is the only independent OD alliance sponsoring national TV advertising to attract new patients for its membership.



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THE REVOLUTION BEGINS NOW



“We are changing the perception of optometry one market and one organization at a time.”

– Jim Greenwood, President and CEO, Vision Source®, April 10, 2014

At the 2014 Exchange, the annual meeting for Vision Source®, Jim Greenwood addressed the success to date in aligning Vision Source® members with health care organizations. Since then, a wide variety of organizations have selected Vision Source® to be their preferred health care provider, including Minuteman, USMD, CoxHealth, Baptist Health Quality Network, Arizona Care Network, Memorial Hermann Health, and WellMed.

This success is not the result of chance. Vision Source® has a plan that enables members to connect with ACOs, Medicare Advantage plans, and other emerging health care organizations in their communities. At the same time, Vision Source® is leading the way in positioning optometry as a vital partner in patient-centered care to the health care community as a whole.

There's a revolution taking place in health care. If you would like to be at the forefront of changing minds and behavior when it comes to optometry, Vision Source® would be honored to have you join us.



VisionSourcePlan.com