GLAUCOMA TODAY

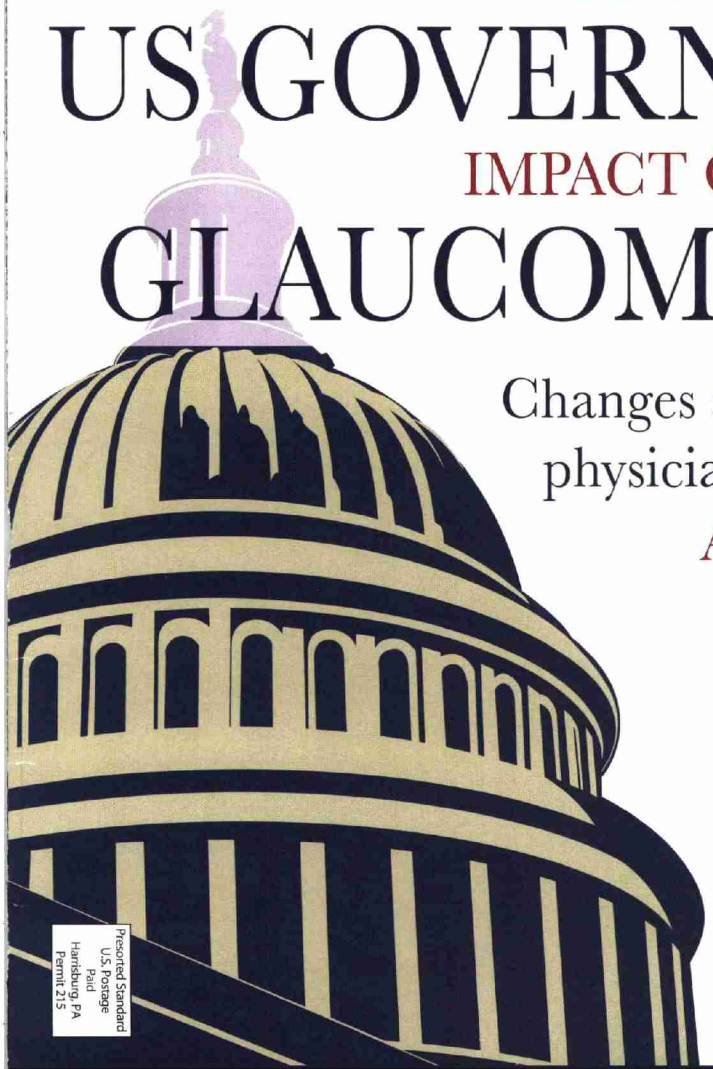
Date: Saturday, February 01, 2014
Location: WAYNE, PA
Circulation (DMA): 10,490 (N/A)
Type (Frequency): Magazine (5Y)
Page: 1,28,29,30
Section: Main
Keyword: Rosalind Franklin University of Medicine and Science

GT's FILM FESTIVAL • FORMATION OF A PUPILLARY MEMBRANE AFTER OCULAR TRAUMA

Glaucoma TODAY

January/February 2014 • Volume 12, No. 1 • www.glaucomatoday.com • eyetube.net

THE US GOVERNMENT'S IMPACT ON GLAUCOMA CARE



Changes are affecting physicians and patients alike.

Are you prepared?

- ICD-10-CM for Glaucomatologists
- Reimbursement Challenges and Solutions With "New" Glaucoma Procedures
- How Will the ACA Affect Glaucoma Practice in 2014?
- The Pros and Cons of Expected Changes in Health Care
- New Governmental Mandates for Ophthalmic Care
- How Will I Alter My Practice During the Next 5 Years?
- Quality-of-Care Standards in Glaucoma
- Maximizing Care of the Underserved Glaucoma Patient Population

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COVER STORY

The Pros and Cons of Expected Changes in Health Care

By Dan Eisenberg, MD

I would argue that history has proven that all centrally controlled, Keynesian-style economic systems eventually collapse. The breakdown may not occur immediately, due to positive swings within a complex system, but the final outcome is sure. By greatly expanding the US government's control of health care, the Affordable Care Act (ACA) creates a massive top-down system that I believe will fail in the long term. Alterations and amendments cannot save the ACA, because the core theory of central control is flawed. No group of humans is smart and selfless enough to design and manage the health care apparatus of the United States.

There are aspects of the ACA likely to yield near- and long-term benefits. For example, for decades, US politicians generally dared not say that the Medicare system is heading toward bankruptcy, but the passage of the ACA (perhaps inadvertently) brought this matter into the light, because the argument in favor of this law cited the unaffordable future cost of health care. The concept of market-based insurance exchanges makes sense: this model has proven valid for hotels, airline tickets, and rental cars, among other commodities. Although the present implementation may lack robustness or a functional website, the idea remains sound and worthy of pursuit.

Encouraging everyone to carry health insurance is reasonable and prudent. Mandating the purchase of a product (in this case, health insurance), however, was not in the minds of those who framed the US Constitution. The ACA highlights the extent of the government's encroachment upon people's personal and professional lives. The founders of this country were willing to fight a war and die for a concept of governance they derived from history. One of the country's current lawmakers reportedly admitted to voting on the ACA without reading it. Legislators are elected and paid by the people to represent the people, yet some in Congress have exempted themselves and anyone connected with them from the ACA. This may not be their first offense, but it is conspicuous to the general public. The most promising future benefit of the ACA may be an awakening of US citizens to distortions of their legislative system.

Dan Eisenberg, MD, is a glaucoma specialist at The Shepherd Eye Center in Las Vegas. Dr. Eisenberg may be reached at (702) 731-2088; glaucoma@cox.net.

By Mildred M. G. Olivier, MD

The Affordable Care Act (ACA) is bringing change to health care. Our patients and practices will be best served if we ophthalmologists take this opportunity to understand what is coming and prepare accordingly. How it will affect each of us depends largely on the people and community we serve. It is important to understand that regional markets shape the ACA's implementation. Decisions being made locally will affect our practices. If there were ever a time for us to support and participate in our state and local ophthalmology associations, it is now.

PROS

An Influx of New Patients

New patients will include people who could not obtain coverage in the past because of pre-existing conditions or a lack of access to employer-supported plans. We can assume that there will be a significant amount of undiagnosed and untreated eye disease. This coincides with age-related eye problems that the baby boomers are starting to encounter.

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No Pre-Existing Condition Exclusions

Insurance companies will operate under stronger restrictions. They will not be able to drop people with pre-existing diseases, so patients with individual health care coverage can keep their coverage (D. Preece, oral communication, November 2013).

Ophthalmology Is Not a Priority Target

Insurers seek to control costs by decreasing utilization. Clinical integration is one of their chief means of doing so. The importance of Accountable Care Organizations (ACOs) is growing. At present, however, analysts predict that ACOs are focusing on bringing down the cost of the most expensive procedures such as cardiovascular and orthopedic surgery.[1]

CONS

Insurers Unaware of Differences in Ophthalmologists and Patient Groups

Some insurance panels do not understand differences among ophthalmologists. The panels may compare the activity in retinal or glaucoma specialties with that in general ophthalmology practices and misconstrue the former's need for more tests and more frequent visits.

Insurers may also be unaware of the way different groups are affected by eye disease. Communities with large numbers of older people, with significant percentages of African Americans and Latinos, are going to have a higher incidence of glaucoma, age-related macular degeneration, and diabetic eye disease.[2,3]

Coverage Dropouts

Younger patients may enroll initially to meet ACA requirements but subsequently discontinue paying premiums. They may feel safe doing so because they can re-enter when they need care by stating that they have pre-existing disease (D. Preece, oral communication, November 2013). A practice may be unaware of such patients' lack of coverage and incur a deduction from incoming payments of a previous distribution.

OPPORTUNITIES

The ACA brings opportunities. This is a great time for us to educate insurance panels on the realities of glaucoma care. Alerting insurers to potential problems can help them to make more informed comparisons with other markets and practices. Each of us must be alert for discussions in our area about referral relationships and ophthalmological services.[4]

For now, the general wisdom suggests that we ophthalmologists should not rush to join ACOs until regional guidelines become clearer. As physicians move under ACO umbrellas, their referral patterns may shift to keep patients within their groups. Although ACA regulations call for Medicare patients to be able to go to whichever doctors they choose, there have been instances of confusion in the past.[1] Communicating with our patients and educating them about their rights to select individual care providers will be important. In the same vein, making sure that referring physicians have the same understanding of the importance of specialty care for their patients may be vital.

The author thanks Derek Preece of BSM Consulting for his expertise and assistance.

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By Rohit Varma, MD, MPH

Most population-based studies in the United States have provided data suggesting that over 50% of patients with primary open-angle glaucoma (POAG) have not been diagnosed or treated.[1] If people with glaucoma remain undiagnosed and untreated until they develop advanced visual field loss, they are at high risk of going blind, and the personal and societal costs of blindness are significant.[1] One way of potentially reducing these costs is the early diagnosis and treatment of POAG. Although the prevalence of the disease is highest in African Americans and Hispanics, in the United States, the largest burden of POAG is currently contributed by older non-Hispanic white women.[2] It is projected that, in the next 4 decades, the largest burden will shift from non-Hispanic whites to Hispanics, however, given the growth and aging of this population.[2]

Major factors associated with being undiagnosed and untreated include a lack of health insurance and low acculturation (in the case of Latinos).[3] The Affordable Care Act (ACA) has the potential to allow an estimated 20 million Americans to obtain health insurance. It is possible that, once a person obtains health insurance, he or she will visit an eye care provider for a complete

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examination, which would lead to the earlier detection and treatment of POAG. This could improve outcomes and reduce the individual and societal economic costs.

Beyond the provision of health insurance, there are numerous challenges to reducing the burden—particularly the disparities in glaucoma. As is clear from numerous studies, significant differences exist not just in the burden of disease but also in the provision of eye care.[4] Contributors include a significant lack of data on disparity-related outcomes, a shortage of trained ophthalmologists, a lack of culturally and linguistically appropriate interaction with and support of patients, a dearth of evidence of the effectiveness of interventions for reducing disparities, and a subsequent need to implement the most effective solutions.

Although the ACA provides additional benefits for Americans and is a welcome first step (despite the initial website and implementation hiccup), it is unclear to what extent the ACA will reduce health disparities and the burden of POAG in the United States. We physicians must continue to be champions for our patients and to explore various alternative approaches to providing excellent care. These approaches include collecting long-term outcomes data, establishing joint optometry-ophthalmology systems for providing care given the impending shortage of ophthalmologists, and increasingly adopting culturally and linguistically appropriate support systems. Finally, we need to explore more creative approaches toward reducing disparities (across the economic spectrum, rural-urban, and racial and ethnic) in the provision and outcomes of glaucoma care. If we are able to do this, we are likely to reduce blindness and vision loss in our patients. ■

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(eg, professional societies). A reevaluation of the CMMI's design is underway.

The CMMI and new payment models will have little to no impact on ophthalmologists this year. Unless employed ACO physicians, glaucoma specialists will continue to be paid a fee for service directly by the Centers for Medicare & Medicaid Services even if the patient is part of an ACO. The opportunity to engage the glaucoma community in a program of bundled payments for chronic open-angle glaucoma was excluded by the CMMI's emphasis on hospital-based interventions and the complexity of designing a risk-adjusted episode of glaucoma care.

IMPROVED QUALITY

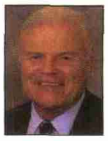
This is the one area in which regulatory changes will dramatically affect the ophthalmic profession this year and beyond. Instituted by the Bush administration, the move to value-based purchasing will expand greatly. Value can be defined as the relationship between improved quality and the resources expended to achieve it.

Ophthalmologists will face penalties of between 5% and 7% of their gross Medicare payments in 2016 and in every successive year if they fail to meet the requirements of the Physician Quality Reporting System (PQRS) and regarding the meaningful use of electronic health records based on 2014 visits. To avoid penalties from the PQRS, meaningful use, and the Value-Based Payment Modifier, physicians may have to successfully report on nine quality measures and ensure that they are not "outliers" in their use of resources. It is hard to imagine achieving quality reporting using Medicare claims.

The ophthalmic community has designed and implemented a new clinical registry, Intelligent Research in Sight, that will enable glaucoma doctors to improve their outcomes, evaluate the impact of new interventions on chronic eye disease, and meet reporting requirements of phase IV Maintenance of Certification, PQRS, and the Value-Based Payment Modifier. Intelligent Research in Sight will be the first registry that can examine patients' care longitudinally and evaluate the impact of intervention, both surgical and pharmacologic, on the natural course of disease in addition to facilitating practitioners' compliance with new, complex quality reporting.

SUMMARY

The most important piece of social legislation since the enactment of Medicare in 1963 will have little effect on glaucoma doctors this year. What the future holds is unclear. ■



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