



Implications of Coverage and Payment for the Future of Eye Care

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This Presentation At A Glance

- Update on accomplishments of Affordable Care Act implementation to date
- Coverage expansion
- New payment and delivery models
- Implications for eye care overall

The Triple Aim



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- Better health
- Better health care
- Lower cost
- Core principle at heart of major U.S. payment and delivery system reform

The Triple Aim, Part Deux



- Better Care
- Smarter Spending
- Healthier People

Global Causes of Blindness

- Cataract (47.9% as of 2002) is the leading cause of visual impairment in all areas of the world, except for developed countries.
- Other main causes of visual are glaucoma (12.3% as of 2002), age-related macular degeneration (8.7%), corneal opacities (5.1%), diabetic retinopathy (4.8%), childhood blindness (3.9%), trachoma (3.6%), and onchocerciasis (0.8%).

Coverage Expansion as of 2015

- HHS: 11.7 million signed up for coverage through federal and state marketplaces during open enrollment 2014-2015
- 50 percent increase over 2013-2014
- 8.8 million in federally-facilitated marketplaces; 2.9 million in state marketplaces
- 86 percent of enrollees received premium subsidies

Sources: Dept. of Health and Human Services; "After the 2015 Open Enrollment Period?", Nov. 10, 2014; Health Reform Monitoring Survey, "Increase in Medicaid Under the ACA Reduces Uninsurance, According to Early Estimates," June 25, 2014; also "Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid," Council of Economic Advisers, July 2014; Medicaid & CHIP June 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report, medicaid.gov

Coverage Expansion

In addition:

- 3.4 million young adults stayed on parents' coverage because of earlier changes
- Enrollment in Medicaid and the Children's Health Insurance Program (CHIP) grew by an estimated 11.2 million – a 19.3 percent increase since 2013
- States that have expanded Medicaid experiences a 26.1 percent growth in enrollment versus 7.1 percent for states not expanding Medicaid)
- Bottom line: Estimated 11 million to 16.4 million have gained coverage
- National Health Interview Survey: Ranks of uninsured US residents under 65 (48.2 million in 2010) down to 36.8 million in 2014 Americans (estimated 32 million as of 2013) has been reduced by 24 percent
- Uninsured rate in US for those under 65, now 13.7 percent, **lowest in decades**

Essential Health Benefits as defined in the Affordable Care Act

- Outpatient and inpatient care; emergency services
- Pregnancy-related care
- Mental health and substance use disorder services, including behavioral health treatment, counseling, and psychotherapy
- Prescription drugs; lab tests
- Services and devices to help you recover if you are injured, or have a disability or chronic condition. This includes physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more.
- Preventive services including counseling, screenings, vaccines; care for managing a chronic disease (**vision screening and comprehensive exams for children only to age 19**)
- Pediatric services, including dental
- **Vision care for adults 19-plus not considered a covered “essential health benefit”**

Vision Care vs. Medical/Surgical Care of Eye

- Traditionally, vision care = eye care provided specifically for management of blurred vision from refractive error including farsightedness, nearsightedness, and astigmatism.
- Eye care for other diseases covered as medical treatment
- Vast majority of employer-provided insurance does not include vision care; vision coverage typically must be purchased separately

Qualified Health Plans and Vision Coverage For Adults

- Some QHPs do offer vision coverage for adults but most do not
- However, some exchanges do list stand-alone vision coverage for purchase, and the number that do is expected to expand over time as “retail” transition takes hold
- Subsidies cannot be applied to standalone vision plans

Example: Cataract Surgery

- Because cataract surgery is performed by a physician rather than an optometrist, it is a covered service under QHPs
- Lens implants also covered; typically one pair of eyeglasses as well

Pediatric Vision Coverage under ACA

ACA-mandated pediatric vision benefits provide coverage to eligible members under age 19 for the following services:

- One preventive eye exam per benefit period: Covered at 100 percent for eligible group members. Subject to copayment, deductible or coinsurance for individual members depending on their specific benefit plan.
- One pair of lenses and frames OR one pair of nondisposable contact lenses per benefit period: Covered at 50 percent after the eligible member's deductible is met, if applicable, and if provided by an in-network provider (40 percent if supplied by out-of-network provider).
 - Includes fittings
 - There is no benefit limit or maximum allowance for the frames. Reimbursement to the provider is based on what the provider pays (i.e., the cost of the frame or lenses); not on the billed amount.
 - Standard fee schedule for the frames (not based on UCR)

Coverage Disparities Reduced

	Baseline Uninsured Rate	Q1 2014	Q3 2014	Q1 2015
		Change in Percentage Points from Baseline Trend		
Whites	14.3	-1.7	-4.7	-5.3
African Americans	22.4	-4.5	-7.2	-9.2
Latinos	41.8	-4.1	-5.9	-12.3

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 3/4/15. All models update the analysis from Sommers et al, *N Eng J Med* 2014. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, household income, state of residence. +/- a linear time trend.

The Unfinished Business: Medicaid Expansion and Other Uninsured (via Exemptions, the undocumented, etc.)



Effects on health and health care: *Diabetes Care, March 2015*

Original Research

Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act

- The number of Medicaid enrolled patients newly diagnosed with diabetes rose 23 percent in 26 states and DC that expanded Medicaid, versus 0.4 percent in non-expansion states
- Increased number of Medicaid patients being diagnosed and treated earlier
- “Can be expected to lead to better long-term outcomes”

Affordability: High Cost-Sharing for Consumers in Exchange Plans

	Silver			Bronze		
	Lowest	Highest	Average	Lowest	Highest	Average
Deductible	\$1,500	\$5,000	\$2,550	\$2,000	\$6,350	\$5,150
Pharmacy Coinsurance for Tier 3 and 4	10%	50%	40%	20%	60%	40%
Primary Care Visit	\$5	\$50	\$30	\$15	\$60	\$39

More than double the average deductible in an employer-provided plan

Components of “lower cost/smarter spending”

- Total costs of care, which will include
- Health care prices
- “Value” for money spent
- Utilization
- Technological advances
- Administrative expenses

Key Features of Our “System”

- With some exceptions, we have traditionally paid for “piece work” (units) of care, regardless of “value” (quality of care, health outcomes etc.)
- Fee-for-service still primary mode of most physician payment and much hospital payment (outside of Medicare)



Goals of Payment and Delivery System Innovation

Improving value and affordability

Old Model

Reward unit cost

Inadequate focus on care efficiency and patient centeredness

Payment for unproven services; limited alignment with quality

New Model

Reward health outcomes and population health

Lower cost while improving patient experience

Improve quality, safety, and evidence

New Goals for Value-Based Payment in Medicare and Private Pay



- Aim of Department of Health and Human Services: Tie 30 percent of traditional Medicare payments to alternative payment models by end of 2016 (was at 20 percent in 2014)
- Achieve 50 percent by end of 2018
- Private-sector Health Care Transformation Task Force, coalition of Ascension Health, Trinity Health, and other health systems, wants 75 percent of contracts to be valued-based by 2020

Top, Secretary of HHS Sylvia Mathews Burwell; bottom, Trinity Health CEO Rick Gilfillan

The ACA, CMS, and Delivery System Reform

CMS support of Health Care Delivery System Reform (DSR)



Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes

VBP, the ACA and the CMS Innovation Center

The Innovation Center portfolio aligns with delivery system reform focus areas

Focus Areas	CMS Innovation Center Portfolio
Pay Providers	<u>Test and expand alternative payment models</u> <ul style="list-style-type: none">▪ Accountable Care▪ Primary Care Transformation▪ Bundled Payment for Care Improvement▪ Initiatives Focused on the Medicaid▪ Dual Eligible (Medicare-Medicaid Enrollees)
Deliver Care	<u>Support providers and states to improve the delivery of care</u> <ul style="list-style-type: none">▪ Learning and Diffusion▪ Health Care Innovation Awards▪ State Innovation Models Initiative▪ Million Heart Initiative
Distribute Information	<u>Increase information available for effective informed decision-making by consumers and providers</u> <ul style="list-style-type: none">▪ Information to providers in CMMI models

CMS: Categories of “value-based payment”

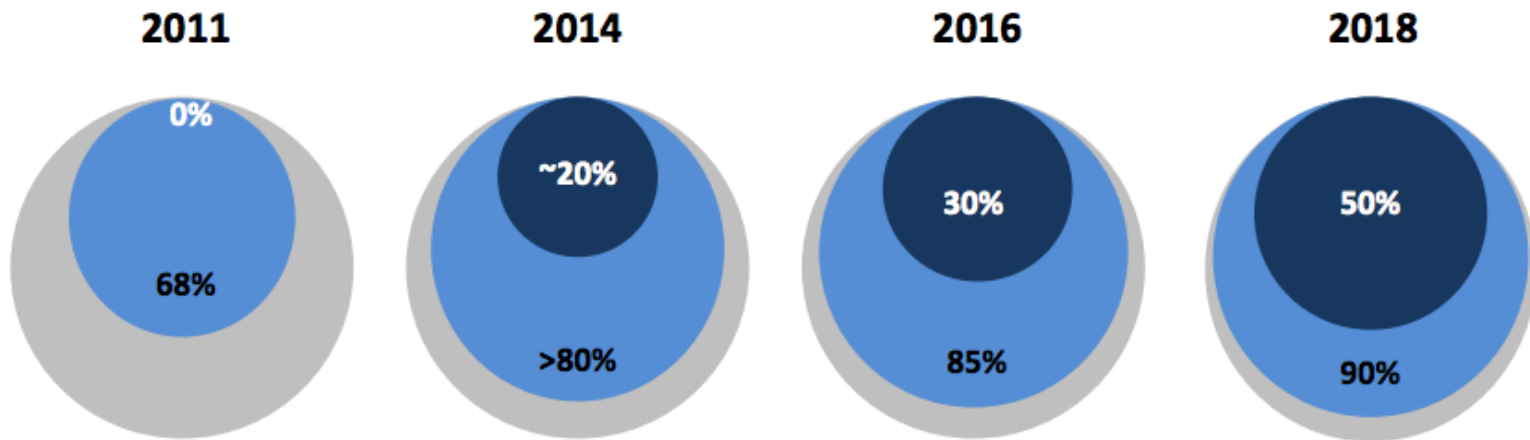
CMS has adopted a framework that categorizes payment to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Value	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-based Payment
Description	<ul style="list-style-type: none"> Payments are based on volume of services and not linked to quality or efficiency 	<ul style="list-style-type: none"> At least a portion of payments vary based on the quality and/or efficiency of health care delivery 	<ul style="list-style-type: none"> Some payment is linked to the effective management of a population or an episode of care Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk 	<ul style="list-style-type: none"> Payment is not directly triggered by service delivery so volume is not linked to payment Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare examples	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions / Hospital Acquired Conditions Reduction Program 	<ul style="list-style-type: none"> Accountable care organization Medical homes Bundled payments Comprehensive primary Care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3-5 Maryland hospitals

CMS: Further intentions to shift to value-based payment

Target percentage of payments in “FFS linked to quality and “alternative payment models” by 2016 and 2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)



Historical Performance

Goals

More to Come: The Medicare Access and CHIP Reauthorization Act of 2015

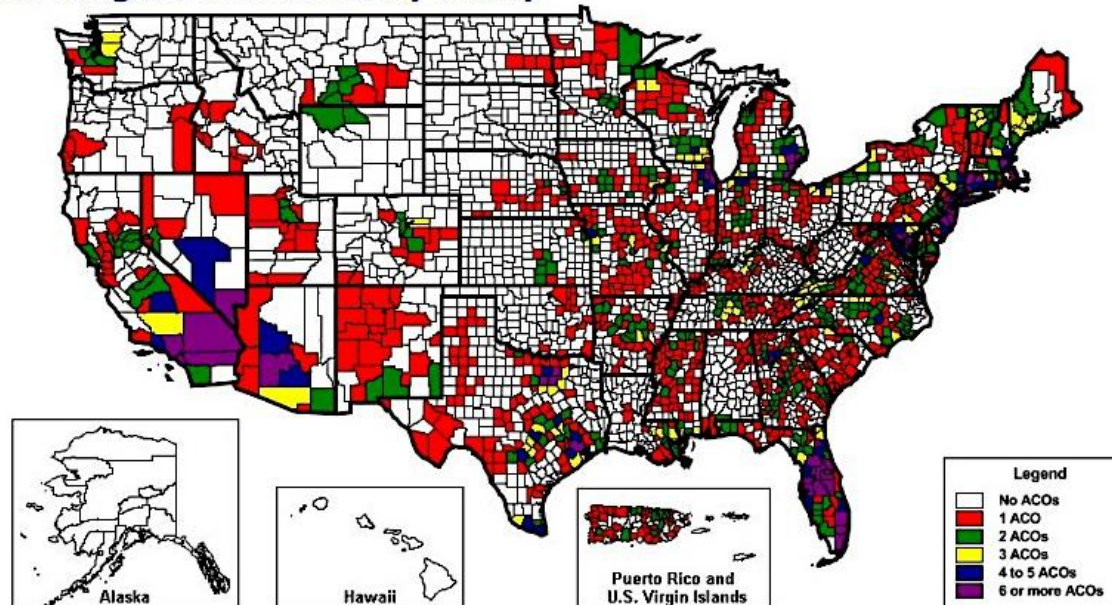
- **Bipartisan Replacement for Sustainable Growth Rate formula in Medicare Part B**
- **Permanently repealed SGR update mechanism, reformed the fee-for-service payment system through greater focus on value over volume, and encouraged participation in alternative payment models (APM).**
- **FFS payment updates of 0.5 percent through 2019**
- **Physicians in alternative payment models receive a 5 percent bonus from 2019 to 2024**

Growth of ACO's

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **424 ACOs** have been established in the MSSP and Pioneer ACO programs
- **7.8 million assigned beneficiaries**
- This includes **89 new ACOS** covering **1.6 million beneficiaries** assigned to the shared saving program in 2015

ACO-Assigned Beneficiaries by County



How It All Comes Together in Action

- Montefiore Medical Center's Pioneer ACO
- Received largest shared savings check from CMS - \$27.4 million for years 1 and 2
- 25,000 Medicare beneficiaries; additional 275,000 patients in commercial ACO-like contracts
- Predictive analytics to identify high-risk patients
- Care coordination interventions: physician house calls; healthy food deliveries for patients with diabetes
- Takeaways: new and different work force
- New and different focus on health



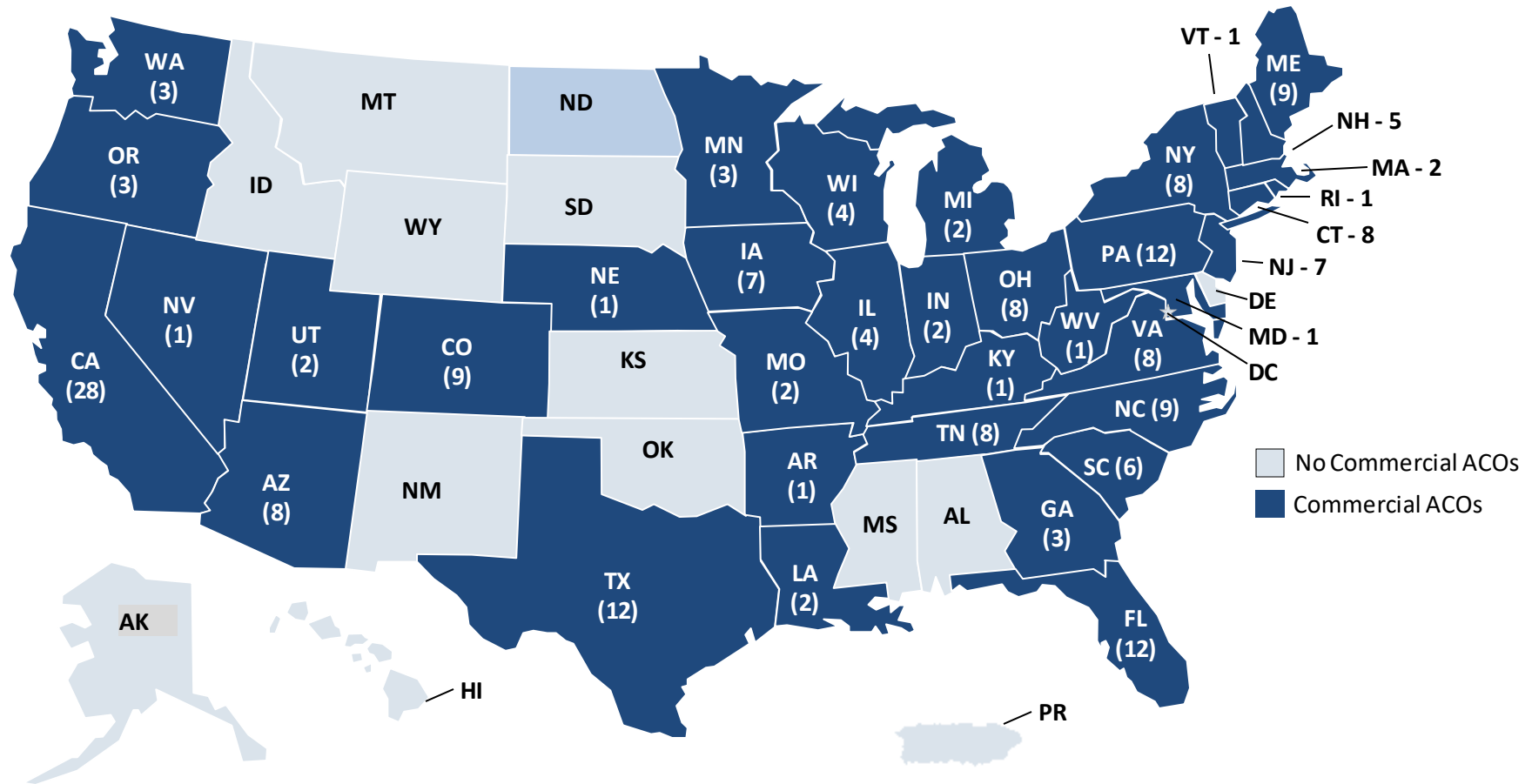
ACOs: Coming Attractions

- “Next Generation” ACO’s to begin in January 2016
- New financial model plus incentives for beneficiaries to join, including greater access to home visits, telehealth services, and skilled nursing facility services; opportunities to receive a reward payment for receiving care from the ACO and certain affiliated providers

Accountable Care Community Model

- “Social accountable care organization” – Medicaid demonstration project in Hennepin County, Minnesota (Minneapolis)
- 6,000 enrollees
- 45% have chemical dependencies; 42% have mental health needs
- 32% have unstable housing; 30% suffer from at least two chronic diseases
- Model includes assigning a single care coordinator to each member; also social workers; on-site behavioral health counselors; licensed alcohol and drug counselors; employment counselor

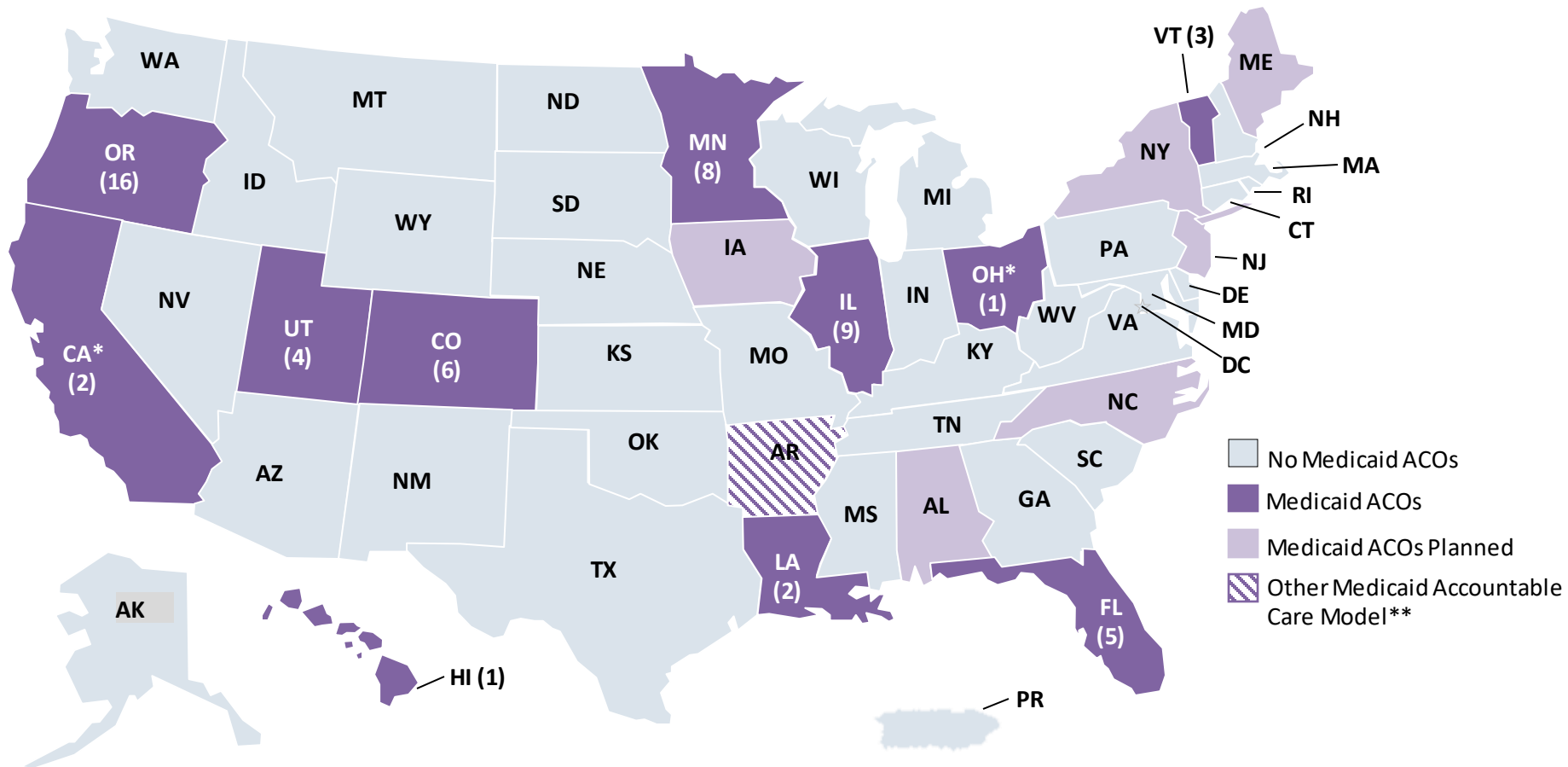
As of September 2014, Commercial Payers Are Sponsoring at Least 190 ACOs Across 36 States



ACO: Accountable Care Organization

Note: Map counts ACOs that operate in multiple states toward the totals for each of those states. ACOs that have agreements with multiple commercial payers only count once. This map was created using publicly available information. The actual number of commercial ACOs may vary depending on criteria used to define an ACO contract.

As of July 2014, Medicaid Programs in 11 States Are Sponsoring 57 ACOs with More Planned



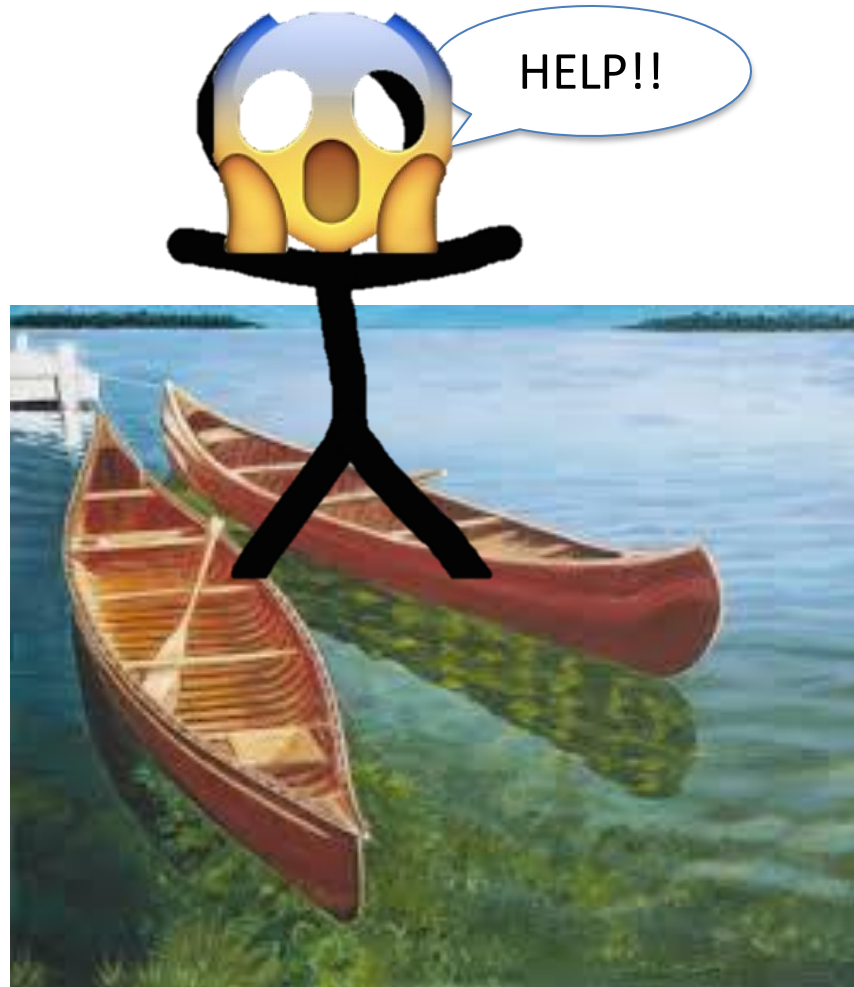
ACO: Accountable Care Organization

*ACOs only include pediatric Medicaid populations

**These models include programs that reward providers for high-quality and low-cost care (e.g., patient-centered medical home).

Note: This map was created using publicly available information. The actual number of Medicaid ACOs may vary depending on criteria used to define an ACO contract.

Issues: The “Foot in Two Canoes” Problem for Systems in Transition



Evolution Underway

- Role of ophthalmology in ACOs and other new payment and delivery models
- Role of vision care for adults in new payment and delivery models

The Bottom Line: Implications for Eye Care

- Tens of millions of previously uninsured Americans now have reliable and fairly affordable health coverage
- All Americans now have guaranteed access to coverage
- Medical and surgical eye care covered in all Qualified Health Plans, including cataract surgery
- Pediatric vision screening and care covered for all children up to age five

The Bottom Line: Implications for Eye Care

- New payment and delivery models should make overall costs more sustainable over time, barring other factors
- New care models leading to more comprehensive and holistic approach to health and health services
- Key question: overall approach to, and incorporation of, vision care as extension of eye care in new models
- Opportunities for prevention and life-course care in new models



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