PPACA(OBAMACARE)
What's Next for Ophthalmology

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Financial Conflicts

- Dr. Rich has no financial conflicts

Goals of PPACA

- Greater access
- Better quality
- Lower costs

Access

Increased Access

- PPACA (aka Obamacare) will expand insurance coverage for 33 million new patients by 2017; 11 million in 2014
- 22 million are patients of color with much higher rates of glaucoma and diabetes.
- Most will be enrolled in Medicaid and lower paying Health Exchange plans with high deductibles
- Undocumented residents –no coverage

Increased Access

- Ophthalmology has a serious workforce shortage (along with primary care, CV surgery, cardiology, general surgery)
- No chance of expanding training slots (418-423 new residency graduates/year)
- How will eye care professionals care for the influx of patients?
- Use of extenders-ODs & techs
- **Increased emphasis on remote monitoring and treatment of patients with chronic disease opens opportunities for new technologies.**

Quality

Quality

- Emphasis on value (quality/cost)
- Quality reporting-PQRS
- HIT-Meaningful Use of EHRs
- Value Based Modifier
- Comparative effectiveness

PQRS-2014

- Report on PQRS and you avoid all penalties (except MU of EHRs).
- 50% on three measures to avoid penalties in 2016 (2% for PQRS and 2% for VBM)
- Nine measures for a 0.5% bonus for 2015-impossible with claims. Doable with IRIS registry

Value-Based Modifier

- CMS issued resource use reports in 2012
- Public reporting of quality performance in 2013
- **CMS mandated to pay doctors differentially on the basis of their quality and efficiency of care**
- Modifier Applied to Payments for MDs providing high cost services with resource variation in 2015
- All MDs by 2017 and budget neutral
- % bonus/penalty unknown at this time-probably -2 to +2

The Value of IRIS™ Registry

Financial Benefits: Earn Incentives and Avoid Penalties

VBP	2013	2014	2015	2016	2017	2018
Meaningful use	-	-	(1)%	(2)%	(3)%	(3-4)%
Physician Quality Reporting System	0.5%	0.5%	(1.5)%	(2)%	(2)%	(2)%
Value-based modifier	-	-	(1)%	(2)% (proposed)	TBD	TBD
Total incentive/cuts avoided	**0.5%**	**0.5%**	**(3.5)%**	**(5)%**	**(6)% or more**	**(6-7)% or more**

The Value of IRIS™ Registry

Impact Per Physician, Assuming $300k of Medicare Revenue Per Year

- 2013: $1,500
- 2014: $1,500
- 2015: -$10,500
- 2016: -$15,000
- 2017: -$18,000
- 2018: -$18,000 to -$21,000

Comparative Effectiveness Research

- The ACA funded the Patient Centered Outcomes Research Initiative, PCORI, with $1.1B
- Costs can not be a factor in including research grants.
- The first two years were spent defining "patient centered" research.
- In 2014 PCORI will reach out to the ophthalmic community for research proposals (COAG, DR, AMD) that address CER, outcomes and disparities for populations at risk.

Cost

COST

- New payment models
- New coverage plans

New Payment Models

- PPACA created the Centers for Medicare and Medicaid Innovation-CMMI
- $11.1B dollars allocated for development of innovative approaches to the delivery of health care that must improve value (quality/cost), safety and outcomes.
- The Medicare Medical Home initiative pays providers fee for service augmented with a monthly per patient fee for coordination of care/remote management using technology and health care extenders. Huge opportunity for glaucoma, DR, AMD.

New Payment Models

- CMMI is now exploring monthly management fees for the remote monitoring and management of patients with HTN. Inputs are not regulated.
- Bundled payments. Current CMS bundled payments are centered around high cost, facility based services-CABG, joint replacement.
- These payments include testing, labs, surgeon and consultants fees, radiology, anesthesia, facility charges along with rehabilitation and post acute care for 90 days. Very complex and of little demonstrated savings.

New Payment Models

- CMMI in 2014 will pursue bundled payment models for cataract, glaucoma, diabetic retinopathy and macular degeneration. These bundles will include all office visits, testing, drugs, biologics, devices, surgical fees, consults for a defined episode of care. To protect patients there are mandated quality metrics that must be reported.

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Why would docs play?

- With cuts to FFS payments, the benefits to ophthalmologists include potential greater revenue for taking risk and the provision of high value care.
- The MD will be credited for participating in a Medicare alternative payment model that will enhance their base payments as part SGR reform.
- Ophthalmologists will become the become the "prudent utilizer/purchaser" of resources and will be stimulated to use the lowest cost, most effective interventions.

New episode of SRNVM

- Duration-2 years
- Bundled services:
  - Physician fees
  - Testing
  - Injections
  - Biologics
  - Drugs

Accountable Care Organizations

- Operational in 2012
- Organized by hospital and large MD IPOs
- Assume total care of Medicare beneficiaries.
- Primary care panel with a minimum of 5,000 patients.
- MDs paid on FFS.
- Two models: Shared savings(220) risk sharing in third year. Pioneer(33):risk sharing and already highly integrated.
- Anti-trust concerns?

ACOs and ophthalmologists

- Hospitals are aggressively hiring physicians: 40% of all residency graduates; 45% of all practicing cardiologists? Why?
- The hospital employed physician's fee for a service provided in an off campus office building is 44% greater than that paid to a doc for the same service in private practice Those specialties that generate the most revenue for hospitals are the most attractive. Fortunately, ophthalmologists are one of the worst sources of $$ for hospitals.

ACOs and ophthalmologists

- ACOs must provide all services to Medicare beneficiaries.
- Eye care services will be assigned to community docs who contract with an ACO.
- **DO NOT SIGN AN EXCLUSIVE CONTRACT!**

ACOs

- 70% of Medicare in FFS; 30% in Medicare Advantage
- 10% of Medicare FFS patients in ACOs
- In 2012, 222 Shared Savings Model and 33 Pioneer

Pioneer ACOs: One Year Results

- O.5% savings while development costs were 2% of operating revenues-not an attractive business model with $2M in start up costs!
- 14 lost money
- Only 13 received money from CMS
- Equivocal quality improvement after demanding relief from 33 measures
- 9 withdrew from Pioneer

Two year results of Pioneer and Shared Savings ACOs

- $417M!!!
- However, this represents a savings of .022% of total expenditures for comparable FFS Medicare-a rounding error.

Why?

- Faulty business model
- The ACOs starting costs were their historic costs which were already lower because of care integration. Should have used regional costs
- Onerous quality reporting
- Imagine the results for shared saving where there is no integration or control of patient flow?
- Prognosis as implemented-grim.

New Coverage Plans

- Since 2005 the most impactful non-recession factor in lowering the rate of inflation in health care costs is the use of narrow networks, higher deductibles/co-pays along with tiered pharmacy plans.
- There are four plans offered on the Federal and state exchanges. The vast majority of patients are enrolling in the two lower tiers with the lowest premiums but with deductibles up to $1200 for individuals and >$12,000 for a family of four with yearly incomes of $53,00. *Wharam, Ross-Degnan and Rosenthal, NEJM, Oct. 17, 2013*)

New Coverage Plans

- A great risk for lower utilization of care for chronic diseases.
- The difficulty of collecting payments at time of visit will result in problems with cash flow

Summary

- Obamacare will result in expanded coverage for the uninsured. The quality metrics are not meaningful to ophthalmologists. The new payment models have questionable chance of reducing costs. However, the use of narrow networks and high deductible plans will continue to slow health care spending at the expense of the delivery of chronic care and with the negative impact on physician cash flow.