VISION SOURCE

The Changing Landscape of Healthcare in America

Frequently Asked Questions

1. **Q**: **What are the key factors that will drive increased costs for employers, leading them to explore innovative programs for employee medical programs?**

   A:

   - *No ceiling on lifetime expenditures for an individual. Certain industry insiders have already noted a rapid increase in the number of catastrophic claims with costs exceeding previous limits.*
   - *Expansion of coverage for mental health benefits.*
   - *Guaranteed issue, lack of underwriting relating to denial of coverage.*

2. **Q**: **Why will Medicare Advantage plans impact our practice?**

   A: *Today, there are 51 million Americans eligible for Medicare, with an additional 10,000 individuals "aging in" each day. A growing number of these 51 million people have opted for a Medicare Advantage (MA) plan as an alternative to traditional fee-for-service Medicare. MA plans provide more financial protection for a senior but typically narrow their choice of providers. United Healthcare and Humana are the leading players in the MA space. With MA, the risk of coverage has shifted from the Federal Government to the commercial plan as the plan receives a fixed monthly payment (capitated revenue) from the government for each covered life. MA plans seek to achieve 5 star ratings (quality scores driven by HEDIS measures) in order to expand the time period during which they can market their programs (beyond the October 15 – December 7 annual enrollment cycles). Our clinicians can play a key role in the achievement of two HEDIS measures (government exams for patients with diabetes).*

3. **Q: Will we see more seniors moving to MA (Medicare Advantage) plans?**

   A: *Yes, in fact there is already significant movement in that direction. Of the 51 million Americans covered by Medicare, 27% are in MA plans now. There are currently over 3,000 MA plans in the United States with over 200 more expected to file by the end of 2013.*

4. **Q: What are some key healthcare system trends that we should be aware of moving forward?**

A: *Let's look at the issues and what the outlook is for each of them:*

Consolidation: Hospital M&A activity increased in recent years and the trend is expected to continue in the foreseeable future.

Employers: Employers are seeking innovative, direct arrangements with health systems (Commercial ACOs)

Physicians: Fifteen years ago nearly two-thirds of physicians were independent. By the end of 2013, it is estimated that this figure will decline to one-third. These large physician groups will begin to take risk and participate in gain sharing programs to enhance reimbursement. As these groups manage risk, quality and population health in accordance with HEDIS measures and evidence-based medicine, they will need to create collaborative care models with optometry.

Quality & Cost Initiatives:

-Shared Savings (Medicare ACO's)

-ACOs must manage patient populations to achieve certain quality metrics and cost less than a risk adjusted benchmark in order to receive a portion of the savings

-Additional ACO models and other quality initiatives to be explored through the CMS Center for Medicare and Medicaid Innovation (CMMI)

-Bundled Payment

-ACA pilot to bundle pre-acute, inpatient, and post-acute payments, with one payment -for services performed before, during and 30 days after in-patient care

-Pay-for-Performance

- Value-based incentive payments to hospitals, with payments based on scores and performance publically reported

-Reimbursement based upon preventable Medicare readmissions and penalties for hospital acquired conditions

Access to Data

-Increasing prevalence of EMRs alters how data is managed and analyzed

Managed Care Trends

-Hospitals acquiring health plans

-Partners HealthCare acquired Neighborhood Health Plan; Catholic Health Initiatives bought Soundpath Health

-Health plans increasing footprint by purchasing physician practices

-WellPoint acquisition of CareMore, an integrated health plan and physician practice to bolster MA capabilities

- Under the CMMI dual eligible demonstration, 2 to 3 million dual eligibles will be migrating to managed care over the next few years

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5. **Q: Will we experience continuing pressure on reimbursement levels?**

***A:** In a word, YES! Here's the dynamic. CMS (Medicare and Medicaid) only has so much money to budget for each individual life covered, and because of the ACA, the system will have tens of millions of incremental lives added. Additionally, each commercial insurance company collects a finite amount of premium per life they insure and employers are looking for innovative ways to bend the cost curve. Out of these dollars, budget from the federal government for CMS and premiums collected for the commercial insurers, a certain amount is taken off the top line revenue to cover marketing, administrative costs, reserves for overruns, etc. The remainder is available to pay claims.*

Because CMS and commercial carriers want to get out of the risk business, they are going to pay the ACO, PCMH, and MA plans to accept the financial risk and responsibility for providing care to the covered, entitled, or insured as the case may be. Rest assured, CMS and commercial carriers will pay as little as possible to accomplish this. Once the ACO, PCMH, and MA plans receive their payments from the CMS and commercial carriers they must retain a certain amount of that money to cover their marketing, administrative costs, reserves for overruns, etc., which of course leaves less to compensate providers or provider organizations to deliver patient care. For every layer of "management" between the payers (CMS and commercial carriers) and the health care providers, there are fewer dollars left for patient care. Reimbursement levels to individual health care providers will also be influenced by performance in the areas of outcomes and efficiency. The HEDIS scores will also be a determining factor in determining the reimbursement levels of individual doctors. The cost pressure will be felt by all providers of healthcare, and this is one of the many reasons that your peers and the leaders of Vision Source® believe 'now is the time' to band together to protect the long term viability and success of our clinicians.

6. **Q: How much money will potentially be at risk, depending how the government implements the system over the coming years?**

***A:** $200-400B over 10 years from Medicare, Medicaid, and ACA would be at risk as Congress identifies additional healthcare savings to pay for: Adjustments to the sequester, future doc-fix legislation, deficit reduction efforts*

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7. Q: What are some examples of likely healthcare reimbursement reductions that could be seen?

A: *Provider specific savings:*

-Approximately $100-200B over 10 years mainly from Medicare Part A providers and some from Medicare Part B

-Up to $100B from hospitals in reductions to Medicare bad debt payments, reductions in graduate medical education payments, reductions in DSH payments, and market basket reductions

-Up to $100B from all other Medicare providers

-Some risk to Part D through the application of Medicaid rebates to the duals in the program

Remainder of savings from Medicare and Medicaid structural reforms:

-Medicare means testing including adjustments to premiums for Parts B and D

-Medicare eligibility age could rise to 67

-Reforming and streamlining deductibles and co-insurance across all of Medicare

-Dual eligible reform: putting lives into managed care

-Copayments for hospitals, post-acute, and prescription drugs

-Chain-weighting CPI (CBO estimates Medicare, Medicaid and CHIP save ~$28B from 2014-23 or

-~$5B from 2014-18; Social Security saves ~$127B from 2014-23 or ~$31B from 2014-18)

-Limitations to certain types of supplemental insurance

-Medigap reform: eliminating first-dollar coverage

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8. Q: Will provider relationships with commercial insurance carriers change like it is with Medicare and Medicaid?

A**:** *Yes, relationships between all physicians, commercial insurance carriers, and health care systems will change as well. If you think of Medicare and Medicaid as "insurance," the same dynamic will drive change in commercially available insurance just as it will in the CMS (Medicare and Medicaid) programs. The dynamic is the desire of CMS as well as commercial insurance carriers to limit their risk. This is where the Accountable Care Organizations (ACO), Patient Centered Medical Home (PCMH), and Medicare Advantage (MA) plans come into play.*

The companies, hospitals, and health care systems who license themselves as an ACO, PCMH or MA, and compete in this market place will be trying to sell themselves to the CMS, commercial insurance carrier or self-funded employer as the best alternative to assume the financial risk for,

and provide comprehensive medical care to specific patient populations in local or regional geographic markets. These defined populations will include the lives formerly insured or covered by large, self-funded employers and commercial insurance carriers, Medicare, and Medicaid. To acquire these specifically defined populations as covered lives, the ACOs, PCMHs, and MA plans will bid for the responsibility of providing increased access decreased cost, and high quality medical care to the covered lives.

By contracting with an ACO, PCMH, or MA plan, CMS, commercial insurance carriers and large employers will pass the risk of rising or unexpected healthcare costs to those entities. The result is that the CMS and commercial insurance carriers will then have a fixed line item expense per covered life and the ACO, PCMH, or MA plans will be managing population health with a strong incentive to deliver the right medicine, to the right patient, at the right time.

9. **Q: How will ACO (Accountable Care Organizations), PCMH (Patient Centered Medical Homes), and MA (Medicare Advantage) plans impact our world?**

   A: *ACO's, PCMH's, and MA plans will become risk taking entities that contract with health care systems, provider networks, and some individual clinicians to deliver patient care. As a result, the ACO, PCMH, and MA plans will become important channels from which your patients and your payments will flow.*

10. **Q: Why are the initiatives we are working on in certain markets important to health plans and physician groups?**

    A: *The initiatives Vision Source® is working on in certain markets are not only important, but critical to Vision Source® members everywhere. To physicians in general, health care plans, accountable care organizations (ACO), patient centered medical homes (PCMH), as well as the medical directors, ownership, and management of those entities, eye care is a very, very small part of the overall health care spend. To them, optometry is largely an unknown quantity. There is confusion about optometry, its scope of practice, and our clinical ability. It is likely that there are decision makers involved with each of the constituents mentioned above who have never been to an optometrist, never referred to an optometrist, nor co-managed patients with an optometrist.*

11. **Q: What is it the medical directors, management and primary care physicians ("PCPs") within these health care organizations are seeking?**

    A: *Simply put, they need an efficient, cost effective solution to a problem. The problem is that the patient populations they manage need convenient and cost effective access to medical eye care delivered in a collaborative manner. The pilot programs we are pursuing are being undertaken because Vision Source® member doctors can be the solution to an important problem.*

The pilot programs are critical to Vision Source® members everywhere because Vision Source® doctors are forging relationships with physicians and decision makers within the health care companies by demonstrating convenient access to care, clinical expertise, information sharing with the PCPs, and doing so in a more timely and cost effective manner.

The medical directors and other decision makers of the health care companies that Vision Source® members are working with have the ability to expand the relationship with Vision Source® members in additional markets that they serve. In addition, these individuals may also influence their peers in other health care organizations that serve other markets across the country.

Success in early pilot programs also provides Vision Source® with a message to share within the healthcare community. The message is that Vision Source® and it's member doctors have already demonstrated the ability to provide medical eye care in a collaborative environment, while improving patient satisfaction, and doing so in a more timely and cost effective manner. This message will get the attention of those who control patient flow in the future, and help insure that those patients are flowing through your Vision Source® practice.

12. Q: What are the most important elements of the Vision Source® value proposition?

A: *The most important elements of the Vision Source® value proposition relative to the ACA are the strengths of our local leadership, over 2800+ locations with some of the most influential doctors in the industry, and our presence in all 50 states. While this gives us an advantage over smaller groups, remember that the ACO, PCMH, and MA plans will serve specific populations in local and regional areas. Because of this, while we may have very impressive coverage nation-wide, we may not have the concentration of members in certain markets to be competitive enough to secure the access to the patients represented. This is why the VS Refer a Friend Program is so critical. We need to increase our coverage more, in order to be more competitive in all local markets, and we want to become competitive by adding Vision Source® members that our existing members respect. The strategy of continuing with large territories in an effort to keep competition out, is now and will become more and more a disadvantage to members individually and Vision Source® as a whole. It will be also be critical that as a united front, we are easy to work with and will be willing to have our doctors assist with helping to build new workflows for getting patients scheduled and getting information back to PCPs after the exam. In essence, we will need to operate as if we are "one entity" while maintaining the level of independence that our members desire and the new marketplace will allow.*