



What do ophthalmology practices stand to gain or lose as ACOs begin participating in the Medicare Shared Savings Program?

POINT

Ophthalmology is ahead of the curve

ACOs are going to become part of our lives in ophthalmology, whether we like it or not. The specialty of ophthalmology is used to dealing with regulatory challenges head on. It will not be a paradigm shift for us to keep our ears open and work hard to ensure we have a place at the table where decisions are being made.

Ophthalmology is at the forefront already in reporting quality measures, monitoring outcomes, moving to electronic health records and advanced technology swiftly, and taking advantage of our data to further care and position ourselves with patients and payers.



Laurie K. Brown

Story continues below ↓

ADVERTISEMENT

SEE 2 DAYS OF LIVE SURGERY!

17th Annual Joint Meeting of

OCULAR SURGERY NEWS
EUROPE EDITION



RICER
Ricerca in Oftalmologia e Cornea e Strabismo

SOI Società Oftalmologica Italiana
Associazione Medici Oculisti Italiani
L. 15/10/1971 n. 3585 del 1971

*Held during the 10th International Congress
of the Italian Society of Ophthalmology*

May 25-26, 2012
Milan, Italy
OSNSuperSite.com/Italy

We are early adopters of new paradigms that will be necessary with this initiative. We have anticipated that we will be measured and evaluated on our outcomes in the future, and the future is here.

With all this ammo, we will need to market ourselves to the ACOs we wish to join as well as the public.

We will not be limited to membership in only one ACO like primary care physicians. While it is true the size of our marketplace may mean it is feasible to belong to only one ACO, if there is more than one in our area, we specialists will be free to lobby for membership in multiple ACOs.

Reimbursement for us, at the start at least, will be the same fee-for-service reimbursement we are receiving now. We need to work to protect it, perhaps with more focus at the local level besides the national work our societies do so well.

While the regulations are not finalized yet, it seems the date of Jan. 1, 2012, is cemented. We need to remain vigilant, educated, active and optimistic while navigating these new waters, and we are very good at that.

We intuitively look for the win-win, gaining expertise in our area to keep us at the top of our game in providing the best outcomes for our patients while working as efficiently as possible, which should serve us well in this arena, too.

I cannot say I agree that lower quality care is a significant problem in ophthalmology, nor the duplicative services as outlined in CMS's description of fragmented care that ACOs are anticipated to correct. CMS also states that providers lack financial incentives to coordinate care. I disagree. I believe physicians desire to provide the best care possible to their patients and be paid appropriately for their work.

Progressive physicians such as mine invest in new technology when it makes sense for patient care by assisting in slowing disease progression and improving outcomes for patients. We invested in healthcare IT when it made us more accurate and efficient, saving all health care stakeholders time while improving care ultimately by making information more readily available to all care providers. Truly, we did not know about any government incentives in 2004 when we made the commitment to electronic health records. We knew it was logically the most advantageous way to deliver care for the future, and we desired the benefits available as soon as possible.

Per CMS: "ACOs would make providers jointly accountable for the health of their patients, giving them strong incentives to cooperate and save money by avoiding unnecessary tests and procedures." I do not know of ophthalmologists performing unnecessary tests or procedures. In my view, this system would be of far greater value by applying it to those found to be abusers in this area, but that is a moot point now.

We are good at marketing ourselves and explaining why we are better. Refractive surgery activities have helped form our public relations efforts thus far, and we need to continue building on those skills. We have already saved the system millions of dollars in lower-cost outpatient surgery and proven we can do it better than higher-overhead hospitals. We have worked with new technology to treat and slow disease progression to the point that we are actively helping reduce visual morbidity and the systemic costs associated with it.

The Medical Group Management Association reports "excessively high start up costs relative to small and uncertain financial benefits and substantial regulatory risks" with the proposed ACO model. I agree. In Oregon, our governor believes the nation's "fiscally unsustainable" health care system is really a problem with how health care is delivered. Our politicians are hoping for reduction in overuse of the hospital ERs, overuse of the ICUs, reduction of brand name drug use and an increase in preventive care. In contrast to an accountable care organization, a "coordinated care organization" seems the better solution. In my mind, if work has been done, meaning appropriate care given, the providers should be paid appropriately. Misusing care providers is inordinately expensive, so directing patients more appropriately and staving off serious health problems when able seems to be the best option for the problems we have today.

CMS states that ACOs are modeled on integrated delivery systems (HMOs) with primary care physicians as gatekeepers. Capitation is mentioned in these discussions, which only served to deny care in ophthalmology when doing so was popular. In our specialty, no good came of such gatekeeping. Steve Lieberman, a visiting scholar at the Engelberg Center for Health Care Reform at the Brookings Institution and the president of Lieberman Consulting Inc., explained that ACOs aim to replicate "the performance of an HMO" in holding down the cost of care while avoiding "the structural features that give the HMO control over [patient] referral patterns," which limited patient options and created a consumer backlash in the 1990s. So far, there is direct language in the ACO proposal ensuring that patients will have no limitation on access to their choice of specialists as well.

Laurie K. Brown, COMT, COE, OSA, OCS, is practice administrator for Drs. Fine, Hoffman, Packer in Eugene, Ore. She serves on the editorial board of OSN's sister publication Premier Surgeon. Disclosure: Ms. Brown has no relevant financial disclosures.

COUNTER

Ophthalmology faces hurdles, risks

Proposed rules implementing new accountable care organizations do not hold a lot of promise for ophthalmologists. Whether you are part of the ACO provider panel or contracting to provide eye care to its beneficiaries, a very high bar has been set in order to achieve the necessary minimum shared savings by the ACO. There are 65 quality measures that must be reported on, and at least 50% of the physicians in or providing service to the ACO must be obtaining meaningful use of an electronic health record.

The CMS estimates that the start-up for smaller physician-led ACOs that are not already providing many of these requirements could be upward of \$2 million. Smaller ACOs have only 2 years to be able to obtain a minimum savings rate before they are subject to risk sharing.

With the uncertainty of how patients will be referred to specialists, ophthalmologists need to closely examine any contract that could limit or exclude them from access to their patients. This is especially true under any aspect of shared risk that could be attributable to ACO-contracted providers. Likewise, physicians who contract with ACOs could be subjected to sanctions or penalties by the ACO if it considers care provided by the specialist as outside of benchmarks it has set for evidence-based medicine. There could also be significant difficulties in providing the care coordination and the Hierarchical Condition Category coding information that the ACO will require of ophthalmologists if EHRs are not interoperable.

Only larger multispecialty ophthalmology practices that are already in mature, integrated network areas may be able to navigate such murky waters. If that is not the case for you, then you may want to steer clear.

Cherie L. McNett is Health Policy Director for the American Academy of Ophthalmology. Disclosure: Ms. McNett has no relevant financial disclosures.



Cherie L. McNett