New Governmental Mandates for Ophthalmic Care

How can we control costs while providing quality care?

BY RONALD L. FELLMAN, MD

What impact will the Affordable Care Act (ACA) have on glaucoma care? No matter what comes down from the Capitol, we ophthalmologists must be incredibly efficient in order to stay profitable. Managerially speaking, the key is for us to be rock stars in demonstrating value to payors for an urgent, blinding disease.

DEMONSTRATING VALUE

The new paradigm from the ACA is a switch from fee-for-service to value-based medicine with bundled care. How are we going to show value to payors in this new system? We have never done so before, and most of us do not even know our cost of doing business. The Physician Quality Reporting System is just a start. The new health care system will involve much more than our reporting on the optic disc and percentage of IOP reduction. The American Glaucoma Society (AGS) and American Academy of Ophthalmology (AAO) are determining how to demonstrate value and simultaneously improve care (through the upcoming Intelligent Research in Sight [IRIS] Registry, one hopes), but how do we demonstrate value in glaucoma care?

A former colleague of mine, Richard J. Starita, MD, who unfortunately left practice far too early in life due to illness, always picked up the patient's chart when he or she died and asked one question: "Did they die seeing?" If so, he would say, "I did my job." Is that the value baton the payors are looking for us to pass? Maybe it should be, considering a recent report from Sweden. The study found that 48% of glaucoma patients were blind in one eye at the time of death, while 16% were blind in both eyes.[1]

The AGS and the AAO have a formidable task. We do not have a cure for glaucoma, yet we must show our worth in treating this sometimes enigmatic disease. We have made great progress in the latter regard, as exemplified by our specialty's response to the Eddy-Billings report, which stated there was no evidence that treating glaucoma was beneficial.[2] Those of us in the field at that time proved the health care and taskforce agencies wrong with multiple heavy-hitting randomized studies demonstrating that glaucoma treatment does prevent or delay vision loss, and we will continue to perform studies that provide evidence-based medical outcomes in glaucoma care. We all thank many of the founding members of the society who initiated these landmark studies.

PREPARING FOR AN INFLUX OF PATIENTS

One big plus of the ACA is a significant improvement in preventive services, but I was saddened to see that glaucoma screening did not make the list. I hope that the 20 to 30 million uninsured who will become insured over the next decade will make up for the lack of screening, because they will now be a part of the system.

We have to be ready for a potential influx of patients, because we will no longer hear, "Doctor, my insurance will not pay for my preexisting glaucoma." Some physicians will opt out of Medicaid because the reimbursement is so low. No doubt, many of the increased coverage lives will be on the Medicaid rolls, so what will happen to those patients? I am not sure, but we have to be ready to take on more glaucoma patients while cutting costs. We have to know our costs of doing business, because capitation will become a bigger part of the picture. If we know our costs of treating glaucoma at various stages of the disease,

we can better determine how to successfully negotiate our livelihoods. In this regard, the glaucoma staging codes enacted by the AGS and AAO should be beneficial in determining not only our costs of doing business but also in providing better care based on disease state.

What about doctors who manage patients with neovascular and developmental childhood glaucoma? How will these practitioners fit into the landscape of the ACA? Their outcomes are not always the best, yet this type of care, which involves a great deal of compassion, is time consuming and not very profitable. How will we show payors the value of compassion? I seriously doubt there will be a value-based modifier to reflect it.

SHAPING THE SYSTEM

The ACA is an effort to cover more lives, but it is our job to mold the system to provide the greatest care. I am game. Nobody can save patients' vision better than us, and I do not want an ophthalmic armchair quarterback who has never taken a sack—be it a suprachoroidal hemorrhage, aqueous misdirection, epithelial downgrowth, childhood glaucoma, or something else—telling me what is best for my patient. Yes, the health care system needs significant improvement, and I, too, am sick of blindness. The AGS needs to think about methods by which to optimize care while also reaching out via programs like IRIS, which should allow the rapid dissemination of vision-saving knowledge through the click of a button. When we get to that point, we will start to save money by more efficiently treating glaucoma. Current AGS President Kuldev Singh, MD, MPH, is leading the charge, and I am proud to be one of his soldiers.

Let us imagine our practices are taking on increasing numbers of glaucoma patients. How do we control costs while providing quality care, not cutting it?

Step 1. We learn who is at greatest risk of blindness from glaucoma, and we concentrate our resources on these patients. Doing so should free up time and dollars versus treating glaucoma suspects who will never develop the disease. In other words, we target the populations at greatest risk of glaucoma-related blindness and educate them about the disease.

Step 2. We identify in advance which surgical procedure is the best choice to safely lower a particular patient's IOP and prevent further vision loss to glaucoma. We need to get it right the first time, which requires better diagnostic techniques. (Is the collector system salvageable, which would indicate a canal-based procedure?)

Step 3. We further perfect our blebless surgical procedures for glaucoma.

Weigh in on this topic now!

Direct link: https://www.surveymonkey.com/s/GT17

How would you characterize your practice's response to the potential influx of patients owing to implementation of the Affordable Care Act?

A. Prepared
B. Currently preparing
C. Will respond when an increase in patients occurs
D. Not expecting to change

Step 4. We develop clinical strategies to see many patients efficiently with a system based on value, not just fee for service. This change will come down to efficient electronic health record systems, a never-ending process of improvement.

Step 5. We continue to search for and disseminate the best practices in glaucoma, a compendium of knowledge popularized by Richard Wilson, MD, when he was president of the AGS. I think this will happen through IRIS, the AAO, and the AGS.

Step 6. We increase the number of fellowship-trained glaucoma specialists to handle the refractory cases, which will become more prevalent as society ages.

Step 7. We create the most efficient staff model that enables us to get through the day without burning out.

Step 8. We save money by performing gonioscopy to diagnose glaucoma correctly the first time around. Yes, I am ending this article with gonioscopy. At least I truly know something about that! ■

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1. Peters D, Bengtsson B, Heijl. Lifetime risk of blindness in open angle glaucoma. *Am J Ophthalmol.* 2013;156(4):724-730.
2. Eddy DM, Billings J. The quality of medical evidence: implications for quality of care. *Health Aff (Millwood).* 1988;7:19-32.