*From: The NHOA Third Party Committee*
*To: All New Hampshire Optometric Association Member ODs*

*In 2013 the NHOA Board of Directors voted to retain Helms and Company, a Concord-based health policy company, to help us understand the changing health care environment in New Hampshire. Drs. Dave Caban and Keith Emery met with David Cawley, a principal of the company, in January 2014. The following summarizes their conversation.*

*Although it's a long summary, I recommend all NH optometrists make the time to read this piece so you can better understand the challenges that lie ahead.*

Friday, January 31, 2014
David Cawley. Senior Consultant, Helms and Company
Dave Caban OD, Keith Emery OD. Representing the NHOA

Meeting summarized by Dave Caban. Editorial comments by others are so noted and *italicized*.

The meeting began with a review of current health care delivery trends in New Hampshire. Mr. Cawley stated that there were two very different balls to keep our eyes on.
1. Select network organizations
2. Accountable Care organizations

At this point in time Mr. Cawley pointed out that it is unclear as to how either of these will fit into the New Hampshire healthcare exchange products in 2015 but did suggest that it made sense to think of "select networks" as being driven with/by insurance companies and ACO's as being built by providers.

Currently there are two select networks in New Hampshire:
1. Elevate Health which is a partnership of Harvard Pilgrim, Dartmouth Hitchcock, Eliot Hospital, Southern New Hampshire Medical Center in Nashua, Cheshire Hospital and Mary Hitchcock in Lebanon (tertiary care only). Mr. Cawley will not be surprised if Elevate Health becomes the next health insurance exchange product probably debuting in 2015. Elevate currently covers a very small number of lives in NH.
2. Anthem Pathways, which is already Anthem's Health Exchange product. It includes about 16 of the 26 hospitals in New Hampshire and their physician networks. There appear to be around 12,000 NH residents currently insured by the exchange.
Harvard Pilgrim will likely be offering a HIX product starting in 2015; establishing a viable hospital network is key to getting started.

Mr. Cawley stated that Elevate Health, in which providers are "part owners", has entirely different motives from the Anthem Pathways exchange. The Elevate Health product is really being designed and delivered by the providers who want a product that they can control themselves. Their plan is to take much of the 20% that the insurance company keeps for administrative purposes and use it for the benefit of the providers. Anthem, on the other hand, is strictly an insurance company whose intention is to maximize profit for the shareholders while delivering a health care product.

When asked what is the advantage of a select network he replied that organized physicians (primarily MDs) are convinced that insurance companies are taking too big a piece of the premium dollar. They believe that they can do as good a job without sharing so much money with the insurer. They are willing,

as providers, to take less reimbursement per unit of care while at the same time increasing their volume, becoming more efficient and sharing in the profits (if any) that are left over at the end of the day. Therefore, the likelihood that Elevate Health will stay with a select group of providers is higher than Anthem.

He also pointed out that Anthem started a "site of service" plan about five years ago. So for example if you are a subscriber to an Anthem health insurance product you may receive a cash incentive, a lower co-pay or less balance billing by going to a specific lab. A distinction Mr. Cawley made was the following; Anthem has made a conscious decision, at least up to now, to not move the "site of service" concept to small dollar provider groups such as physical therapists (we assume optometrists would also be a "small provider group"). That means that even though they might be able to provide lower compensation to a specific physical therapy facility, versus what they pay a hospital, they have chosen not to do so. Apparently, Anthem believes that it's not worth the battle over such a small piece of the "medical spend" as compared to radiology or surgery. With that in mind, he thought that optometry might be able to escape the "select" approach since we are such a very small part of health care dollars that they pay out and it's not worth the complaints from patients by limiting the provider network. But, he made no guarantees and felt that it is a correct decision to try to control/influence our own fate from here.

There is a third potential player in the healthcare exchange for 2015. That would be Minuteman Health out of Massachusetts which is a co-operative healthcare product. Federal money is available to capitalize not for profit insurance companies which are run by the subscribers. Minuteman is an example in Massachusetts of such an approach and they will likely expand into New Hampshire. Mr. Cawley was going to look at Minuteman in Massachusetts to see how optometry is treated there. The cooperative concept has subscribers running the company by voting for boards of trustees. Fewer than 50% of the elected trustees can be health care professionals; the remainder must be individuals who have the business sense to run a cooperative healthcare network. Minuteman's network is comprised of the lower cost hospitals and provider groups in MA (you won't find Mass General or Children's Hospital). Specialty care is farmed out on an as needed basis (only when the services are not delivered in network) and premiums are kept low by operating in this fashion. If Minuteman expands into NH, which is being discussed, it is unclear whether they will only talk with the less expensive delivery systems or with all providers.

*Dave/Keith comments: Minuteman is very hard to call right now. They have had discussions with a couple of hospitals and the Insurance Commissioner would love to see them as a player offering a product on the Exchange for 2015 but they would need a statewide network. From the hospital's perspective however, this is a hard sell since the current participating hospitals (currently with Anthem) agreed to accept Medicare reimbursement with the anticipation of increased volume due to exclusivity. At the present time, neither Harvard nor Minuteman is offering exclusivity so why should the hospitals play ball with either of them?*

The next major discussion concerned Accountable Care Organizations. There are currently two Medicare ACOs in New Hampshire.

1. Pioneer ACO
2. Concord Eliot ACO

Pioneer ACO is comprised of Dartmouth Hitchcock, St. Joseph's in Nashua, Exeter Hospital, CMC, New London and Cheshire Hospital. There are approximately 60,000 to 70,000 lives serviced by this ACO. This ACO has both upside and downside risk. That means that the total cost for patients attributed to the ACO are measured against a target and if all of the money is not spent on the patient the remaining

balance is split between the ACO and Medicare. If there are cost overruns the liability is also shared and split between the ACO and Medicare.
Pioneer ACO is not selective; the patient can go to any Medicare provider. However, the ACO has the incentive to drive their subscribers to the best (in our case) eye care provider. That is, a provider who delivers the necessary services most cost effectively. Cost effectiveness does not necessarily mean low per unit cost but does mean the best value for the total cost of the care (glaucoma treatment for example).

*Dave/Keith comments: Dartmouth does currently have two satellites; one is in Keene at the Cheshire hospital. This an OD/MD practice consisting of one full scope OD and three OMDs. The second is in Manchester at the DHMC clinic on Wellington road. There is only one OD there with no OMDs. ….Dave Cawley was told that a proposal for an eye care network might be of interest to DH (but there is also risk to this). Something like a select OD/OMD IPA might be entertained. Cliff Belden, MD would be the person to contact if we go this route. Mr. Cawley doesn't think that there will be an effort to push PCPs to refer exclusively to Dartmouth Hitchcock employed eye care providers at this time but that could change. So here are two possible scenarios that may play out: 1. DH employs more ODs (and possibly OMDs) and tries to refer to them exclusively, effectively expanding their current satellite clinic arrangement. 2. Pioneer (of which DHMC is a member) decides to refer to a "select IPA". One could happen without the other it's just too soon to tell. This is where we could possibly approach them now (I'm not necessarily recommending this) to try to control our future.*

Concord Eliot Medicare ACO this is comprised of Concord Hospital, Elliot Hospital, Southern New Hampshire Medical Center in Nashua and Wentworth Douglass Hospital The latter two just "joined" on 1/1/14.) He stated that it is presumed that there are approximately 40,000 lives attributed to this ACO. It faces the same upside and downside risk as Pioneer and the same principle of incentives to refer to particular providers, who are cost-effective; this drives decision-making on the part of the PCP.

Federally qualified health centers in the North Country are looking at possibly establishing an ACO. This would include, among others Coos County health Center and Mid-State Health Center. Mr. Cawley thinks that the small number of potential lives makes this organization especially "risky."
Commercial ACO's (not Medicare) are basically shared risk arrangements. Currently Dartmouth Hitchcock has a risk arrangement with CIGNA, Lakes Region General Hospital, Concord Hospital, Southern New Hampshire Medical Center Wentworth Douglass and Eliot have a risk arrangement with CIGNA and Dartmouth Hitchcock also has a risk arrangement with Harvard Pilgrim. In all cases a target is established with upside and downside risk.

So how does this apply to optometry? The bottom line is that insurers do not want to contract with an entity that is not clinically and financially responsible. The entity needs to have skin in the game. Like the ACOs that we spoke about earlier they must be willing to take upside and downside risk and maintain strict member standards and protocols.

So that leaves out a professional association such as the New Hampshire Optometric Association. Anybody can join the NHOA by paying dues. There are really no credentialing standards other than that you must be a licensed optometrist in the state. The insurers do not want to deal with fragmented care; they are all about population health management which is executed by a group that has established protocols, credentialing, review of provider standards and the ability to fire or reprimand based upon performance.

*Summary comments:*
*The NHOA, because of its nature, may have limited ability to negotiate with a third party payer in any new payment schemes.*
*Optometry, because of its nature, may remain at least partially a fee for service class of providers.*
*Helms & Co. can assist us by making introductions to insurance company executives who have totally overlooked optometry as a provider class but they cannot negotiate fees for us.*
*David Cawley strongly suggested that we align ourselves and support any organization that is lobbying for or introducing legislation that proposes any willing provider.*
*An IPA (Vista?) especially if it was composed of both ODs and OMDs, might be attractive to an ACO. However, there is risk associated with this and the status quo might serve our profession better. The NHOA would certainly have to distance itself from an IPA.*
*ACO's and Health Insurance Exchanges are both involved in population health management, and anything we can contribute in this regard would be viewed positively.*
*On a final note he stated that he believes Anthem Pathways HIE will have more hospitals next year.*

*The meeting ended with Dave and Keith agreeing to touch base with Mr. Cawley periodically to learn of any new developments in the health care landscape.*

*Respectfully submitted*
*David J. Caban, OD*
*Keith Emery, OD*

*Summary comments by Joe Raczek OD*

*If you've made it this far you can see that the health care system is changing in a way that can't be entirely predicted at this time. Hospitals and physician groups, along with insurance companies, drive the system, and there is a limited amount optometrists can collectively do to influence major components of the system. However, that does not imply there is NOTHING we can do. We should continue to monitor the process and look for advocacy opportunities. When we find these opportunities our message should be the same basic message as we so recently advocated for during the Medicaid managed care transition.*

1. *Payment by procedure and code, same for ODs and OMDs*
2. *Ability to practice full scope optometry to the extent allowed by law.*
3. *Equal policies for ODs and OMDs (basically 1-3 means no discrimination based on type of provider license).*
4. *Use of standard CPT/ICD 9/10 codes*
5. *Full integration optometrists into the medical care system.*

*Note the last statement may entail some changes in the way we operate. There will be upside and down side risk. There may be financial risk, and we likely will have to fully participate in quality measures such as PQRS, full use of EMRs, possible board certification requirements, and more.*
*As always, comments are welcome.*

*Joe Raczek OD*
*NHOA Third Party Chairman*
*April 25th, 2014*