



Illinois Optometric Association

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Director Hamos,

The Illinois Optometric Association represents over 2100 optometrists in the state of Illinois. The IOA's mission is to assist our members in providing exemplary care to the citizens of Illinois. The IOA has worked to maintain an excellent relationship with the Department of Healthcare and Human Services, and has worked together with the department in encouraging optometrists to participate in the Medicaid program. Currently, optometrists provide over 90% of the non-surgical eye care including medical eyecare to the Medicaid population.

Optometrists are primary care physicians that treat, diagnose, and manage conditions of the eye and adnexa. In Illinois, all optometrists are licensed to prescribe all medications for the treatment of eye diseases with few exceptions. This would include the treatment of diseases such as glaucoma, infections such as pink eye and the removal of foreign bodies. Optometrists in Illinois receive intensive, continuous training on medical conditions that impact ocular health, such as hypertension, diabetes, and neurological conditions. Optometrists play an important role in the integrated care model not only in the management of systemic conditions but in reducing the overall cost of healthcare. Indeed, many times the optometrist is the first doctor to notice signs of systemic disease. Conditions such as hypertension and diabetes may be "silent" initially, not significantly affecting the patient's daily activities and therefore go unnoticed. Vision problems are less frequently ignored, and a comprehensive eye examination frequently detects these conditions early, and prompts a referral to the primary care physician.

Comments on the Coordinated Care Program Key Policy Issues

The following questions represent issues important to patient access to Illinois Optometrists:

1a. *Do you think that coordinated care should require contracts with specific entities that arrange for care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration?*

We believe that the patient should continue to have access to quality eye care directly without barriers. This can be done through coordinated care but it will have to be carefully structured to avoid unnecessary office visits. The division of eye health care from vision care as it is currently being complicated will not result in the best, timely care for the patient.

1f. *What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks.*

Simplicity in the enrollment process is key. The current model of Integrated Care in Illinois for older adults and individuals with disabilities requires first that the doctor be credentialed with Medicaid, and second that the doctor determine which of the two administrating plans the client is signed up for. The doctor must then credential with each of the 3rd party providers and each of the subcontractors to maintain access to his current patient base.

In regards to “vision services”, the two options given to optometrists differ greatly. Opticare (linked with IlliniCare) represents the best option as the payment to the provider and services covered are exactly the same as currently realized by billing to Medicaid directly.

March (linked with Aetna Better Health) represents a barrier to care. March restricts the number of visits and type of care provided by an optometrist, which is directly in conflict with current Medicaid rules. In addition, March requires optometrists to be a participating provider to its non-Medicaid clients as well. Included in that provision is the taking a discount off the reimbursement of Medicare to the optometrist for a NON-MEDICAID client. There is also a clause that requires the optometrist to accept their commercial non-Medicaid patients at a reduced payment rate. These provisions will cause many optometrists to reject this plan in favor of OptiCare, who has more favorable terms and potentially leave many Medicaid clients with difficulty in accessing care. We have used insurer’s names here only to provide you with a current reference and an example of the problem. We expect that this problem will exist as long as sub-contractors are permitted to set their own rules regardless of the provider.

Multiple 3rd party administrators with different rules add confusion to this system not only for the provider but to the patient. The choice of one plan over the other automatically restricts the patient’s access to providers, unless the physician is signed up with all of them.

The Medicaid benefit is clearly defined, so a choice in 3rd party payers seems complicated and necessary.

3a. *Should the Department offer bonuses for investments on EHR systems, above the substantial incentives from ARRA?*

In order for healthcare to be truly “integrated”, all practitioners must operate on the same level of care to communicate effectively. Optometrists in Illinois may participate in the Medicare stimulus incentives for implementing EHR because of their physician status with that entity. This is not the case in Medicaid. Some providers who wish to continue to see Medicaid clients need financial assistance in implementing EHR as it is not offered through other venues.

Illinois Medicaid has room to interpret the Federal guidelines for eligibility in the Medicaid Stimulus program. There is no logical reason to exclude one physician type so long as they meet the criteria required for the bonus payments when the goal is to integrate care and gain efficiency. It is our understanding that HFS is currently working diligently with the Federal Government to resolve this and that it may be a non-issue by the time coordinated care is expanded.

5d. What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?

The Coordinated Care Model should not restrict a patient's access to specialty care. Any willing provider should be able to provide specialty care to a patient, regardless of the primary care physicians own personal bias. A referral for specialty care should be given for treatment of a specific condition, and not to a specific provider type. It is reasonable to provide a subset of physician names in a geographical area convenient to the patient and allow the patient to choose.

7a. How do we assume continuity of care as entities come and go or change contractual status?

When multiple "entities" are allowed to modify Medicaid services, they no longer are equivalent plans. Third party administrators of Medicaid should offer the same services across the board. In that way, the entity may change but the benefits to the patient do not.

In addition, credentialing of physicians should be centralized within Medicaid. Becoming a Medicaid provider should be enough to qualify a physician to be a provider with its third party administrator. Independent credentialing by individual "entities" adds another layer of red tape and confusion.

7c. Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if a client income or other circumstances change?

Major medical plans already offer multiple insurance products with varying benefit levels under the same brand. Physicians only need to credential once to have access to all the plan's covered lives. It would be a great benefit for a Medicaid third party administrator to offer diversified products to meet the needs of more lives in our state. Movement between payment sources should not effect the availability or provision of service to the patient.

Respectfully Submitted,

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