HOW DOES MANAGED CARE AFFECT YOUR PRACTICE?

WE WILL EXAMINE THE ISSUES YOUR PRACTICE FACES DEALING WITH MCO’S (MANAGED CARE ORGANIZATIONS)
FIRST LET’S LOOK AT CURRENT DATA COMPILLED BY MCOL ABOUT MANAGED CARE

![National HMO Enrollment Chart]

CURRENT NATIONAL MANAGED CARE ENROLLMENT 2015

<table>
<thead>
<tr>
<th>TYPE</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Maintenance Organization (HMO)</td>
<td>90.4 Million</td>
</tr>
<tr>
<td>Preferred Provider Organization (PPO)</td>
<td>156.4 Million</td>
</tr>
<tr>
<td>Point of Service (POS)</td>
<td>6.0 Million</td>
</tr>
<tr>
<td>High Deductible Health Plan (HDHP)</td>
<td>19.7 Million</td>
</tr>
<tr>
<td>Total</td>
<td>272.5 Million</td>
</tr>
</tbody>
</table>

MAJOR NATIONAL HEALTH PLANS

<table>
<thead>
<tr>
<th>Company</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Health Group, Inc.</td>
<td>48.0 million</td>
</tr>
<tr>
<td>Anthem</td>
<td>39.6 million</td>
</tr>
<tr>
<td>Aetna, Inc.</td>
<td>23.0 million</td>
</tr>
<tr>
<td>Cigna HealthCare, Inc.</td>
<td>15.1 million</td>
</tr>
<tr>
<td>Health Care Service Corporation</td>
<td>15.0 million</td>
</tr>
<tr>
<td>Humana</td>
<td>14.2 million</td>
</tr>
<tr>
<td>Centene (including HealthNet)</td>
<td>11.4 million</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>10.6 million</td>
</tr>
<tr>
<td>Molina</td>
<td>4.3 million</td>
</tr>
<tr>
<td>Wellcare</td>
<td>3.8 million</td>
</tr>
</tbody>
</table>

NATIONAL MANAGED CARE PENETRATION 2016

<table>
<thead>
<tr>
<th>Segment</th>
<th>Total U.S.</th>
<th>Percent U.S.</th>
<th>Managed Care Millions</th>
<th>Managed Care %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>56.5</td>
<td>17.5%</td>
<td>17.3</td>
<td>30.6%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>72.4</td>
<td>22.4%</td>
<td>45.4</td>
<td>62.7%</td>
</tr>
<tr>
<td>Military</td>
<td>4.8</td>
<td>1.5%</td>
<td>4.8</td>
<td>100.00%</td>
</tr>
<tr>
<td>Commercial</td>
<td>160.5</td>
<td>49.7%</td>
<td>159.0</td>
<td>99.1%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>28.6</td>
<td>8.9%</td>
<td>0.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>322.8</td>
<td>100%</td>
<td>226.5</td>
<td>70.2%</td>
</tr>
</tbody>
</table>
EXPERT PANEL INPUT

- MICHAEL SELTZER – CEO HUMANA FLORIDA (RETIRED)
- JAMES BOWERMAN, M.D. – CHIEF MEDICAL OFFICER MOLINA HEALTHCARE
- ED BROWN – CEO THE IOWA CLINIC

WHERE DOES OPHTHALMOLOGY STAND IN TERMS OF CONTRACT PRIORITIZATION WITHIN MCO’S

- GENERALLY FALLS WITHIN THE LOWER 1/3 OF ALL SPECIALTY MEDICAL SERVICES IN TERMS OF FINANCIAL IMPACT TO THE MCO

WHAT ARE THE HIGHEST PRIORITIES THE MCO HAS IN TERMS OF COST CONTROL?

- HOSPITAL CONTRACTING
- PHARMACY CONTRACTING
- LAB CONTRACTING

THE AVERAGE NET PROFITABILITY PER YEAR FOR MOST MCO’S RUNS AT ABOUT A 3% PROFIT MARGIN

WHAT EFFECTS MOST HEALTH PLANS THE MOST IN TERMS OF PROFITABILITY?
ANSWER...

THE NUMBER OF CATASTROPHIC CASES PER YEAR

- NEONATOLOGY SPECIFICALLY AND HEART OR OTHER TRANSPLANT SURGERIES

WHAT DETERMINES MEDICARE ALLOWABLE COMPENSATION?

- GEOGRAPHY
  - RURAL PRACTICES GENERALLY RECEIVE A HIGHER REIMBURSEMENT THAN URBAN PRACTICES
  - PRACTICE STATUS WITHIN A GEOGRAPHY

MEDICAL CONTRACTING FOR OPHTHALMOLOGY

NETWORK PROVIDER COMPENSATION MODELS

MEDICARE ALLOWABLE

- 85% - 125% OF MEDICARE ALLOWABLE RATES FOR MOST MARKETS, THE STANDARD IS 100% OF MEDICARE ALLOWABLE REIMBURSEMENT

CAPITATION

MCO’S USE A CAPITATION PAYMENT METHOD FOR CERTAIN GEOGRAPHIC AREAS
WHAT IS CAPITATION?

CAPITATION REFERS TO A FORM OF A HEALTHCARE PAYMENT SYSTEM. IN A CAPITATION MODEL, A HEALTHCARE PROVIDER OR PRACTICE IS PAID BY THE INSURER (OR ANOTHER PAYOR) A FIXED AMOUNT PER PATIENT DURING A GIVEN PERIOD OF TIME.

THIS IS A RISK BASED PAYMENT SYSTEM.

IN THIS EXAMPLE THE INSURER WOULD PAY THE PHYSICIAN $500,000 PER YEAR TO MANAGE THIS 1,000 PEOPLE GROUP. IF ONE PERSON USED $1,500 WORTH OF HEALTH SERVICES, THE PHYSICIAN WOULD LOOSE $1,000.

CAPITATION MODEL EXAMPLE

AN INSURER OR PAYOR NEGOTIATES TO PAY AN EYE PHYSICIAN $500 PER YEAR PER PERSON IN A DEFINED GROUP OF 1,000 PEOPLE (PMPM).

IF THE NEXT PERSON USED $100 OF HEALTH SERVICES, THE PHYSICIAN WOULD MAKE A PROFIT OF $400. IN A CAPITATION MODEL THE GOAL OF THE PHYSICIAN IS TO KEEP AS MUCH OF THE CAPITATION AMOUNT AS POSSIBLE.
<table>
<thead>
<tr>
<th>HOW IS THIS ACCOMPLISHED?</th>
<th>BENEFITS OF CAPITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>BY CONTROLLING UTILIZATION AND HAVING PREDEFINED SPECIFIC PROTOCOLS FOR PROCEDURES SUCH AS CATARACT REPLACEMENT SURGERY (IOL’S)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRAWBACKS OF CAPITATION</th>
<th>FEE FOR SERVICE MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAY PROMOTE HEALTHCARE RATIONING IN PHYSICIAN DECISION MAKING</td>
<td>IN SOME CASES INSURERS ENTER INTO A FEE FOR SERVICE AGREEMENT WITH PHYSICIANS FOR OPHTHALMOLOGY SERVICES</td>
</tr>
</tbody>
</table>
WHAT IS A FEE FOR SERVICE MODEL?

THIS MODEL IS BASED ON A REDUCTION OF NORMAL FEE FOR SERVICE CHARGES AT A PREDETERMINED DISCOUNT USUALLY BY CONTRACTUAL AGREEMENT WITH THE MCO

- GENERALLY A 45 – 70% REDUCTION OFF NORMAL CHARGES

WHY SHOULD YOUR MD OFFICE PARTICIPATE IN ROUTINE EYE CARE?

HERE ARE SOME MAJOR REASONS...

- INCREASE PATIENT FLOW
- CONVERSION TO MEDICAL PATIENTS
- AN EXCELLENT PATIENT RETENTION STRATEGY
- ADDITIONAL REVENUE STREAM

PLAN PARTICIPATION ... AN OVERVIEW

HOW DO WE CHOOSE WHICH PLANS TO PARTICIPATE IN?

1. SET UP CRITERIA ...
   - PERCENT OF MANAGED CARE PRACTICE PENETRATION GOAL
   - AVERAGE PRACTICE TARGET 25-30%
   - GEOGRAPHY OF YOUR PRACTICE
   - URBAN OR RURAL

2. EVALUATION OF BENEFIT DESIGN AND REIMBURSEMENTS FOR EACH PLAN UNDER CONSIDERATION.
   - PRACTICE FOOTPRINT ISSUES
   - SIZE OF DISPENSARY
   - PRACTICE STAFFING ISSUES IN DISPENSING AND CLAIMS PROCESSING AREAS
   - COST OF ADDITIONAL STAFF
3. WHICH PLANS TO JOIN?
   - NATIONAL PLANS?...YES.
   - REGIONAL PLANS?...MAYBE.

4. WHICH MCO’S HAVE A HIGH MARKET PENETRATION IN YOUR AREA (MEMBERSHIP)?

5. WHO ARE THE MAJOR EMPLOYER GROUPS IN YOUR AREA?

STRATEGIES FOR SUCCESS...

TARGET JOINING VSP AND EYEMED...

- THE TWO LARGEST ROUTINE MANAGED VISION CARE PROVIDERS IN THE U.S.
- THESE TWO PROVIDERS WILL OFFER ACCESS TO OVER 60% OF THE MANAGED VISIONCARE EMPLOYER GROUPS IN THE COUNTRY

COMPARISON OF VSP AND EYEMED

VSP

AUTHORIZATION – PREAUTHORIZATION ONLINE OR TELEPHONE

NETWORK – 95% O.D. AND M.D. LOCATIONS
   - RECENTLY ADDED COSTCO & ECCA RETAIL LOCATIONS

LAB – ALL WORK MUST BE SENT TO VSP LABORATORY FOR PROCESSING

FRAME – MUST BE FROM VSP APPROVED FRAME VENDOR UP TO PLAN ALLOWANCE

NON-COVERED ITEMS – PATIENT MUST PAY AT DISCOUNTED RATE

CLAIMS – ELECTRONIC

REIMBURSEMENT – MONTHLY STATEMENT REFLECTS CHARGES FOR NON-COVERED ITEMS MINUS REIMBURSEMENT CHARGES FOR EXAMS AND MATERIALS
COMPARISON OF VSP AND EYEMED

EYEMED

AUTHORIZATION – PREAUTHORIZATION ONLINE OR TELEPHONE

NETWORK - COMBINATION RETAIL AND M.D./O.D. LOCATIONS

LAB – CAN USE ANY LABORATORY

FRAME – CAN USE ANY FRAME UP TO PLAN ALLOWABLE

NON-COVERED ITEMS – PATIENT MUST PAY AT DISCOUNTED RATE

CLAIMS – ELECTRONIC

REIMBURSEMENT – GENERATES ONE REIMBURSEMENT EOB AND CHECK FOR EACH EXAM AND MATERIAL CLAIM.

ADDITIONAL STRATEGIES FOR VSP AND EYEMED

- AS A GENERAL RULE YOUR PRACTICE SHOULD ELECT TO PARTICIPATE IN ALL PLAN DESIGNS BY EACH MCVO.
- SELECTIVE PARTICIPATION YIELDS NEGATIVE LONG TERM RELATIONSHIPS WITH EACH MCVO.
- DEVELOP A MANAGED CARE FRAME PRODUCT OFFERING. SET MINIMAL U&C RETAIL FRAME COST AT $89 - $99.
- DEVELOP SPECIAL PRICING PROGRAMS WITH OPTICAL LABORATORIES WHEN APPLICABLE.
- COMPUTERIZE ELIGIBILITY AND CLAIMS SUBMISSIONS TO REDUCE COSTS.
- DEVELOP A WORKING RELATIONSHIP WITH THE PROVIDER RELATIONS DEPARTMENT AT BOTH VSP AND EYEMED.
- Track the following data monthly and quarterly.
  - % patient utilization for VSP/Eyemed vs. total patient volume
  - % eyeglass sales for managed care vs. total sales
  - Dollar sales volumes for managed care vs. total sales
  - Set benchmarking goals for each area above

Which plans do we avoid?
- Providers with mechanical processes
- Discount only plans
- Providers who only reimburse for dispensing services
- Providers with very low exam reimbursements (less than $35)
- Providers who supply you with consignment frame inventories

Summary
Three key strategies for success and profit
1. Select compatible managed care plans that mirror your strategic objectives
   - Volume increase
   - Conversion to medical
   - Key employer groups in your MSA
2. EMBRACE MANAGED CARE TO BECOME A CONTROLLED PORTION OF YOUR PRACTICE VOLUME
   - SET 25-30% AS TARGET

3. USE MANAGED CARE AS A PLATFORM FOR ADDITIONAL REVENUE OPPORTUNITIES
   - UPSELL EYEWEAR PRODUCTS
   - CONVERSION INTO MEDICAL PATIENTS

BONUS
THE FUTURE OF MANAGED CARE

- LARGE HMO’S PURCHASE SECOND TIER OR REGIONAL COMPETITORS TO EXPAND BOOK OF BUSINESS
- A FOCUS ON MEDICARE
  - DEMOGRAPHICS
  - MORE CATARACT PATIENTS
- A FOCUS ON MEDICAID
  - A SHIFT FROM MEDICAID TO HMO PLANS
  - COST SAVINGS?

BONUS
SUMMARY

A LOOK AT CATARACT SURGERY RATES ACROSS THE U.S.*

KEY FINDINGS...
- RATE OF CATARACT SURGERY HAS INCREASED IN THE LAST TWO DECADES MOSTLY DUE TO THE AGING U.S. POPULATION

*2016 DATA
RICKI LEWIS, PHD.
JAMA 12/30/16

- THE LOWEST AGE STANDARDIZED CATARACT SURGERY RATE WAS 7.5% SEEN IN HONOLULU, HAWAII
- THE HIGHEST AGE STANDARDIZED CATARACT SURGERY RATE OF 37.3% IN ST. CHARLES, LOUISIANA
- FOR EVERY 1% INCREASE IN LATITUDE THE LIKELIHOOD OF CATARACT SURGERY DECREASED BY 1% DUE TO EXPOSURE OF LOWER LEVELS OF ULTRAVIOLET LIGHT
- For every additional optometrist in a community per 100,000 enrollees, the hazard of cataract surgery increased by .1%. The number of ophthalmologists had no bearing on this statistic.

- Patients living in rural communities had a 5 – 7% increased hazard of cataract surgery compared with those living in urban areas. The researchers speculate that rural patients are exposed to a greater amount of sunlight.