The Participation of Optometrists in New York City's Medicaid Program

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THE Medical Assistance Program of New York City is the largest publicly funded program for the provision of personal health care in any urban jurisdiction in the United States. During the fiscal year ending June 1, 1968, more than $750 million were expended for services by physicians, dentists, pharmacists, optometrists, podiatrists, and chiropractors in private offices, hospitals, outpatient clinics, and nursing homes. In relation to the U.S. Medicaid program, the Medicaid program in New York City accounts for about $1 of every $4 spent for Medicaid and one of every five Medicaid patients enrolled.

Medicaid administrators elsewhere have consulted those in New York City for help with problems within smaller and less complex programs. To assess its present status and to predict the future of optometry in New York City's Medicaid program, it is helpful to be familiar with the history of optometry and welfare clients' health care in the city.

Pre-Medicaid Provisions

The New York City Medicaid program came into being April 30, 1966, when the New York State Legislature passed title XI of the State Social Welfare Law implementing title XIX of the 1965 Federal Social Security Amendments. Previously, publicly funded health care was administered by the city's department of welfare, subsequently renamed the department of social services. A panel of physicians provided care at their private offices and on house calls, but ambulatory welfare patients received most of their care at the outpatient departments of municipal and voluntary hospitals. The clients received dental care at welfare department dental clinics. The city's health department provided care for children at well-baby clinics and at pediatric clinics. Optometrists were not on the public payroll under the system.

In 1963 the New York State Optometric Association initiated a lawsuit against the city, which resulted, for the first time, in the hiring of approximately 10 optometrists in health department clinics in 1965. These optometrists were supervised by ophthalmologists. The city's only other publicly funded optometric clinic, at the then experimental Gouverneur Ambulatory Care Unit, was staffed and supervised by the Optometric Center of New York (*1*).

Clients on public assistance received their

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glasses from the welfare department. After being examined, the patients went to a welfare center for measurements. A single optical company, holding a low bid contract with the department of welfare, dispensed glasses.

The costs were low, and quality control was seriously limited (*2*). Standards and tolerances of materials, although officially established, were virtually ignored. The average welfare patient had scant choice of frames. The waiting period for prescribed glasses was usually more than 1 month, with 2- or 3-month delays quite common. The vendors did not always adjust the glasses but merely handed them to the patient. Whether the patient could muster or maintain any dignity under such a system was conjectural.

Optometrists, among others in New York City, were dissatisfied with this system. In their view, the virtual exclusion of optometrists promoted poor quality vision care for welfare clients and cast an aura of doubt upon the legitimacy of optometry as a profession.

The New York City Medicaid Plan

In a statement on Medicaid to the New York City commissioners of health and social services, Alexander and Bellin delineated the changed concepts and policy concerning delivery of the city's publicly funded health care services (*3*).

> The philosophy underlying the Medicaid program in New York City is that publicly funded health care can be comprehensive in nature. "Comprehensive" means the vigorous participation of all relevant professional disciplines: medicine, dentistry, pharmacy, optometry, podiatry, clinical psychology, etc., and all relevant health care institutions: hospitals, hospital outpatient departments, extended care facilities, homes for aged, half-way houses, etc.
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> "Comprehensive" means a blending of preventive, therapeutic and rehabilitative care. Explicitly, the Medicaid program must act to facilitate the patient's entry into the complex health care system of professionals and institutions, and to assist the passage of the patient from professional to professional, and from institution to institution according to his needs.
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> Inherent in this system is an insistence on high quality of service rendered in a fashion to insure the dignity of the individual. Interposed in the process is the Health Department's development of realistic standards of care and evaluation of the quality of services delivered.
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> Unless the New York City Medical Plan encompasses a realistic methodology of health care standard setting, surveillance, and enforcement, the Medicaid Program must deteriorate to the level of traditional welfare medical care, which historically provided mediocre care to optionless poor. Indeed, the chief reason for the Health Department's participation in administering the Medicaid Program is to prevent such a development. The mere fact of Health Department participation is clearly no automatic surety that future care for the poor will be to any significant extent better than what was provided in the past under the Welfare Department auspices.
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> Without the operative features of standard setting, surveillance, and enforcement of these standards built into the Medical Plan, one must predict that the overriding preoccupation of Medicaid will be determining client eligibility and making payments through professional and institutional providers of care, with the attendant "Poor Law" approach that such a policy had historically implied.

The optometrists in the city were encouraged by the change in the official attitude toward their profession reflected in this policy statement. Now, after 3 years of operation, the policies can be assessed in relation to the actual delivery of health services in the city. Has the pledge of "comprehensive care" been fulfilled with respect to optometric services?

Optometrists' Participation

To judge the quality of optometrists' participation, we shall invoke the principle of peer review. Dr. Henry B. Peters, a faculty member of the School of Optometry and the School of Public Health, University of California, has listed eight provisos as standards for participation by optometrists in comprehensive community health programs (*4*). How congruent are the realities of New York City Medicaid to these provisos?

CONDITION 1. *That optometrists be allowed to join with others to serve the health needs of all our people.*

New York City Medicaid provides compensation for every kind of licensed health care professional, including optometrists. The patient is free to choose the practitioner. The patient determines who will examine his eyes—the ophthalmologist or the optometrist. Preliminary statistical data suggest that more than 75 percent of the private vision services under New York City's Medicaid program are provided by optometrists.

New York City restricts remuneration to self-employed optometrists, eliminating payment of certain fees to corporations. Of the 979 registered optometrists in the city, 625 (63.8 percent) participated in Medicaid as of December 31, 1968. Many of those not participating are either retired or not in private practice. Others have refused to join the program, do not comply with the 25 hours per year postgraduate education

requirement, or have been suspended from the program for not adhering to established standards of practice. In comparison, participation by physicians is 44 percent, by dentists 66 percent, by podiatrists 67.2 percent.

CONDITION 2. *The optometrist be permitted to provide the highest quality and broadest scope of vision services to all people.*

The city's Medicaid administrators' attitude on this subject is promulgated in the standards of care set forth in the Health Department Bulletin effective June 1, 1968 (*5*), and is summarized as follows: not only is the optometrist permitted to provide the highest quality of vision services, but it is demanded of him. The Health Department Bulletin specifies minimum standards for test procedures, test time, instrumentation, and appliances (*5*). For example, no less than 30 minutes are to be applied to the average routine optometric examination, and the examination must include patient's history, external examination, ophthalmoscopy, uncorrected visual acuity, retinoscopy, subjective refraction (distance and near), quantitative muscle balance and fusion evaluation, gross visual fields, completion of forms (for school or drivers), and optometric diagnosis. As an example of instrument requirements, a slit lamp must be employed in the fitting of contact lenses.

For the standards and tolerances of spectacles, the Medicaid program has adopted the specifications of the United States of America Standards Institute. The individual optometrist may exceed any of the minimum standards of practice.

Regarding the scope of vision services, the program encompasses all aspects of optometric practice. There are codes for paying optometrists for examination, perimetry, orthoptic evaluation, orthoptic treatment, tonometry, contact lens fitting, fitting and dispensing prosthetics, subnormal vision examination, subnormal vision fitting and rehabilitation, frame repair, and adjustment. Thus, the New York City Medicaid program is using the full scope of optometric services.

CONDITION 3. *The optometrist's dignity and code of ethics be respected.*

The New York City Medicaid program respects the dignity and code of ethics of optometrists. However, auditing of services conducted under the auspices of the city health department may include reexamination of patients and office visits. Some practitioners resent any administrative control and might construe this aspect of the program as an affront to their professional dignity. As a purchaser of services, however, government is obligated to ascertain whether services provided are in accord with stipulated standards.

Auditing of services is necessary for the protection of the taxpayer who is financing the program and the patient-consumer who is receiving its benefits. Optometry is not singled out in this respect. It is subject to the same scrutiny as all other services for which Medicaid compensates the vendors.

CONDITION 4. *The optometrist be subject only to the judgment of his peers in his professional activities.*

Peer judgment is a concept the New York City Medicaid has accepted. Services requiring prior authorization are reviewed by the director of optometry. Visits to optometric offices are made by optometrists. The Optometric Center of New York supervises reexamination of samples of patients who have received services from optometrists under Medicaid.

Optometrists who allegedly abuse or do not conform to the standards of the program have the option of reviews before committees of their local society. In matters of fraud, investigative authorities are notified. In matters of quality, optometric authorities make determinations.

CONDITION 5. *The optometrist have freedom of professional judgment within his field of competence.*

In New York City Medicaid, freedom of judgment generally is respected, but there are a few exceptions. Although the minimum test procedures for some services have been specified, the right to render and be paid for certain services, such as orthoptics, is contingent upon review and prior authorization. Similar restrictions exist for the other health care disciplines. These restrictions reflect the acceptance of responsibility by the department of health rather than governmental interference.

Other limitations are not so general. For example, patients with aphakia or keratoconus

must have consent of an ophthalmologist before being fitted with contact lenses. Optometrists might interpret this requirement as an infringement on professional judgment. The point is debatable. The regulation represents an extra measure of caution in regard to these special patients. There are a few other comparable regulations. However, these regulations are miniscule when considered in the context of the overall optometry program.

CONDITION 6. *The optometrist have reasonable remuneration commensurate with his education and professional service.*

The schedule of fees in the Health Department Bulletin (*5*) is generally reasonable as evidenced by the participation of optometrists in the program.

CONDITION 7. *The optometrist have opportunity to enhance his knowledge and skills through continuing education.*

New York State and New York City Medicaid programs require optometrists who wish to participate in the program to attend approved courses an average of 25 hours per year. The New York State Optometric Association has cooperated with government in developing certified courses and in enforcing this provision.

On the other hand, the professional societies of medicine and dentistry have objected publicly to a compulsory continuing education provision for their respective members. These associations have characterized the compulsory feature of continuing education (50 hours per year for general medical practitioners and 25 hours per year for dentists) as "secondary licensure" and unwarranted encroachment into the legal prerogatives and obligations of the originally designated licensing authority. Indeed, two local dental societies in New York City have brought an injunction against the health department to block the enforcement of the provision pertaining to dentists.

CONDITION 8. *The optometrist participate in the planning process for his own and his colleagues' services.*

The basic standards of practice for all vision care professionals in New York City were drafted jointly by the director of optical services, an ophthalmologist, and by the director of optometry, an optometrist. These standards were further refined after a series of 12 meetings with practicing optometrists, ophthalmologists, ophthalmic dispensers, lens and frame manufacturers, wholesale optical laboratories, and practitioners specializing in the fitting of low-vision aids and prosthetics. Before their publication, the standards were reviewed and revised by the permanent Medicaid Advisory Committee on Quality Vision Care. Four of the 10 members of this committee are optometrists. Thus, optometrists clearly are major participants in the basic planning process for optometric services.

In addition to establishing a committee on quality vision care, the city Medicaid administration has developed liaison with local professional societies to promote cooperation. The relationships have been particularly useful in auditing services and enforcing standards. Whenever possible, the Medicaid administration delays punitive action against a professional to enable his peer group to try to influence the practitioner to take corrective measures.

Conclusions

The optometric component of the Medical Assistance Program of New York City correlates with the eight standards suggested by Dr. Henry B. Peters of the University of California to serve as guidelines for participation of optometrists in a comprehensive community health program. Practicing optometrists in New York City appear reasonably satisfied with the operative provisions of Medicaid, as evidenced by their percentage of participation.

Optometry has achieved prominence in municipal health care with the advent of Medicaid. New York City Medicaid, the largest Medicaid program in the country with an annual expenditure of more than $750 million in the fiscal year ending June 1, 1968, and close to 1,800,000 enrollees, may be a useful prototype of how the professional optometrist can contribute to publicly funded comprehensive health care programs. The New York City Medicaid program has demonstrated that ophthalmologists and optometrists can work together productively.

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Tearsheet Requests

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The foundation will function as a nonprofit, charitable organization to service the fields of psychiatry, medicine, religion, psychology, the paramedical disciplines, social sciences, nursing, social welfare, philosophy, and theology, as well as to assist directly the bereaved.

The Foundation of Thanatology derived initial impetus from a group of more than 100 author-contributors to a series of books written for lay persons who deal with recovery from bereavement and a medical text for the health professions, entitled "Loss and Grief: Psychological management in medical practice," to be published by the Columbia University Press. Its board of professional advisers originally consisted of a group of contributors and creative consultants who were responsible for these books. It now includes persons in many professions and disciplines who have become interested in the foundation and have offered their services to carry forward the organizational, publications, and research activities.

The purposes of the foundation are as follows:

1. As a multidisciplinary organization, the foundation solicits the interest of all persons, who are concerned with the subjects set forth, and attempts to be of service to them.

2. Development of a publications program including "The Archives of the Foundation of Thanatology" (started in April 1969), to be sent to members and academic libraries; publication of a scientific-professional-pastoral journal, *The Journal of Thanatology*, beginning next year; publication of worthy manuscripts submitted to the foundation for this purpose; inauguration of an annual review volume; selected collected readings compiled as books; and the foundation transactions.

3. Sponsorship of an annual symposium with subsequent publication of papers and workshop proceedings as multidisciplinary books. The first of these, "Psychosocial Aspects of Terminal Care," will take place next year. The second is entitled "Psychopharmacologic Agents in the Care of the Terminally Ill and the Bereaved."

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