Value-based, quality and performance reimbursement programs continue to evolve

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Quality of care and efficiency are elusive concepts that third-party payors have been struggling to measure as they attempt to transition away from traditional fee-for-service reimbursement models. One recent local approach may impact both primary care physicians (PCPs) and specialists depending on how the payor uses the data it has gathered.

Highmark launched a program entitled "True Performance" in January 2017, stating that its goal was to improve healthcare quality outcomes for members, reduce annual increases in total healthcare costs and help physicians engage in patient care coordination and population health management. This approach measures quality and cost control both at the primary care and specialist levels. As with the Medicare Shared Savings program and other Accountable Care Organization-style programs, Highmark measures costs of episodes of care against certain benchmarks and provides financial incentives to meeting those targets. The new wrinkle is that Highmark has begun to compile and circulate a Specialist Efficiency Report to its PCPs, intended to show them which specialists are deemed efficient in managing the costs of care and help PCPs make more informed referral decisions.

Continued on Page 120

From Page 119

These report cards evaluate specialist practices on a rolling 22-month lookback based on total episode costs compared to market average costs, adjusted for region, a patient's risk profile, and inclusion of a procedure or surgery, producing what Highmark designates a composite "cost efficiency score." Each "episode of care" is assigned to an Episode Treatment Group (ETG), a DRG-like series of illness classifications developed by Optum, a data analytics consulting company who markets its services to insurers, employers, providers and government agencies. An ETG evaluates costs by grouping claims that are considered part of an episode of care (diagnosis, treatment and conclusion) related to a patient's medical condition. Each ETG incorporates all clinically relevant inpatient, outpatient, post-acute, professional and ancillary services, including prescription medications. Cost-efficiency profiles will be compared to practices in the same region, initially only Allegheny, Beaver, Butler, Washington and Westmoreland counties, but covering all of Highmark's territories by year end.

The reports will initially track only cardiology, electrophysiology, orthopedics, dermatology, gastroenterology, endocrinology and neurology. Specialists will be sent their own reports, and participating primary care physicians will receive a list of "efficient" specialist practices, i.e., those whose profiles are within the benchmarks. No specific rankings or statistics will be provided to PCPs, just a list of the specialists who met the targets. Both AHN-employed and non-AHN employed specialists will be ranked, and Highmark states that they are not directing or requiring PCPs to refer only to designated "efficient" specialists.

Readers with long memories may recall Highmark's earlier foray into a case-rate payment methodology for ophthalmologists, orthopedic surgeons and cardiologists, which was floated nearly 20 years ago but ultimately abandoned after meeting with resistance from the affected specialties. That system, developed by Highmark's consultants Adesso Healthcare Information Service of San Jose, Calif., was designed to set reimbursements for each episode of care on a fixed rate for Highmark's Medicare HMO population under its SelectBlue product. Specialist advocates and their medical societies (including ACMS) pushed back, citing lack of transparency, Adesso's uneven track record in other markets, and Highmark's use of its all-products clause to force participation in what was promoted as a voluntary program.

As was the case with the ill-fated Adesso effort, there are concerns that this True Performance program may trigger unintended consequences including penalizing or stigmatizing specialists who treat the most complicated cases, or discouraging them from accepting higher-risk patients. Highmark says the data used for the cost efficiency score will be risk adjusted for practices who see very sick patients, but it is unclear how those adjustments will be applied. Notably, the first round of scores does not include a specialty-specific outcome or quality component. Highmark states that specific, standalone quality metrics for the seven specialties are currently under development and will be rolled out at a later time, but that the scores do take into account quality indicators such as appropriateness criteria for care delivery, readmission rates and emergency services utilization. Specialists were sent their reports two weeks prior to when the list was released to PCPs and given an opportunity to raise any concerns.

While it's not a return to the capitation-and-gatekeeper days of earlier HMOs, the True Performance program does share some elements of those former approaches intended to incentivize PCPs to focus on costs and utilization beyond the four walls of their own offices. Highmark reported that its subscribers who are seeing a PCP in the True Performance program had 11 percent fewer Emergency Room visits and 16 percent fewer inpatient admissions in 2017 than those seeing a PCP not in the program, and this was prior to the introduction of the specialist reports. They also report savings of $260 million in the program's first year of operation.

Both PCPs and subspecialists will need to adapt to the evolving payment environment that increasingly measures population health and costs against benchmarks and takes into account factors beyond what each physician directly provides. ACOs, shared savings programs and gainsharing programs continue to erode the traditional fee-for-service model, and these programs will not remain voluntary for long. In fact, even physicians who do not affirmatively join these programs can be impacted by them as their data is managed and utilized to influence referral patterns. These efforts began in the private insurance community well before the Affordable Care Act expanded them to Medicare through the Shared Savings Program, and private insurers can be anticipated to expand them further if they can be shown to deliver results.

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