CHAPTER 5: CARE AND QUALITY MANAGEMENT

UNIT 7: VALUE-BASED REIMBURSEMENT PROGRAMS

IN THIS UNIT

TOPIC	SEE PAGE
Payment Innovation	2
True Performance Program	5
Quality Blue Hospital Pay for Value Program	8

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

- The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.
- The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.
- The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

5.7 PAYMENT INNOVATION

Introduction

Highmark's network management methodology utilizes value-based reimbursement models, performance, and high-value networks and products. This strategy emphasizes efficiency and appropriateness over volume and waste, encourages provider/payer collaboration, and increases cost and quality improvement potential.

Highmark's value-based reimbursement strategy evaluates providers' ability to deliver the right care at the right time and in the most appropriate setting. Our value-based reimbursement programs place intense focus on care coordination and population health management principles.

Along with our focus on member incentives and social determinants of health, these initiatives will mature the care continuum to shared quality and cost accountability, with fully capitated reimbursement methodologies launching for high performers in 2019.

Primary care solution

Highmark launched the True Performance value-based reimbursement program in January 2017. True Performance is a contracted program that replaced all previous pay-for-value and quality incentive PCP programs across all of our service areas and member populations. In True Performance, physicians are rewarded for their performance on quality and cost/utilization metrics and may be eligible to earn monthly care coordination reimbursement and quarterly or annual lump sum reimbursement.

This program is designed to continue to improve the quality of health care delivered to our members while working to reduce the overall cost of health for our members. For our provider partners, True Performance reduces the complexity of multiple programs, offers a higher performance-based reimbursement opportunity, and provides timely and actionable reporting.

For additional information, please see the **True Performance** Program section of this unit.

Continued on next page

5.7 PAYMENT INNOVATION, Continued

Specialist solutions

Highmark will be transitioning specialist reimbursement toward risk through the Bundled Payment and Specialist Efficiency programs beginning in 2018.

Highmark will be piloting bundled payment solutions using retrospective gain shares in 2018, and will progress from retrospective gain shares to prospective payments beginning in 2019. They will be based on high-volume, high-cost episodes of care (e.g., major joint replacement) using a solid foundation of nationally recognized grouper logic, such as Symmetry® Episode Treatment Groups® (ETG®) and Procedure Episode Groups® (PEG®) and the Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI).

We have already begun exploring the use of bundled payments in an integrated way through the close collaboration with Allegheny Health Network (AHN), our own integrated delivery and financing health system. Working closely with AHN orthopaedic surgeons and oncologists, we have co-developed clinical pathways that maximize quality while reducing overall costs and improving patient experiences.

To assist in impactful referrals, PCPs will receive information on the highest-value specialists through Specialist Efficiency, which monitors cost and detects variability in care delivery within select specialties.

Facility value-based solution

Highmark's facility-based value-based reimbursement program, Quality Blue Hospital Pay for Value, is operational in all service areas. The Quality Blue Hospital Program is designed to help providers align care with industry standards and best practices to better manage the care our members receive and improve outcomes. Under the Quality Blue Hospital Program, facilities contract with Highmark to place a portion of their reimbursement "at risk," dependent on their performance on rigorous clinical quality and cost measures that align with those advanced through national organizations, including the National Quality Forum (NQF) and National Committee for Quality Assurance (NCQA).

Incentives are paid on a retrospective performance basis. In addition to the clinical quality measures, the program includes measures for cost and utilization evaluation on select, high-volume episodes of care (COPD, Simple Pneumonia, and Major Joint Replacement of the Lower Extremities) based on CMS BPCI logic and reduces wasteful spending while improving care.

Please see the **Quality Blue Hospital Pay for Value Program** section in this unit for additional program information.

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5.7 PAYMENT INNOVATION, Continued

Post-acute solutions

HM Home & Community Services is a Highmark fully-owned subsidiary that manages post-acute services. HM Home & Community Services is creating and operating a number of ongoing initiatives aimed at managing avoidable costs while increasing quality.

Through the Skilled Nursing Facility (SNF) Pay-For-Value Program, skilled nursing facilities are financially incentivized to provide high-value care and have readmission rates that are less than or equal to industry benchmarks. The program will be incorporating more advanced reimbursement methodologies that will echo across our Home Health and Long-Term Acute Care (LTAC) Pay-For-Value Programs in 2018, including episodic and bundled payments, as well as foster collaboration between acute and post-acute providers.

Clinically Integrated Networks (CINs)

Highmark is supportive of Clinically Integrated Networks (CINs) and strives to partner with as many providers as possible to ensure delivery of high quality, affordable care. We will usually encourage their formation if strategic value is created for the provider(s) involved, and will design custom arrangements for them depending on their needs and aspirations.

Highmark is currently developing advanced reimbursement models that incorporate pay-for-value, shared savings, shared risk, and capitation for entities across our multi-state service area, and expects to see more partnerships with CINs in 2018 and beyond.

Pharmaceutical solutions

Value-based payment methodologies for pharmaceuticals and incentives for following the evidence-based Care Pathways program have been implemented at our own integrated delivery and financing health system, Allegheny Health Network (AHN). They were rolled out in 2017, have been highly utilized, and will be further developed and enhanced in 2018.

In addition, Highmark has value-based purchasing agreements in place with select pharmaceutical manufacturers and are expanding them for 2018.

5.7 TRUE PERFORMANCE PROGRAM

Overview

The True Performance Program is a leap forward in value-based reimbursement methodology and offers primary care practices additional funds for managing their attributed population of Highmark members. Our True Performance value-based program is one of the largest PCP-based private value-based reimbursement programs in the country.

Physicians are rewarded for their performance on quality and cost/utilization metrics and may be eligible to earn monthly care coordination reimbursement, as well as quarterly or annual lump sum reimbursement. Timely and actionable reports are provided to give physicians regular insight into determining which care and referral decisions contribute to optimum results for quality, outcomes, and value.

In addition, True Performance meets the nationally-consistent criteria for patient-centered, value-based care to be designated as a program of Blue Distinction® Total Care, an initiative of the Blue Cross Blue Shield Association. For more information, please see the **Blue Distinction Programs** section in the manual's **Chapter 5.1: Care Management Overview**.

Participants

True Performance is a contracted program offered to entities in Highmark service areas that have at least 250 uniquely attributed members, whose providers practice primary care, and who accept placement of approximately 30 percent (30%) of their revenue risk based on performance cost and quality metrics.

Physician value-based contracts are expected to steadily increase through the next few years as participation in value-based programs expands across all of Highmark's service areas.

Reimbursement opportunities

True Performance provides PCP practices with two reimbursement opportunities – Monthly Care Coordination and Performance Lump Sum.

Care Coordination is based on achieving quality thresholds for the practice's pediatric, adult, and senior patients. It accounts for 25 percent (25%) of potential total program reimbursement.

Lump Sum encompasses those same quality measure, plus three cost and utilization metrics – total cost per member per month (PMPM), emergency department utilization, and all-cause readmissions. Lump Sum accounts for 75 percent (75%) of total program reimbursement.

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5.7 TRUE PERFORMANCE PROGRAM, Continued

Reimbursement opportunities (continued)

Participating practices that meet or exceed a minimum level of quality performance on their attributed membership receive risk-adjusted Care Coordination Reimbursement on a PMPM basis. Performance Lump Sum Reimbursement is paid on a quarterly or annual basis and is based on performance across both program components of Quality and Cost/Utilization. Calendar year performance determines the amount of Lump Sum Reimbursement earned as a percentage of maximum potential Lump Sum Reimbursement, which is based on a practice's attributed membership.

Quality metrics

Risk-adjusted care coordination fees are advanced monthly for each attributed member as long as a minimum quality performance on thirty (30) quality metrics, as scored by age group (e.g., pediatric, adult, senior), is maintained.

Industry-supported quality metrics are nationally sourced from National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) Stars and align with:

1. Appropriate Treatment for Children with URI
2. Adolescent Well-Care Visits
3. Well-Child Visits in the First 15 Months of Life
4. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
5. Childhood Immunization Status: Combination 10
6. Immunizations for Adolescents
7. Development Screening in the First Three Years of Life
8. Medication Management for People With Asthma
9. Cervical Cancer Screening
10. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
11. Chlamydia Screening in Women
12. Comprehensive Diabetes Care: Medical Attention for Nephropathy
13. Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
14. Breast Cancer Screening
15. Colorectal Cancer Screening
16. Adult BMI Assessment
17. Comprehensive Diabetes Care: HbA1c Control (≤ 9%)
18. Medication Adherence for Diabetes Medication
19. Medication Adherence for Hypertension: Renin Angiotensin System Antagonists (RASA)
20. Medication Adherence for Cholesterol (Statins)
21. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
22. All-Cause Readmissions
23. Annual Monitoring for Patients on Persistent Medications
24. Statin Therapy for Patients With Cardiovascular Disease
25. MTM Program Completion Rate for CMR

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5.7 TRUE PERFORMANCE PROGRAM, Continued

Quality Metrics (continued)

26. Osteoporosis Management in Women Who Had a Fracture
27. Annual Wellness and Initial Preventative Physical Exam Rate
28. Statin Therapy for Patients With Diabetes
29. Medication Reconciliation Post Discharge
30. Use of High-Risk Medications in the Elderly

Opportunities for advanced arrangements

In 2018, opportunities for both upside and downside shared risk arrangements were offered to select providers who excelled at cost and care management. True Performance will continue to serve as the foundational value-based program and select well-performing providers will be offered more advanced arrangements to increase their reimbursement opportunities through shared savings and/or shared risk in 2019 and beyond.

5.7 QUALITY BLUE HOSPITAL PAY FOR VALUE PROGRAM

Introduction

The Quality Blue Hospital Pay for Value Program is a contract-based initiative in which a hospital agrees to put a portion of its Highmark reimbursement at risk, contingent upon attainment of specified objectives in the areas of quality improvement and patient safety.

Purpose

Highmark seeks to improve the health of its members by bringing to the market an innovative approach that supports providers in continuously improving the care and services delivered to their patients and our members. Highmark understands that an efficient health care delivery system promotes and maintains a high standard of quality and rewards cost-efficient care.

Highmark also understands that hospitals provide a unique opportunity to promote health care through collaboration, coordination, and communication among all providers by aligning services and enhancing the patient experience. This can be achieved by providing resource support, data sharing, aligning objectives, and encouraging care coordination across all aspects of care delivery.

Definition

The Quality Blue Hospital Program focuses on improving quality, controlling costs, and enhancing the member/patient experience. The Program components have been carefully designed to demonstrate value for Highmark, our customers and members, and our Participants and support Highmark's Mission, Vision, and Values.

Program participation

Eligibility in Highmark's Quality Blue Hospital Program requires Participants to have a current contract with Highmark for the period of July 1, 2018 through June 30, 2019 (hereafter fiscal year; "FY 2019").

In order to have a current contract for FY 2019, a hospital must meet the following criteria:

- The hospital has signed one or more Highmark network participating contracts that under the terms of such contracts will be in effect during FY 2019.
- The hospital is not in default under the terms and conditions of the aforesaid network contracts at any time during FY 2019.
- The hospital has not provided a notice of termination to Highmark or Highmark's regulators with respect to any Highmark network participating contract and such notice provides for termination prior to June 30, 2019 (for avoidance of doubt, this criteria is satisfied by the notice providing for a termination date prior to June 30, 2019, whether the contract is actually terminated on June 30, 2019).

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5.7 QUALITY BLUE HOSPITAL PAY FOR VALUE PROGRAM, Continued

Program participation (continued)

Once enrolled in the program, contracted hospitals become eligible facility partners (hereafter, "Participants"). Participants are required to complete the following component metrics:

- Quality Bundle
- Readmissions
- 3-Day Returns to the Emergency Department (ED)
- Palliative Care for Complex Patients
- Average Episode of Care Costs for Chronic Obstructive Pulmonary Disease ("COPD"), Simple Pneumonia, and Major Joints of the Lower Extremities

For calendar year 2018 ("CY 2018"), Palliative Care for Complex Patients will not be an applicable measure for Specialty Care Hospitals since they predominantly treat certain diagnoses or perform certain procedures. Hospitals with employed physician practices will be required to complete the Quality Bundle metric.

Program components

The Quality Blue Hospital Pay-for-Value Program focuses on key public health topics that have been identified nationally as areas of opportunity for improvement. For CY 2018, two component categories each with specific standardized metrics have been established to address these topics and include the following:

1) Quality:
   a. Quality Bundle
   b. Clinical Quality Measures
      i. Readmissions
      ii. 3-Day Returns to the ED
      iii. Palliative Care Consults for Complex Patients
2) Cost and Utilization:
   a. Average Episode of Care Costs
      i. Chronic Obstructive Pulmonary Disease ("COPD")
      ii. Simple Pneumonia
      iii. Major Joints of the Lower Extremities

Program evaluation and scoring

Participant performance will be monitored throughout the program year and dashboard reports will be shared quarterly in an effort to provide insight for further process improvements.

Performance measurement for the CY 2018 Program begins January 1, 2018, and concludes December 31, 2018. The claims-based reporting methodology requires that the measurement period begins in advance of the program start date to allow for sufficient time for data collection and claim run-out so that comprehensive and complete results can be provided. Individual metric measurement periods and, when applicable, baseline information can be found in the Program manual.

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5.7 QUALITY BLUE HOSPITAL PAY FOR VALUE PROGRAM, Continued

Program evaluation and scoring (continued)

A final three month run-out period will be used on program components to identify all claims that should be included for performance measurement and scoring purposes. Participants are scored at the end of the program year.

Participants will be measured and scored on all program components for which they qualify. Participants with accountability for participating in all program component metrics have an opportunity to receive a maximum of 100 points (105 points with potential Quality Bundle bonus points). Participants that do not meet the criteria for inclusion in all program components (due to specific component requirements or other exclusions) will have their applicable component scores converted to a score out of 100 percent.

Ongoing changes to the program

The Quality Blue Hospital Program continually evolves to meet the needs of Highmark and participating network facilities. Accordingly, the Quality Blue Hospital Program will be reviewed and revised annually.

FOR MORE INFORMATION

For additional information regarding the Quality Blue Hospital Program, contact your Highmark Clinical Transformation Consultant or Provider Account Liaison.