

The Effects of Economic Profiling on Ophthalmic Practice

How payers are guiding patients away from specialists' offices.

BY RUTH D. WILLIAMS, MD

Access to patients is the most important issue for ophthalmologists in private practice. As health systems consolidate, ophthalmologists work within the footprint of only a few health systems and fewer payers. In a conversation with Wheaton Eye Clinic's administrator, David Dopp (September 2012), he told me that health care is evolving into an oligopoly of providers and payers. The payers, the employers, and the large, consolidated health systems become aligned in looking for ways to cut health care costs, and the economic profiling of physicians is becoming an increasingly powerful tool for that purpose.

The American Academy of Family Physicians defines *physician profiling* as "an analytic tool that uses epidemiological methods to compare physician practice patterns across various quality of care dimensions."¹ Although most payers discuss quality and cost in the same sentence, in reality, it is the cost measures that are currently used.

Medicare and private insurance payers are measuring ophthalmologists for quality and cost, and both link payments to the data. Whereas the Physician Quality Reporting System attempts to measure quality, the Value-based Payment Modifier is designed to adjust payments based on cost. Earlier this year, US Department of Health and Human Services Secretary Sylvia Burwell announced the agency's new initiative, "Better, Smarter, Healthier"—a pledge to link 90% of Medicare reimbursements to quality or value by 2018.² Private insurers are also linking cost and quality data to reimbursements.

THE SHIFT

The economic profiling of ophthalmologists is nothing new. Many of the academic articles about physician

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profiling date from the late 1990s to about 2005, when the issue received a great deal of attention. Insurance companies have been developing data about the resource use of individual physicians for decades, but the data are now used to shift patients toward lower-cost providers.

Insurance companies employ subtle and not-so-subtle methods to encourage patients to see doctors who cost less, and these providers are almost never subspecialists. For example, UnitedHealthcare uses a tiered program for many of its plans. Physicians are rated on cost and quality and placed into one of several tiers. An icon appears next to the name of a UnitedHealth Premium Tier 1 Physician. According to the insurer's website, "Members in health plans that offer tiered benefits may pay lower co-payments and co-insurance amounts for services provided by UnitedHealth Premium Tier 1 physicians."³ Tiered networks are a strategy to maintain patients' choice of provider while creating economic incentives for them to select the lower-cost provider.

Do patients care? Yes and no. Those who have received care from a specialist for a long time develop a

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loyalty to that physician. They will pay \$10 to \$30 more per visit to maintain continuity of care, especially for the treatment of a chronic disease like glaucoma, diabetic retinopathy, or macular degeneration. A study by Sinaiko and Rosenthal, however, found that a patient selecting a doctor for a first visit will choose the one with the lower copayment.⁴ Over time, tiered networks and copayment differentials shift patients away from higher-cost providers.

PROBLEMS WITH THE DATA

One of the most frustrating aspects of economic profiling is that the data are poorly developed. Most of the cost data about individual physicians are derived from episode grouping software. Most episode groupers are proprietary software designed to assign raw medical claims into sets of clinically coherent episodes.⁵ The data are developed in an opaque fashion and do not adequately account for disease severity or case mix. Risk-adjustment methodologies have not yet been developed. Because the data do not account for disease severity, subspecialists are particularly vulnerable to the effects of economic profiling.

COPING STRATEGIES FOR OPHTHALMOLOGISTS

Many doctors are not aware that economic profiling is affecting their access to patients. The reports about quality and cost designation are typically sent in an e-mail message or a form letter once a year. Ophthalmologists should look for and carefully read these communications. Often, a specialist will be placed in a category that suggests, “did not meet requirements for cost or quality.”³ An appeal process is usually described, and the ophthalmologist should pursue it.

In addition, the ophthalmologist should ask for an explanation of the methodology for determining the quality designation and that for determining the cost. It

is important to consistently request transparency and validated methodology.

The American Academy of Family Practice laid out some guiding principles for any physician-profiling program such as

- Clearly define what is being measured.
- Explicitly describe the data sources on which measurement is based.
- Include appropriate risk adjustment and case mix measures.¹

As the Centers for Medicare & Medicaid Services, private payers, and Medicaid programs link payments to quality and cost measures, it is imperative that payers incorporate innovative risk adjustment methodology into episode grouping software.⁵

CONCLUSION

The Centers for Medicare & Medicaid Services and many private payers are committed to shifting from fee-for-service payments to payments based on quality and/or efficiency measurements. Ophthalmologists have been collaborative in developing quality measures that are evidence based and fair. They must also advocate for fair and transparent cost data. ■

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