Critical changes in U.S. medical market place with physician compensation and healthcare delivery

By Carlo Koren, Corporate Vice President, Stratum International LLC, and Bobby Stamper, Valuation Consultant, Pinnacle Healthcare Consulting, Centennial, Colorado

Gain-sharing is a contractual arrangement that sets up a formal reward system in which participating workers share in cost savings resulting from increased efficiency.

The U.S. medical market place has seen significant changes in the last number of years with those changes accelerating with each new year. These changes have affected every segment but especially reimbursement for physicians and physician practices, hospital reimbursement and hospital delivery processes and life science companies – all with an impact on the ultimate market place participant, the patient. Controlling costs and streamlining healthcare delivery have entered into a new age of options, needs and expectations. Understanding those changes are critical both for the delivery of healthcare and becoming more efficient and cost effective.

As reimbursement moves from fee-for-service to pay-for-value, health systems are engaging physicians to help manage patients and processes across the continuum of care. Several programmes developed by the Center for Medicare & Medicaid Innovation specifically discuss compensating physicians for the services they provide. Health systems, however, continue to struggle with how to compensate physicians who refer patients to the health system while still complying with laws that restrict paying physicians more than fair market value (FMV).

Regulatory movement to control cost and quality

We have conducted extensive industry research to ascertain key factors related to shared savings, value-based, pay-for-performance arrangements, and associated physician payments. The U.S. Affordable Care Act (ACA) focuses on moving the healthcare system toward payment models that hold healthcare providers more accountable for the costs and quality of the care they provide, thereby encouraging greater efficiency and improved outcomes. The gain-sharing model is one variant of these systems emphasised under healthcare reform. Gain-sharing is a contractual arrangement that sets up a formal reward system in which participating workers share in cost savings resulting from increased efficiency.

Gain-sharing models were developed in healthcare because of the misalignment of incentives between hospitals and physicians. In the traditional hospital setting, physicians are independent agents who not only use hospital facilities, but can directly or indirectly, knowingly or unknowingly, affect hospital costs. Specifically,

- Reimbursement trends continue to transition from fee-for-service models to quality and cost-focused models.
- Current financial incentives for physicians to practice efficiently in traditional hospital settings are limited.
- Hospitals are seeking innovative ways to partner with physicians in the midst of changing reimbursement.
- Arrangements developed to improve quality/efficiency should have defined at-risk performance metrics.
- Determining compliant fair market value (FMV) physician compensation plans for value brought through clinical co-management or hospital efficiency arrangements is a challenge for hospitals.

physicians may unknowingly increase hospital costs through unnecessary use of supplies (e.g., disposable surgical supplies), use of expensive devices (e.g., stents and implants), and inefficient use of hospital resources (e.g., operating room time). Furthermore, physicians may also knowingly increase hospital costs by, for example, ordering additional testing. Additional tests could be duplicative and/or inefficient.

Gain-sharing and other shared savings-focused programmes offer one potential solution to remedy misalignment of hospital and physician incentives. Gain-sharing works by providing physicians with a financial stake in controlling hospital costs. Specifically, in a hospital-physician gain-sharing programme, hospitals offer physicians a share of cost savings achieved by the hospital as a result of the physicians' behaviour or decisions. Therefore, gain-sharing differs from a pay-for-performance or incentive programme, in which payments are made for a certain behaviour (e.g., meeting certain quality standards or adhering to quality protocols). However, recent industry information and trends indicate that models combining both cost savings incentives (i.e., gain-sharing) and quality incentives are becoming increasingly prevalent. Notably, the recent Sustainable Growth Rate (SGR) legislation added the words "medically necessary" to modify the term "services" cited in 42 U.S.C. 1320a-7a(b)(1). As a result, the gain-sharing civil monetary penalty (CMP) only applies to payments that induce the reduction or limitation of "medically necessary" services. This change arguably makes gain-sharing programmes between hospitals and physicians less restrictive than previously.

OIG Advisory language

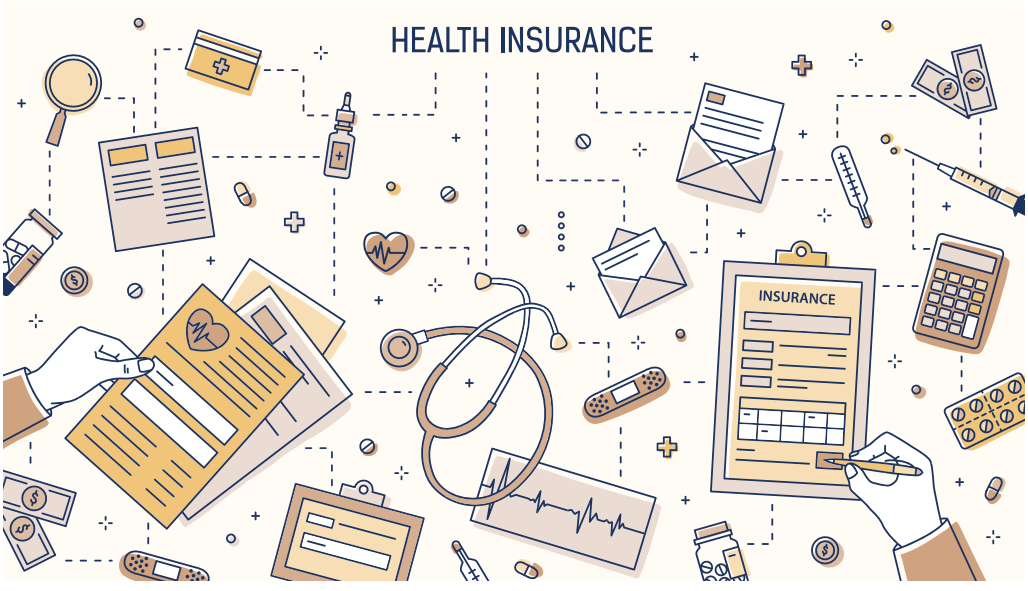
Given the trend toward arrangements based on cost and quality, we also recently reviewed Advisory Opinions issued by the Office of the Inspector General (OIG) pertaining to an arrangement involving incentive payments for physician services (in that instance, co-management services). Although such guidance pertains only to the particular parties requesting the advisory opinion, information contained therein provides helpful insights related to similar arrangements. In the instance reviewed in Advisory Opinion 12-22, physicians were to receive incentive compensation for their management services for three years as part of an arrangement with an acute care hospital. The physicians' remuneration for such services included performance-based payments at graduated levels depending upon the pre-defined metrics achieved.

As part of its analysis in this Advisory Opinion, the OIG identified several key considerations that are particularly pertinent for these types of arrangements, including the following:

- Incentive compensation arrangements are designed to align incentives by offering physician

Recent industry trends indicate that models combining both cost savings and quality incentives are becoming increasingly prevalent.

Properly structured arrangements may increase efficiency and reduce waste, thereby potentially increasing a hospital's profitability.



compensation in exchange for implementing strategies to meet quality, service, and cost savings targets.

- Properly structured arrangements that compensate physicians for achieving hospital cost savings can serve legitimate business and medical purposes. Specifically, properly structured arrangements may increase efficiency and reduce waste, thereby potentially increasing a hospital's profitability.
- However, such arrangements must be evaluated in light of applicable regulations and the potential for abuse. Furthermore, such arrangements should not influence physician judgment to the detriment of patient care.

Reimbursement determination for shared savings

To assess the FMV attributable to assisting a hospital in achieving quality improvements in outcomes and patient satisfaction, we have reviewed various quality bonus programmes currently offered by public and private insurance payers to providers. With the establishment of the Medicare Shared Savings Program (MSSP), general industry sentiment is that reimbursement will continue to move from fee-for-service to some form of hybrid payment based on volumes and quality with certain models geared toward population health management. Furthermore, when the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed, the sustainable growth Rate (SGR) to the Medicare physician fee schedule was repealed. As a result, in 2019 MACRA requires CMS to use a new adjustment, the Merit-Based Incentive Payment System (MIPS). The MIPS will shift payments to physicians who meet payment requirements based on quality and value and move reimbursement away from the fee-for-service model.

Other new payment models

In addition to gain-sharing, Medicare is testing several different payment models both independently and with non-governmental insurance companies. These models include:

- Accountable Care Organizations (ACO);
- Oncology Care Model (OCM);
- Bundled Payments for Care Improvement Initiative (BPCI); and
- Comprehensive Care for Joint Replacement Model (CCJR).

Each of these models was developed with the goal of reducing the cost of healthcare. ACOs are compensated based on the ACO's ability to generate savings for patients insured by Medicare through the management of each patient's care. The OCM, BPCI, and CCJR programmes pay a fixed amount for care (i.e., a bundled payment), which requires the providers receiving the payment to operate efficiently and at a high-quality level to maximise profits. Under each of the models, hospitals and physicians must work together to succeed in maximising profits while still providing quality care to patients.

Under each of the models, hospitals and physicians must work together to succeed in maximising profits while still providing quality care to patients.

Contracting with providers to enhance efficiency and quality

Many hospitals have engaged physicians through clinical co-management (CCM) agreements to help the hospital operate a specific programme (e.g., cardiology, orthopaedic surgery) efficiently

to improve quality and reduce costs. CCM agreements pay for time spent providing actual management services and additional compensation for achieving improvements in reducing costs, improving quality, and realising efficiency. A number of hospitals that have engaged physicians through CCM agreements have employed the physicians subject to the CCM agreement.

Other organisations have shied away from engaging physicians specifically in management services and are developing hospital efficiency programmes (HEPs) through which a pool of funds is distributed when certain targets around the care of patients or the operations of the hospital are met. These HEPs often include requirements for physicians to participate in committee meetings to define, measure, and implement various efficiency and quality goals of the HEP, as well as a set of management-type duties more focused on clinical functions that are often completed during the course of the day-to-day activities of the physicians.

When determining the amount of funds in the pool available to compensate participating physicians, most professionals will determine an FMV hourly compensation for the specialty of the physician who provides the services and the number of hours necessary to provide the services. Except for committee participation, quantifying the number of hours under a HEP is difficult at best.

Typical goals and/or metrics of HEPs often include, but are not limited to:

- Reducing supply costs per inpatient discharge,
- Improving episodic care management capabilities,
- Improving hospital 10-day readmission rates, and
- Reducing the incidence of hospital acquired infections.

Much like the industry is now seeing fee-for-service evolve into value-based payment and CCM into HEPs, HEPs are likely to further evolve into other integrated programmes designed to achieve reduced costs, improve efficiency, and enhance quality of care across the continuum, such as clinically integrated networks.

Conclusion

One continuing challenge is determining compensation to physicians for the value brought through these hybrid services in accordance with OIG guidance and FMV standards. Working to quantify this value should consider numerous factors including, potential cost savings; health impacts on patient populations; impacts on government pay for performance models; and physician time and work effort. Ultimately, the transition from fee-for-service models to quality and cost-focused models continues across the healthcare system. This transition has brought about the need for innovative yet compliant payment models to encourage engagement and improvement for all stakeholders across the continuum of care.

The transition from fee-for-service models to quality and cost-focused models continues across the healthcare system.