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A strong moral compass

an interview with Leslie Caldwell

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Physician compensation in hospital quality and efficiency programs

» 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.

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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 programs 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 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 gainsharing model is one variant of these systems emphasized under healthcare reform. Gainsharing is a contractual arrangement that sets up a formal reward system in which participating workers share in cost savings resulting from increased efficiency.

Gainsharing 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, 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, but they are ordered because the physician routinely does so or feels the need to practice defensive medicine. Local practice patterns, not necessarily consistent with evidence-based or best clinical practice guidelines, may also influence physician behavior and lead to less efficient clinical care.

The introduction of diagnosis-related group (DRG) codes in Medicare added to the misalignment of incentives between hospitals and physicians. Under the DRG system, hospitals are paid a fixed amount, depending on the admitting diagnosis that comprises the majority of the associated hospital costs, including those under a physician's control. Because Medicare generally pays physicians based on the volume of procedures they perform, there is no financial incentive for the physicians to provide more efficient care in an effort to lower hospital costs. Since physicians control the treatment and diagnosis of patients, a physician paid on a fee-for-service model who provides more services to a hospitalized patient will typically receive more reimbursement. However, physicians also often control the use of supplies and the selection of devices, which are paid for by the hospital. Consequently, physicians have limited incentives to use facilities and supplies efficiently or to negotiate for greater efficiency (e.g., lower-cost devices with manufacturers).

Gainsharing and other shared savings-focused programs offer one potential solution to remedy this misalignment of hospital and physician incentives. Gainsharing works by providing physicians with a financial stake in controlling hospital costs. Specifically, in a hospital-physician gainsharing program, hospitals offer physicians a share of cost savings achieved by the hospital as a result of the physicians' behavior or decisions. Therefore, gainsharing differs from a pay-for-performance or incentive program, in which payments are made for a certain behavior (e.g., meeting certain quality standards or adhering to quality protocols).[1] However, recent industry information and trends indicate that models combining both cost savings incentives (i.e., gainsharing) *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 gainsharing civil monetary penalty (CMP) only applies to payments that induce the reduction or limitation of "medically necessary" services. This change arguably makes gainsharing programs 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).[2,3] 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 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.

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Given these key considerations and the specific facts in that instance, the OIG in Advisory Opinion 12-22 ultimately found that the arrangement did not warrant the imposition of sanctions under the Civil Monetary Penalties Law or the Anti-Kickback Statute. Certain factors were key to this finding, including:

- The hospital certified that the arrangement did not adversely impact patient care;
- The low risk that the arrangement would lead the physicians to apply a specific cost savings measure;
- The financial incentive tied to a cost savings component was reasonably limited in duration and amount;
- The physicians' receipt of any performance-based compensation was conditioned upon their not taking certain pre-defined actions (e.g., increasing referrals, altering patient care, "cherry-picking" patients);
- The hospital certified that compensation paid to the physicians was fair market value and did not vary with the number of patients treated; and
- The performance measures were defined specifically in a written agreement with a reasonable term supported with a fair market value opinion.

In 2012, CMS implemented the Hospital Value-Based Purchasing (VBP) Program, which is an initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to patients with Medicare. VBP payments are made based on performance of measured quality metrics, which are divided into two categories—the "patient experience of care" or nonclinical metrics, and the "process of care" or clinical metrics. The Fiscal Year 2016 Hospital VBP adjusted hospitals' payments based on their performance on four domains that reflect hospital quality: the clinical process of care domain, the patient experience of care domain, the outcome domain, and the efficiency domain. The Total Performance Score (TPS) composed the clinical process of care domain score (weighted as 10% of the TPS), the patient experience of care domain (weighted as 25% of the TPS), the outcome domain score (weighted as 40% of the TPS), and the

efficiency domain score (weighted as 25% of the TPS).[4]

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 programs 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 gainsharing, 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 programs 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 maximize profits. Under each of the models, hospitals and physicians must work together to succeed in maximizing 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 program (e.g., cardiology, orthopedic 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 realizing efficiency. A number of hospitals that have engaged physicians through CCM agreements have employed the physicians subject to the CCM agreement.

Other organizations have shied away from engaging physicians specifically in management services and are developing hospital efficiency programs (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 a 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. As an alternate approach, the pool of funds available to participating physicians can be based on the opportunity for cost savings or maintenance of high quality and tied back to compensation for the physicians who provide the services. The pool of funds is typically 100% at risk for the attainment of various goals related to the HEP. 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.

The goals and/or metrics used in HEPs often align similarly with those of other Medicare programs, including VBP, BPCI, CCJR, and gainsharing, but can be expanded to include all other hospital payers. 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 programs 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 will require considering 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.

1. CMS: Evaluation of the Medicare Gainsharing Demonstration: Final Report. January 2014. Available online at http://bit.ly/2yLPBP0
2. DHHS OIG: Advisory Opinion 12-22, December 31, 2012. Available at http://bit.ly/2fE9LWA
3. DHHS OIG: Advisory Opinion 08-16, October 7, 2008. Available at http://bit.ly/2xQzNg1
4. Medicare.gov: Hospital Value-Based Purchasing. Available at http://bit.ly/2woRsrw