Jen Johnson

hfm
healthcare financial management association www.hfma.org

do you know the fair market value of quality?

Hospitals must rely upon physicians to help them successfully compete in today's quality-focused healthcare market. The trick is in understanding the legal constraints involved in paying physicians for improving quality.

At one time, the critical factor of a hospital's success was its financial performance. Today, however, the critical success factors for hospitals are beginning to shift to the quality of their clinical performance benchmarked to national standards.

The growing emphasis on quality and transparency also is increasing the need for physician alignment. Because physicians control the delivery, management, and utilization of services, their engagement is critical for hospitals and health systems to achieve high-quality outcomes. Many hospitals, therefore, are involving physicians in various types of service arrangements, which often include management and leadership positions (see the sidebar on page 55).

Many of these arrangements today include an incentive payment for the physician's efforts toward helping the hospital achieve high-quality outcomes. Although such payments ultimately can produce clear benefits not only for hospitals but also for patients, it is important for hospital leaders to understand the legal constraints: Healthcare fraud and abuse laws dictate that any such compensation to physicians must be set at fair market value (FMV). Failure to do so could result in criminal and/or civil penalties.

These constraints create a serious challenge for hospitals. On the one hand, studies have shown that programs that offer incentives for quality can be effective (see the sidebar on page 56). And such programs clearly will become more prevalent as government and the private payers continue to explore new approaches to paying for quality (see the sidebar on page 57). On the other hand, with the growth of these programs comes a challenging question: What is the FMV for achieving high-quality care? Unfortunately, little guidance is available to hospitals in this area. The following discussion offers some tips on how hospitals might begin to answer this important question.

Look at Market Data on Quality Incentive Payments

To determine a reasonable amount of incentive compensation for producing improved clinical results, one should start with information on incentive programs from various payers in the marketplace. Market data show that incentives

AT A GLANCE

To develop a physician compensation package that includes fair-market-value incentive payments for their efforts to improve healthcare quality, a hospital first needs to:

- Evaluate current market data on quality incentive payments
- Be familiar with the existing regulatory guidelines related to paying for quality
- Understand the requirements for complying with the regulations

are paid for superior clinical outcomes, including improvement and performance above the 50th percentile of industry data. Some programs also reduce reimbursement for poor performance.

There are hundreds of pay-for-performance programs in the marketplace, with incentives as high as 10 percent of reimbursement. The following are examples of incentive legislation and programs for both reporting and quality outcomes. As a basis for determining payments to physicians, these examples reflect a more conservative approach.

The Medicare Improvements for Patients and Providers Act of 2008. This recently enacted legislation increased the bonus payment for reporting clinical outcomes from 1.5 percent to 2 percent of reimbursement, beginning in 2009.[a]

The Reporting Hospital Quality Data for Annual Payment Update Program and the Hospital Outpatient Quality Data Reporting Program. These CMS programs penalize providers 2 percent of their reimbursement if they fail to report quality data to improve the quality of physician services.

Hospital Quality Incentive Demonstration (HQID). CMS's pay-for-performance pilot program includes financial incentives for the top 20 percent of hospitals. Under HQID, the top 10 percent of hospitals receive an incentive payment of 2 percent of reimbursement, and the second decile receives an incentive payment of 1 percent of reimbursement.

Value-based Purchasing (VBP). Although not officially launched, CMS's proposed VBP program is expected to pay 2 percent to 5 percent of reimbursement for superior quality.

The Bridges to Excellence Program. This program established by Bridges to Excellence—a not-for-profit, coalition-based organization—has paid physicians incentives up to 10 percent of their annual income for meeting certain targets.[b]

Understand Regulatory Guidelines

Before any hospital embarks on an arrangement that gives physicians financial incentives to improve the quality of care, it is critically important that the hospital understand the regulatory guidelines surrounding these arrangements. The essential question is, How should an arrangement be structured to facilitate physician alignment while remaining compliant with the highly regulated environment surrounding payments to physicians?

Indications of what the regulatory authorities are looking for in constructing a compliant arrangement for incentive compensation are numerous. In the proposed 2009 physician fee schedule, CMS described a new regulatory exception to the Stark Law that would permit hospitals to provide monetary incentives to physicians for improving patient quality care and sharing patient care cost savings. The final physician fee schedule did not finalize the exception, but instead reopened the comment period for another 90 days.[c]

a. See Fuchs, E., "CMS Expands Pay-For-Reporting Initiative," *AAMC Reporter*, October 2008 (www.aamc.org/newsroom/reporter/oct08/cms.htm).

b. See also Endsley, S., Kirkegaard, M., Baker, G., and Murcko, A.C., "Getting Rewards for Your Results: Pay-for-Performance Programs," *Family Practice Management*, March 2004 (www.aafp.org/fpm/20040300/45gett.html).

c. See, for example, "Final 2009 Medicare Physician Fee Schedule Rule: An Analysis," McDermott Will & Emory, Nov. 14, 2008 (www.mwe.com/info/news/wp1108a.pdf); "Hospital Groups Say CMS Proposal for Incentive Payment and Shared Savings Programs Would Stifle Innovation," *AHLA Weekly*, Feb. 20, 2009 (www.healthlawyers.org/news); and Blesch, G., "CMS Puts Gain Sharing, Incentive Blessing on Hold," *Modern Physician*, Nov. 17, 2008 (www.modernphysician.com/article/20081117/modernphysician/311099979/-1).

Regardless of the finality of the proposed exception, the guidelines suggested by CMS present a solid foundation for determining what the agency expects from a carefully constructed arrangement. In addition, the Office of Inspector General (OIG) has issued several advisory opinions in recent years indicating similar guidelines. The following is a summary of pertinent points provided by CMS and the OIG related to financial incentives to physicians for providing high-quality care:

> Quality measures should be clearly and separately identified.
> Quality measures should use an objective methodology that is verifiable and supported by credible medical evidence.
> Quality measures should be reasonably related to the hospital's practice and consider the patient population.
> Incentive payments should consider the hospital's historical baseline data and target levels developed by national benchmarks.
> Incentive payments should be based on FMV.
> Thresholds should exist where no payment will accrue.
> Patients should be notified of the program.
> Payments should not be based on the value or volume of referrals.
> The program should be offered to all applicable providers.
> Hospitals should monitor program to protect reduction in patient care.

The guidelines suggested by CMS present a solid foundation for determining what the agency expects from a carefully constructed arrangement.

Quality Depends on Physician Engagement

The growth of pay-for-performance programs indicates providers, payers, and consumers are using quality measures in negotiating payment and selecting services. This trend has prompted healthcare organizations to seek physicians' collaboration under various types of arrangements, because they are best equipped to understand and implement the best practices and protocols for achieving superior clinical outcomes. A typical payment structure for a quality incentive arrangement includes hourly base compensation for services rendered and an incentive component that is variable based on the achievement of quality targets. However, other types of arrangements for aligning physicians with quality outcomes will likely evolve as pay-for-performance programs continue to proliferate.

One model for collaboration with physicians is the performance management arrangement (PMA). Under a PMA arrangement, a hospital engages a group of physicians to manage clinical care delivery for a service line in exchange for base compensation plus performance-based compensation linked to the attainment of quality measures.[a] A similar model is a comanagement arrangement where a new company is formed to align physicians with the goals of the service line, which include improving quality. Other unique arrangements are being seen in the marketplace. One such model involves the tying of call coverage payments to quality outcomes. This arrangement puts the call coverage payments for a service line at risk based on the attainment of certain quality benchmarks.

a. See, for example, Pinna, J., "Collaboration for Quality—Performance Management Arrangements," *ABA Health eSource*, February 2009 (www.abanet.org/health/esource/Volume5/06/Pinna.html).

The History of Quality Incentive Programs

Before hospital leaders can begin to create incentives for physicians to deliver high-quality care, they must understand what defines high-quality care. To begin to define what constitutes such care, the Centers for Medicare & Medicaid Services (CMS) established a program for reporting clinical outcomes. The 2006 Tax Relief and Health Care Act required the agency to establish a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries. CMS named this program the Physician Quality Reporting Initiative (PQRI).

The PQRI program is a precursor to the vast array of pay-for-performance programs that exist in health care today. A pay-for-performance program aims to increase the value of care by rewarding providers for delivering improving the quality of care. Incentive compensation also may be awarded attaining superior quality based on the achievement of predefined benchmarks.

Although the PQRI program fueled many pay-for-performance programs, the idea of giving physicians incentives to achieve high-quality outcomes actually predated the program. One of the greatest catalysts of performance-incentive programs was the landmark 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century* issued by the Institute of Medicine (IOM), which recommended that the federal government—with input from relevant private and public interests—identify, test, and evaluate various payment options to more closely align compensation with quality improvement goals. The IOM report offered a framework to better align incentives inherent in payment and accountability with improvement in quality.

From this, the Bridges to Excellence program was launched in 2003. Bridges to Excellence is a not-for-profit organization developed by CMS, employers, physicians, healthcare services, researchers, and other industry experts (www.bridgestoexcellence.org). Its purpose is to improve the quality of care by giving healthcare providers incentives to implement comprehensive solutions in delivering safe, timely, and effective patient care. Today, the program operates in more than 13 states with thousands of participating physicians.

In late 2003, CMS and Premier Inc. launched the Hospital Quality Incentive Demonstration (HQID), thereby taking a significant step toward realizing the idea of offering financial incentives to improve the quality of health care. The HQID project has included more than 250 hospitals, and raised overall quality by an average of 15.8 percent over its first three years. The project, which was extended through FY09, uses 30 nationally standardized and widely accepted care measures to patients in five clinical areas. Data show that the majority of hospitals in the HQID project—even those on the lower end of the scale—improved their quality of care across the board with respect to reliable use of scientifically based practices (www.premierinc.com/p4p/hqi).

Other payers quickly followed suit. By March 2004, research showed approximately 35 health plans representing 30 million members were offering pay-for-performance programs.

Since then, these programs have continued to grow and flourish. Research shows pay-for-performance programs are effective at improving quality. As an example, in 2008, the Robert Wood Johnson Foundation and California HealthCare Foundation reported results of a national program that tested the use of financial incentives to improve the quality of health care (*Rewarding Results: Aligning Payments with High-Quality Health Care*, June 27, 2008). The program supported seven projects across the nation that implemented systems designed to measure the performance of healthcare providers and adjust their compensation based on performance scores. Six projects involved physician incentives and one involved hospital incentives. The seven demonstrations paid out tens of millions of dollars in provider incentives and instituted performance reports to help physicians gauge and improve the quality of their care. Six of the seven projects continued after program funding ended and were operational as of December 2007. Among the notable findings from the program were that:

> Financial incentives motivate change
> Alignment with physicians is a critical activity for quality outcomes
> Public reporting is a strong catalyst for providers to improve care

It is clear that in addition to the payment levels, the terms of such an arrangement should be developed cautiously.

Understand Compliance Requirements

Based on the above guidelines and various regulations surrounding payments to physicians, the following recommendations for compliance should be considered while structuring these arrangements:

> Create specific and transparent contracts with safeguards based on reliable clinical data and outcomes benchmarked to nationally recognized sources of outcomes.
> Do not consider the value or volume of referrals. Instead, open the incentive program up to all applicable/current medical staff and utilize base-year volume in calculating compensation.
> Consider varying payout thresholds. For example, payment parameters for improvement should be less than those for achieving top decile performance, and there should be no payment at certain levels.
> Set maximum payment and various thresholds in advance and update them annually based on new baseline data.
> Understand and outline who is responsible for the metrics and ensure the incentive payment is distributed to the appropriate parties.

The Future of Quality Incentive Programs

Currently, both reporting requirements and pay-for-performance programs are growing at a rapid rate. The Centers for Medicare & Medicaid Services (CMS) has recently developed the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, which was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This section of MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. The RHQDAPU program currently requires hospitals to report 30 inpatient measures, and CMS has proposed 13 new measures for FY10. The data are publicly available on the Hospital Compare web site, which experiences over 2.5 million page views per month (www.hospitalcompare.hhs.gov).

In 2007, Congress established the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). Similar to RHQDAPU, this program requires outpatient facilities to report clinical outcomes. CMS also proposes to adopt four claims-based imaging measures for calendar year (CY) 2010 and 18 new measures related to other clinical topics such as cancer treatment for CY11. The agency also plans to expand the scope of these programs to cover ambulatory surgery centers in future rulemaking. It is likely that after reporting is well established, pay-for-performance will be the next step for these programs.

Although there is not yet a nationwide CMS pay-for-performance program, it is expected to come soon. CMS has already established successful pay-for-performance pilot programs and has plans to implement a similar program applicable to all Medicare providers. In fact, Congress authorized the development and implementation of a value-based purchasing (VBP) program to replace the RHQDAPU program. This new program also would use financial incentives and reporting to encourage high-quality care, and performance would be based on either improving historical performance or attaining superior outcomes compared with national benchmarks. It is projected that these incentive payments would be 2 percent to 5 percent of reimbursement. The VBP program is currently being tested.

Meanwhile, the number of private programs continues to increase exponentially, with more than half of commercial HMOs having programs in place already.[a]

a. See, for example, Wagonhurst, C.L., and Habte, M.L. "Quality-Based Payments: Incentives and Disincentives for Improvement," Health Care Compliance Association, Compliance Today, November 2008, www.foley.com (search publications and articles under keywords Quality-Based Payments [no quotes]).

> Consider the payment for each metric in context. Specifically, ask whether the results are easily attainable, whether payment is rendered for average performance without improvement, and whether the more difficult metrics are excluded.
> Understand FMV, which continues to be the standard of value for healthcare arrangements involving physicians and hospitals.

Pay for Performance: By the Numbers

The trend in paying for quality care spans federal and state healthcare programs as well as commercial payers. The following are examples of how this trend is reflected in actual dollars earmarked for or paid to hospitals, physician groups, and individual physicians as a reward for their efforts to improve the quality of care:

> For FY10, the Chronic Care Improvement Program (CCIP), which was authorized under the 2003 Medicare Modernization Act, has budgeted $13.6 million to expand pay for performance in the CCIP under the Missouri Medicaid program.
> The Centers for Medicare & Medicaid Services (CMS) awarded approximately $7.5 million in incentive payments to more than 560 physician practices in 2008 as part of the Medicare Care Management Performance demonstration. The average payment per practice was $14,000.
> CMS awarded incentive payments of $12 million based on 2007 data as part of its Premier Hospital Quality Incentive Demonstration (HQID) project.
> Five physician groups earned a total of $25.3 million in performance payments based on 2007 data under CMS's Physician Group Practice demonstration.
> In 2007, California health plans paid more than $65 million to physician groups to reward quality of patient care under the Pay for Performance program.
> Under the Bridges to Excellence program in Minnesota, physicians received $97,000 in rewards in 2006 and $260,000 in 2007 for providing optimal diabetes care to at least 10 percent of their patients.
> The top performing hospital in the HQID project received bonuses of approximately $744,000 and $365,000 based on 2006 and 2007 data, respectively.
> Blue Cross Blue Shield of North Carolina and the State Health Plan for Teachers and State Employees have paid $4.2 million in incentive compensation since 2006 to physicians meeting certain quality standards in diabetes care, heart/stroke care, or physician practice management efficiencies.
> The *Deseret Morning News* reported recently that, over the past year, Medicare paid Utah physicians more than $1.5 million in performance payments (range: $260 to $62,500 per medical practice) "for providing high-quality preventive care for patients with chronic illness" (Moore, C., "Medicare Rewards UTA Doctors," Sept. 1, 2009).

Determining FMV for a Quality Incentive Arrangement

The method for determining FMV compensation stipulated in a quality incentive arrangement depends on several factors. Most important, the structure and terms of the compensation arrangement, which can vary considerably, should be clearly defined before valuing incentive compensation.

Because paying for quality care is a relatively new idea, several forms of these arrangements exist, and they continue to evolve. Compensation for quality care may be based on a fixed fee, a variable fee, or a combination thereof. Regardless of the structure of the arrangement, considering the compliance points discussed above is important in determining FMV for these payments under any type of arrangement.

As suggested previously, common compensation arrangements for quality incentives include performance management agreements and comanagement agreements. The following outlines the basic compensation structure and FMV method for determining incentive compensation under these types of agreements.

Fixed fee. A quality committee is formed comprising physicians and, in some instances, nonphysician hospital employees. Hours for the physicians are logged and they are paid an hourly rate for time dedicated to meetings designed to improve the overall quality of care for a specific service line. The FMV of this hourly rate should be based on what it would cost the hospital to engage a physician to provide similar services. Compensation

survey data for physicians in administrative and clinical roles should be considered when determining the FMV for this hourly rate.

Variable fee. Quality targets are outlined in an agreement, and incentive payments are provided to those responsible for developing and implementing best practices to achieve the predefined targets. Under this payment model, the market has shown it compensates for both improvement in quality and the attainment of high quality compared with peer performance. To determine the FMV for quality incentive payments based on a variable fee, a hospital should undertake two broad actions, each involving four steps.

First, to understand what constitutes superior quality and improvement, the hospital should:

> Identify key quality metrics for the service line
> Obtain industry-recognized benchmark data for the quality metrics, at the very least to understand the average or median and top or 90th percentile performance benchmarks
> Determine the service line's historical performance for the quality metrics
> Develop a schedule whereby historical and national data are outlined and levels of improvement and attainment of top quality are clearly identified

Second, to calculate the incentive compensation pool, the hospital should:

> Determine the net revenues for the service line being managed
> Determine the appropriate market rates for improving and achieving superior quality care
> Understand who is responsible for developing and implementing the strategy to achieve the targets, and allocate the incentive compensation pool accordingly
> Create payment tiers for incentives that compensate minimal amounts for improvement over a benchmarked average or median and that compensate higher amounts when the service line is placed in the top tier for quality

A note regarding determining market rates: Medicare-mandated rates are typically considered conservative. However, if the hospital is enrolled in a quality program whereby a third-party payer compensates the hospital for high quality, these market rates should be considered as well.

In any event, hospitals should keep two key points in mind: There are several methods for determining FMV, and when paying financial incentives for improving care quality, the structure of the arrangement should be based on a careful consideration of all the facts and circumstances, including a clear understanding of the services being provided and resulting quality outcomes that must be achieved.

The Bottom Line

Based on the industrywide focus of quality outcomes, recent OIG opinions, and the growth of pay-for-performance programs, it appears that paying for quality will be a new staple in many healthcare arrangements. Both the terms of the contracts with physicians and the analytical process for determining the payment will be essential in defending the arrangement before regulatory authorities. ●

About the author

Jen Johnson, CFA
is senior manager, professional service valuation, VMG Health, LLC, Dallas (jenj@vmghealth.com).

This article is not to be construed as legal advice.