HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

Volume Thirteen
Number Eight
August 2011
Published Monthly

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Compliance checklist: Compensating physicians for quality care

By Jen Johnson, CFA

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Because hospitals' critical success factors are shifting towards quality performance benchmarked to national standards, many health systems are involving physicians in various types of service arrangements to assist in the effort to improve quality outcomes. It is important to understand that compensating physicians for assisting in the attainment of high quality care must be set at fair market value (FMV) and that the terms of the arrangement must be consistent with regulatory guidelines. Failure to do so could result in criminal and/or civil penalties based on health care fraud and abuse laws.

Numerous pay-for-performance (P4P) programs indicate that compensating hospitals and physicians for quality care is becoming more common. Currently, there are a growing number of governmental and private payor P4P programs. In 2003, the Centers for Medicare and Medicaid Services (CMS) started financially incentivizing hospitals for quality through a P4P program launched by CMS and Premier Inc., the Hospital Quality Incentive Demonstration (HQID) program. HQID includes more than 250 hospitals and is based on 30 nationally standardized and widely accepted care measures to patients in five clinical areas.[1] Similarly, there are governmental pilot P4P programs specifically related to physicians' quality outcomes.

Although there is not yet a nation-wide CMS P4P program, a national Value Based Purchasing (VBP) program is expected. On January 7, 2011, CMS released a proposed rule establishing the VBP program. This program would be mandated under Section 3001 of the Affordable Care Act and is expected to provide value-based incentive payments to hospitals beginning in Fiscal Year 2013, based on their achievement or improvement related to quality care measures.[2] Meanwhile, the commercial payor landscape shows the number of P4P programs continues to experience rapid growth for both hospitals and physicians.

The payoff for quality incentives

Research shows P4P programs are effective at improving quality. The majority of hospitals involved in the HQID project, even those on the lower end of the scale, improved their quality of care across the board. The most recent HQID results show that hospitals raised overall quality by an average of approximately 18% over five years.[3]

As another example, Rewarding Results: Aligning Payments with High-Quality Health Care was a national program of the Robert Wood Johnson Foundation and California HealthCare Foundation that tested the use of financial incentives to improve the quality of health care through seven programs for both hospitals and physicians. Notable results from the programs conclude that financial incentives motivate change and physician participation is a key factor in improving quality.[4]

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Although the majority of studies show these programs work, some research shows otherwise. Quality programs may fail when payments are made to physicians without any measurable improvement in quality. Therefore, the structure, implementation plan, and compensation parameters must be defined upfront to ensure the physician payments are linked to actual improvement or superior outcomes.

Regulatory guidelines related to paying for quality

Once the hospital and physician(s) have decided to focus on improved quality, processes for implementing and monitoring the agreement between the parties will be the key to compliance. The following is a summary of pertinent regulatory guidance related to financially incentivizing for quality care.[5]

Quality measures

- should be clearly and separately identified,
- should use an objective methodology which is verifiable and supported by credible medical evidence, and
- should be reasonably related to the patient population.

Incentive payments

- should consider historical baseline data and target levels developed by national benchmarks,
- should have thresholds beyond which no payment will accrue, and
- should be based on fair market value and not consider the value and volume of referrals.

The program

- should notify all patients of the quality incentive program,
- ideally will be offered to all applicable providers, and
- should be monitored to protect against reduction in patient care.

It is clear that in addition to the payments, the terms of the arrangement will need to be cautiously developed if a health care organization is considering paying for quality care. There are various types of quality incentive arrangements in the market, all of which should consider the guidelines above. The following outlines a checklist to consider when valuing the compensation available to physicians for improving quality care.

Compensation checklist

Incentive payments may be found in agreements such as employment, independent contractor arrangements, and clinical co-management agreements. The following checklist should be reviewed when constructing an arrangement that financially incentivizes physicians for quality care.

Fee structure. Regulatory guidelines require that payments to physicians be set at FMV. In order to document an arrangement is at FMV, understanding the services being provided per the agreement and resulting quality outcomes will be essential. Therefore, determining the FMV compensation for such an arrangement should be assessed after an agreement has been drafted and services have been outlined. Ideally, the FMV analysis will reflect the services and structure as exactly outlined in the agreement.

Quality metrics. Once the structure has been defined, a significant amount of due diligence should be involved with choosing the appropriate quality metrics since the resulting outcomes will be the driver for the fee. The metrics chosen should be reasonably related to the relevant patient population and consider current performance.

Benchmarking. A fundamental step to incentivizing quality care requires understanding what defines superior quality, as well as improvement. Regulatory guidance suggests that when incentivizing for quality care, the quality measures should be individually tracked and use an objective methodology which is verifiable and supported by credible medical evidence. Specifically, it is prudent that quality targets be developed by, and measured against, national benchmarks. At the very least,

one should understand the average or median, and top or 90th percentile performance. This will assist one in documenting what constitutes average and superior quality outcomes.

Historical performance. Regulatory authorities have stipulated that incentive payments should take into account historical baseline data. Understanding historical performance is the only way to support that improvement was actually achieved. Another reason to consider historical performance is to ensure that a portion of the chosen metrics reflect areas that need improvement.

Legal guidelines. It is critical that health care executives are able to defend incentive compensation stated in any agreement. Risk levels and physician alignment strategies vary greatly among hospitals across the nation, making structure and fee decisions more complicated due to lack of industry standards. It is important to step back once the terms and compensation of an arrangement are outlined and ask if it makes sense, based on the economics and/or the hospital's mission, without considering referrals.

Bottom line

Based on the growth of commercial and governmental P4P programs, paying for quality care appears to be the way of the future. If a health care organization is considering implementing an arrangement which financially incentivizes physicians to improve the quality of care, understanding the regulatory guidelines surrounding these arrangements is as important as ensuring the payments are set at FMV. Both the terms of the agreement and the analytical process for determining the payments will be essential in defending the arrangement before regulatory authorities. ■

This article is not to be construed as legal advice.

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