A Balancing Act: Alternative Payment Models and Physician Compensation

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Presentation Overview

- Introductions & Perspective
- Trends in Physician Compensation
- Recent Regulatory Take-Aways
- New Structures and Implementation
- Compliance Tips for Alternative Payment Models
Jen Johnson, CFA

- **Perspective:** 3rd party valuation expert with understanding of legal and compliance issues.

- Managing Director at VMG Health & has led Professional Service Agreements Division for 10 years
- Integral in developing internal compensation solutions for some of the largest health systems in the country
- P4P Thought Leader
- Published and presented over 50 times related to physician compensation and fair market value
- Previously with KPMG’s Litigation Services practice & Former Finance professor from the University of North Texas
Kenya Woodruff, JD

- **Perspective:** Outside counsel to providers, accountable care organizations and other entities with innovative delivery models; Former in-house counsel at an urban public hospital

- **Partner; Chair of the Health Care Practice Group, Haynes and Boone**

- Assists providers in the creation and implementation of innovative delivery models, including the design of compliant payment models that meet the clients business and operational needs

- More than 15 years of experience in the healthcare industry, having previously served as a Compliance Officer and Privacy Officer of a national publicly-traded radiology services company and as Deputy General Counsel at Parkland Health & Hospital System.
Trends in Physician Compensation
### Compensation Arrangement Types

<table>
<thead>
<tr>
<th>Administrative Services</th>
<th>Call Coverage</th>
<th>Co-management (fixed + variable)</th>
<th>Subsidy</th>
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<tbody>
<tr>
<td>P4P, Bundled, HEIP, IDN, &amp; ACO Payment models</td>
<td>PSA Model ($/WRVU + expenses)</td>
<td>Professional/technical splits</td>
<td>Clinical Services</td>
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<tr>
<td>Billing and Collection Management/IT Development</td>
<td>Medical Director</td>
<td>AMCs Tier 1,2,3 (Sunshine Provision)</td>
<td>Telemedicine Hub to spoke Hub to provider System to Vendor</td>
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### LATEST IN PHYSICIAN COMPENSATION

1 - Regulatory Scrutiny
2 - Internal processes for setting compensation
3 - P4P – newest challenges for determining FMV
Top 3 Trends in 2016

1 - Increased regulatory scrutiny
   1. Huge surge in Qui Tam suits – physicians, compliance officers, etc…
   2. Federal funding for fraud and abuse investigations growing
   3. Numerous and material settlements over past several years (Tuomey, Citizens, Halifax, Bradford, Lexington, etc…)
   4. Personal accountability now a real thing

2 – New processes to streamline physician compensation
   1. Save time
   2. Save money
   3. Increase compliance

3 - New types of arrangements – APM, P4P, ACO, IDN, HEIP
   1. Government and commercial payors continue to introduce payment models at a rapid rate.
   2. Market data and regulatory guidelines for these payments scarce
   3. Waivers conflict with Stark and only cover some deals
   4. FFS plus P4P – how to ensure its OK?
Recent Health Care Fraud Efforts

- **Why?** For every $1 spent on healthcare fraud related investigations, government recovers $6.10

- **2016 stats:**
  - Strike force teams in 9 areas targeting local doctors and large companies have resulted in 2,185 indictments and nearly $2 billion in recoveries
  - DOJ recovered nearly $5 billion in FCA cases, 25% more than 2015
  - June 2016 – DOJ and HHS reports landmark charging 301 individuals for false billing of $900 million

- **Yates memo and OIG alerts warn individuals are at risk criminally and financially**
Real people, Real problems – New Area for Concern

✓ Columbus Regional in Georgia - Claims for payment to federal health care programs that misrepresented the level of services they provided - Dr. Pippas to pay $425,000.

✓ Tuomey – hospital settled case and over one year later, former CEO fined $1 million.

✓ North American Health Care Inc, - False claims to government health care programs for medically unnecessary rehabilitation therapy services - chairman of the board agreed to pay $1 million and the senior vice president agreed to pay $500,000.

✓ Sacred Heart Hospital - Former executives and physicians for alleged role in orchestration and participation in unlawful kickback compensation schemes - convicted and sentenced to prison terms.

✓ Recovery Home Care Inc - Former Owner, Mark T. Conklin allegedly paid dozens of physicians thousands of dollars per month to serve as sham medical directors - agreed to pay $1.75 million to settle lawsuit.

✓ Physician Assistant, Kyle D. Gandy - Sentenced to 14 months in prison and ordered to pay $18,030 in restitution for accepting illegal kickbacks for referring patients to medical clinics, physical therapy clinics, and a home health care agency.
Internal Processes for Setting Physician Compensation

Many health systems have a partially or fully automated opinion process primarily for traditional arrangements which remain at the forefront of scrutiny

1. Medical Director
2. On-call Coverage
3. Clinical Compensation

Options for determining and documenting FMV

1. Verify all arrangements internally
2. Split between internal process and outsourcing higher risk arrangements
3. Verify all externally

Not all health systems are structured alike, FMV process differs based upon:

- Risk tolerance (may change with leadership as well as external market forces) – where are thresholds, 75th ok?
- Health system’s approach to physician agreements (consistent -> each unique)
- Structure of physician alignment team and decision process
  - Team dedicated to physician compensation
  - Legal, business development, compliance, or facility-level decisions
  - Decentralized or centralized opinion requests
Balancing Compliance with Internal Processes for Setting Physician Compensation

The 3 C’s of FMV Deliverables – must be understood and balanced

- Cost – importance
- Compliance – risk tolerance
- Convenience – speed, need for assistance

Benefits of building strong internal processes and compensation team

- Shows consistency and lowers risk if set up properly
- Saves money on outside valuations
- Should speed up process to get deals done

Disadvantages of relying solely on internal compensation team

1. Monitoring processes are properly developed and followed
2. Complex deals may fall outside of many processes
3. Risks of over-automation (software products)
   - Raw Survey license restrictions may limit data usage
   - May eliminate all judgment
   - User error

4. **New P4P may be difficult to streamline and value properly internally**

Striking the balance should consider executive and compensation team structure, risk tolerance, and competitive environment
PAY FOR PERFORMANCE

PERFORMANCE
P4P Background

Quality payment focus primarily 2003-2010 (sharing savings was a slippery slope)

- Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals: 2003-2009
- Physician Group Practice Demonstration for ten physician groups: 2005-2010
- Third party payors and health systems start incentivizing for quality

Savings alone (Capitation) no longer in the mix – but ACOs emerge with savings and quality thresholds

Multiple models and arrangements exist today beyond Commercial and Medicare ACOs

- Medicare Shared Savings Program
- Bundled Payments for Care Improvement
- Commercial payor P4P programs growing exponentially
- Government launching of numerous APMs

*Valuation process should consider regulatory guidance, governmental programs and third party payor models*
Goals per CMS – FFS and P4P Co-exist during Transition

- Financial Viability—where the financial viability of the traditional Medicare fee-for-service program is protected for beneficiaries and taxpayers.

- Payment Incentives—where Medicare payments are linked to the value (quality and efficiency) of care provided.

- Joint Accountability—where physicians and providers have joint clinical and financial accountability for healthcare in their communities.

- Effectiveness—where care is evidence-based and outcomes-driven to better manage diseases and prevent complications from them.

- Ensuring Access—where a restructured Medicare fee-for-service payment system provides equal access to high quality, affordable care.

- Safety and Transparency—where a value based payment system gives beneficiaries information on the quality, cost, and safety of their healthcare.

- Smooth Transitions—where payment systems support well coordinated care across different providers and settings.

- Electronic Health Records—where value driven healthcare supports the use of information technology to give providers the ability to deliver high quality, efficient, well coordinated care.
Overview

- U.S. Department of Health and Human Services requested study
- 129 VBP programs (91 P4P, 27 ACOs, 11 bundled payments)
- Measures: Clinical Quality, Cost, Outcomes, Experience

Recommendations

- Set measurable goals, use national data
- Case-mix adjust outcomes measures, use broad set of measures, identify overtreatment measures, monitor
- Evolve from narrow process measures to broader set emphasizing outcomes
- Sponsor engage providers in design/implementation
- VBP sponsors should collect a common set of factors to find best working program

Conclusion - Need More Information

- HHS should develop a structured research agenda to address gaps in VBP knowledge base
- CMS should study private-sector programs, program design information not available
- Study changes and investments, experiences and challenges
### Evolution of P4P Arrangements

#### What We Do Know

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<th>Standard Process Leading Up to P4P Payments</th>
<th>Common Factors Included in P4P Arrangements</th>
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<tr>
<td>▪ Recognized organization identifies quality metrics or average costs</td>
<td>▪ Lowering costs without sacrificing quality</td>
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<td>▪ Reporting measures is required, or costs are tracked</td>
<td>▪ Quality outcomes payments—individual, services line level, entire population</td>
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<td>▪ Benchmarking data is gathered</td>
<td>▪ Use of technology</td>
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<td>▪ Payments for outcomes or savings is observed in market</td>
<td>▪ Use of care coordinators</td>
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<th>Justification for Payments Changing</th>
<th>Valuation Drivers</th>
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<tr>
<td>▪ Payments for Reporting (i.e.: PQRI)</td>
<td>▪ Outcomes</td>
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<tr>
<td>▪ Pay for Process</td>
<td>▪ New dollars coming in from 3rd parties</td>
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<tr>
<td>▪ Pay for Outcomes</td>
<td>▪ Understand service line, practice level or population</td>
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<tr>
<td>▪ At risk for sub-par quality</td>
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*MACRA will provide new insight related to what CMS approves for incentivizing physicians*
# P4P Types of Arrangements

## Co-Management/Service line
- Understand and value each service
- Identify savings or quality metrics
- Suggest benchmarking
- Consider OIG’s gainshare and co-management opinions

## Bundled Payments/Individual/Employment
- Understand market reimbursement for physician services and quality
- Identify risk and responsibility of all parties
- Consider caps and stacking
- Understand MACRA

## ACO Type Model/Population/HEIP
- **Balanced approach for overall model should be assessed**
  - Opinion on allocation to parties (physicians, hospital)
  - Opinion on distribution among physicians
- **Value Drivers:**
  - Third party funded or from hospital
  - Infrastructure cost recovery
  - Buy-in or participation Fee
  - Time spent/effect – hourly rate paid/existing compensation model
  - Split of savings – existence of minimum savings threshold
  - Split of quality - benchmarks utilized, targets tough
  - Upside and downside risk
  - Care coordinator payments – i.e.: Nurse care manager
  - Available data key to determining support for individual performance payments
Recent Regulatory Trends
Recent Regulatory Trends

• DOJ Enforcement
• Current State of Stark
• MACRA – MIPS/APMs
DOJ Enforcement

• 4.76 billion in civil False Claims Act ("FCA") settlements in FY2016

• 2.5 billion from the healthcare industry

• 3rd highest annual recovery since the FCA was established
DOJ Enforcement

• Number of qui tam suits
  ▪ FY2015 – 638
  ▪ FY2016 – 702

• % of cases where the government declined to intervene decreased from 31% to 2.2%
Yates Memorandum

• The title of the memo is “Individual Accountability for Corporate Wrongdoing”

• Emphasizes DOJ’s commitment to combat fraud “by individuals”

• Recommends:
  ▪ Not to give cooperation credit unless company provides facts about specific individual activity
  ▪ To focus investigations on individuals “from the inception”
  ▪ Not to release “culpable individuals” from liability absent “extraordinary circumstances”
  ▪ Not to settle with company without “clear plan to resolve related individual cases”
DOJ Pursuing - Individual Liability

• Dynasplint Systems, Inc. (Dec. 2015)
  ▪ Company and its founder and president agreed to pay approximately $10.3 million to resolve allegations that they violated the False Claims Act by improperly billing Medicare for splints provided to patients in skilled nursing facilities

• Bostwick Laboratories (January 2016)
  ▪ Dr. David G. Bostwick agreed to pay the United States up to $3.75 million to resolve alleged violations of the FCA for billing Medicare and Medicaid for medically unnecessary cancer detection tests and offering incentives to physicians to obtain Medicare and Medicaid business.
DOJ Pursuing - Individual Liability

• Recovery Home Care Inc. and Recovery Home Care Services Inc. (March 2016)
  ▪ Former owner, operator and sole shareholder of RHC agreed to pay $1.75 million to resolve a lawsuit alleging that he violated the FCA by causing RHC to pay illegal kickbacks to doctors who agreed to refer Medicare patients to RHC for home health care services.

• Prost-Data, Inc., d/b/a OURLab, OPKO Health, Inc., and OPKO Lab, LLC (June 2016)
  ▪ Companies and former owner and CEO of Nashville drug testing company agreed to pay 9.35 million. The alleged Stark and AKS violations related to donations that OURLab and Oppenheimer made toward electronic health records (“EHR”) systems purchased by their client physician practices from EHR vendors.
DOJ Pursuing - Individual Liability

• Tuomey Healthcare System (Sept. 2016)
  ▪ former chief executive officer of Tuomey Healthcare System agreed to pay $1 million for his involvement in the hospital’s violations of the Stark law for billing for services referred by physicians with whom the hospital had improper financial relationships
  ▪ The settlement was separate from the $72.4 million settlement against Tuomey

• North American Health Care, Inc. (Dec. 2016)
  ▪ Chairman and SVP agreed to pay $1 million and $500,000, respectively, to resolve an FCA suit alleging submission of false claims for medically unnecessary services
  ▪ NAHC agreed to pay $28.5 million
Potential Stark Repeal?

As MACRA and other statutory reforms shift the health care system away from FFS, we also may be moving away from the law’s primary impetus. The Senate Committee on Finance recently noted,

The risk of overutilization, which drove the passage of the Stark law, is largely or entirely eliminated in alternative payment models. When physicians earn profit margins not by the volume of services but by the efficiency of services and treatment outcomes, their economic self-interest aligns with the interest to eliminate unnecessary services.

What is MACRA?

- The Medicare Access and CHIP Reauthorization Act of 2015

- MACRA contains
  - Physician Fee Schedule (PFS) updates
  - A new Merit-Based Incentive Payment System (MIPS)
  - A new Technical Advisory Committee for assessing Physician Focused Payment Model (PFPM) proposals and
  - Incentive payments for participation in Alternative Payment Models (APMs)
Changes to Physician Reimbursement

• Physician fees increase by 0.5% per year from 2016 to 2019

• Beginning in 2019, further move towards compensating physicians for value versus volume utilizing the Quality Payment Program
The Quality Payment Program (QPP)

Two Components:

1. Merit Based Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)
MIPS
4 MIPS Categories

1. **Quality** accounts for 50% of a clinician’s score in the first year. Clinicians choose to report six quality measures.

2. **Cost** (also called “Resource Use”) represents 10% of a clinician’s score in the first year. The score is based on Medicare claims, which means no reporting requirement for clinicians - uses more than 40 episode-specific measures.
4 MIPS Categories (cont’d)

3. **Clinical Practice Improvement Activities** constitute 15% of a clinician’s score in the first year. This metric rewards physicians for clinical practice improvement activities, including those focused on care coordination, beneficiary engagement, and patient safety.

4. **Advancing Care Information** (also known as “Meaningful Use”) constitutes 25% of a clinician’s score in the first year. Clinicians report customizable measures that reflect how they use EHR technology in their day-to-day practices - does not require all-or-nothing EHR measurement or quarterly reporting.
How much can MIPS adjust payments?

**Note:** MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.

*Potential for **3x** adjustment*
APM
What is a Medicare APM?

- A CMMI model under section 1115A (other than a Health Care Innovation Award)
- Medicare Shared Savings Program (MSSP)
- A demonstration under the Health Care Quality Demonstration Program or
- A demonstration required by Federal law
An Eligible Alternative Payment Entity

• Eligible alternative payment entity means, with respect to a year, an entity that:
  ▪ uses certified electronic health record technology;
  ▪ pays clinicians based on measures of quality comparable to those used for MIPS; and
  ▪ adopts a Medicaid Medical Home Model or bears more than a nominal amount of financial risk
Other Qualifying APM Models

• Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization arrangement)

• Comprehensive Primary Care Plus

• Medicare Shared Savings Program (Tracks 2 and 3)

• Next Generation ACO Model

• Oncology Care Model – Two Sided Risk Arrangement

(May add an ACO Track 1+)
Putting it all together:

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<tr>
<td>+0.5% each year</td>
<td>No change</td>
<td>+0.25% or 0.75%</td>
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<tr>
<th>MIPS</th>
<th>Max Adjustment (+/-)</th>
<th>4</th>
<th>5</th>
<th>7</th>
<th>9</th>
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<tr>
<th>QP in Advanced APM</th>
<th>+5% bonus (excluded from MIPS)</th>
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source: www.cms.gov
How will MACRA affect me?

Am I in an APM?

Yes

Am I in an eligible APM?

Yes

Do I have enough payments or patients through my eligible APM?

Qualifying APM Participant
- 5% lump sum bonus payment 2019-2024
- Higher fee schedule updates 2026+
- APM-specific rewards
- Excluded from MIPS

Bottom line: There are opportunities for financial incentives for participating in an APM, even if you don’t become a QP.

No

No

Is this my first year in Medicare OR am I below the low-volume threshold?

Yes

Not subject to MIPS

No

Subject to MIPS

source: www.cms.gov
New Healthcare Models
Patient Centered Care

Patient

PCP

Specialist

Home Health

CCM
Models to Control Care, Quality and Cost

• ACOs

• CIINs

• Joint Ventures

• Leveraging Physician Practices
Hospital ACO Structure

- Hospital
- ACO
- ACO Participants (e.g., Contracted Physicians)
- MSSP Agreement
- Participation Agreements
- Medicare

Key:
- Shared Savings
- Contractual Relationship
- Equity Interest
Independent Physician ACO Structure

Physicians

Third-Party Investors

ACO

Participation Agreements

ACO Participants (e.g., Physicians)

MSSP Agreement

Medicare

Key

- Shared Savings
- Contractual Relationship
- Equity Interest
ACO Waivers

1) **ACO pre-participation waiver** that applies to ACO-related start up arrangements in anticipation of starting an ACO

2) **ACO participation waiver** that applies broadly to ACO-related arrangements during the term of the ACO’s participation agreement

3) A “**shared savings distributions**” waiver that applies to distributions and uses of shared savings payments earned under the Shared Savings Program

4) **Compliance with the Stark Law Waiver**

5) A “**patient incentive**” waiver to encourage preventive care and compliance with treatment regimens
FTC Guidance on CINs

• Mechanisms to monitor and control healthcare services that are designed to control costs and ensure quality

• Choose CI network physicians who are likely to further these efficiency objectives

• Investment of capital – monetary and human – in the necessary infrastructure to realize the claimed efficiencies
Clinically Integrated Network

Figure 1: Overview of Clinical Integration

- Lab
- Billing
- Electronic Medical Record (EMR)

- Claims
- Care Management
- Provider Network

- Integrated Health System (IHS)
- Radiology
- Pharmacy

- Telemedicine
- Remote Monitoring
- Personal Health Record (PHR)

Source: Considerations of Clinical Integration, Truven Health Analytics (Dec. 2011)
Joint Venture

Owner Entity #1

70% (LP)

Owner Entity #2

30% (GP)

JV Entity

Provider Entity
Leveraging Physician Practices
FMV & Compliance Tips
Compliance Basics - Commercially Reasonable

- An arrangement will be considered “commercially reasonable” in the absence of referrals if the arrangement would make commercial sense … even if there were no potential DHS (designated health services) referrals. (69 Federal Register (March 26, 2004), Page 16093)

- Pre-cursor to determining FMV

- Hospital leadership must understand this standard since they will primarily be the individuals who assess CR. Sample P4P considerations:
  - Operational assessment – are the quality metrics relevant for the patient population?
  - Physician requirements – do physicians impact the metrics being measured and would they be considered stretch goals for the physicians?
  - Financial options – are there more viable ways to impact quality (ie: nurse care coordinators)?

- Counsels role – did hospital leadership walk through the business considerations?

- Valuation firm role – is the compensation at FMV?
Agreements should carefully be constructed

- Compensation should not be tied to expected or actual referrals. This is important when establishing compensation or when setting mechanism to drive compensation.
- Carefully construct alternative payment models (gainshare, MSSP, ACO, bundled payments) since often tied to other (non-physician) income streams.

Do not determine FMV based on

- What the hospital next door is paying.
- Non-comparable services and associated fees (ie: management vs. co-management).
- Weak valuation methodology lacking logic/explanation

Understand governmental and third party payor models
3 Largest Value Drivers for P4P Model to Impact Compensation

1. Follow the money - understand if the payments are self-funded from the health system or coming from third party.
   - There is more flexibility with compensation if third party generated and the commercially reasonable standard is easier to meet.
   - If self-funded, additional compensation based on a portion of any savings may be easier to support compared to quality payments because financial support is not required.

2. Responsibility of parties – parties who have a demonstrable impact on quality and/or cost savings may warrant more of the payment received under a P4P model.
   - Need to understand metrics and who is impacting them (physicians vs. health system employees)
   - Primary care versus specialist

3. Risk of parties – parties who take on risk may earn more, while those with limited risk may have limited upside potential.
Steps when Setting Up a P4P Incentive Model

1. Determine that the arrangement is commercial reasonable.
2. Select performance metrics that directly align with the hospital’s mission and values.
3. Understand where dollars are coming from and who is responsible for them.
4. Benchmark performance against historical and national data in order to identify superior outcomes.
5. Understand how base level and maximum payouts relate to risk and responsibilities. Does it properly incentivize the physician based on his/her level of risk, services and performance under that model?
6. Create an infrastructure to track and monitor quality performance, responsibility for quality and expense incurred (i.e. nurse care managers, IT system, etc.).
7. Make a FMV determination to ensure the various payouts under the agreement is reasonable.
Compliance Checklist – P4P Arrangements

Quality Payments
- Metrics outlined
- Primarily outcomes metrics (versus process or reporting)
- Be careful with low hanging fruit metrics
- Benchmark performance against medical credible evidence
- Ensure physician(s) will have demonstrable impact on quality
- Check for overlap of payments from co-management, bundled payments, etc…

Shared Savings
- No cherry picking or lemon dropping
- Identify separate identifiable cost savings opportunities in advance
- Ensure physician(s) will have demonstrable impact on cost savings
- Consider cap methodology applied in CMS models

- Understand the risk and responsibility of parties prior to determining split of quality or savings payments
Questions and Discussion