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evaluating the fair market value of pay for performance

A critical test for determining whether a pay-for-performance arrangement is effective and can pass regulatory scrutiny is to assess and document the fair market value of the arrangement.

AT A GLANCE

When assessing a pay-for-performance arrangement, the following factors should be considered:

- > Existence and/or size of minimum savings threshold before savings are allocated
- > Savings allocation percentage available to physicians
- > Benchmarks used to measure quality against past performance and/or medical evidence
- > Ways in which quality outcomes are measured and paid for
- > Per member per month payments for patient management
- > Physician investment (participation fee, time, or capital)
- > Existence of downside risk to physicians
- > Employed compensation structure (if applicable)

There has been a surge in new physician alignment strategies focused on cost savings and quality—and the result is evolving compensation models for physician services, including pay for performance. With these models, careful assessment of economic, market, and regulatory factors is required to decide how much of a financial incentive to offer physicians for their efforts in achieving high-quality care or reducing costs.

Various bodies of law have indicated that pay-for-performance payments to physicians must be set in advance at *fair market value* (FMV), defined by the International Glossary of Business Valuation Terms as “the price, expressed in terms of cash equivalents, at which a property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s-length in an open and unrestricted market, when neither is under compulsion to buy nor to sell, and when both have reasonable knowledge of the relevant facts.”

It is important to recognize that the FMV standard applies to the myriad payment models that are emerging in the shift toward value-based business models, not just pay for performance. Healthcare leaders should consider several factors when determining what to pay physicians under these models. They also should carefully document how FMV was determined in developing the methodology for such payment models.

Why FMV Is Important

In general, if a program drives referrals, the FMV standard should be considered.

The implications of defining FMV correctly are crucial to most healthcare arrangements between hospitals and physicians. Regulatory constraints imposed by the IRS on tax-exempt organizations, by the Centers for Medicare & Medicaid Services (CMS) under the Stark law, and by the

Office of Inspector General (OIG) under the anti-kickback statute require FMV as a standard. The OIG states that “the compensation must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician” (*Federal Register*, March 26, 2004). Furthermore, the OIG has provided guidance that creative arrangements should be carefully constructed.

Although there is an exception to Stark law for savings arrangements within accountable care organizations (ACOs) under the Medicare Shared Savings Program (MSSP), the exception may not encompass all potential arrangements with physicians providing services related to an ACO

entity (*Federal Register*, Nov. 2, 2011). Furthermore, the MSSP waiver does not cover commercial ACO arrangements.

A recently decided case serves as a reminder of the potential damage that a fraud and abuse violation carries (*United States of America ex rel Michael L. Drakeford, MD, versus Tuomey d/b/a Toumey Healthcare System, Inc.*, Sept. 30, 2013). This case involved a qui tam complaint filed against Tuomey Healthcare System for entering into part-time employment arrangements with a number of specialists who were compensated in a 10-year agreement to perform all outpatient procedures at one of the health system’s facilities, in lieu of a competing surgery center, and who signed noncompete clauses. The government

Pay for Performance: Taking a Closer Look

Because of health care’s focus on improving quality and reducing cost, entities are aligning with physicians under various arrangements and allocating both shared savings and quality-related payments to physicians through pay-for-performance arrangements. The goals of such arrangements are captured in what the Centers for Medicare & Medicaid Services (CMS) refers to as the “Triple Aim”:

- > Improving care for individuals
- > Improving health of populations
- > Lowering growth in expenditures

Several organizational alignment strategies focus on pay for performance. The most well-known strategy is the development of an accountable care organization (ACO). According to CMS, an ACO is “an organization of health-care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it” (“Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program,” CMS, November 2012). The goal of an ACO is to provide a continuum of patient-centered care for Medicare beneficiaries through physician communication and improved information technology infrastructure while maintaining quality of care.

In late 2011, CMS finalized new rules under the Affordable Care Act to help providers better coordinate care for

Medicare patients through an ACO: “[P]roviders of services and suppliers can continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B, and be eligible for additional payments if they meet specified quality and savings requirements” (*Federal Register*, Nov. 2, 2011).

Beyond Medicare ACOs, many commercial ACOs and other pay-for-performance programs exist throughout the country. Typical, these programs:

- > Focus on clinical areas such as asthma, depression, diabetes, coronary artery disease, congestive heart failure, and generic prescribing
- > Focus on high-acuity patients and preventive care
- > Require infrastructure investment
- > Use care managers to facilitate coordination
- > Focus in providing care across the continuum
- > Make providers eligible for shared savings distributions after meeting quality thresholds
- > Consider objective and credible medical evidence and historical performance to set quality benchmarks

Another pay-for-performance model is gainsharing, which lost momentum as a payment method several years ago, but has had a renewal recently. Under gainsharing, physicians share in cost savings that occur as a result of physicians and hospitals collaborating to reduce the cost of patient care. Traditionally, the Office of Inspector General (OIG) has

argued that the compensation was above FMV and considered the value and volume of the physicians' referrals.

The court found Tuomey's physician compensation agreements to be in violation of the Stark law, and imposed penalties amounting to nearly \$240 million. Although this case did not involve an integrated delivery system or ACO, it illustrates the importance of setting FMV compensation for physicians.

The need for FMV compensation in a pay-for-performance arrangement also was addressed in comments of the U.S. Department of Justice (DOJ) in response to a gainsharing arrangement undertaken by the Greater New York Hospital Association (GNYHA) (see the sidebar below).

The DOJ notes that, among the GYNHA's representations, the association indicated that it would take steps to conduct a fair market value analysis "to ensure that the hospital and its physicians have actually taken concrete steps to justify the award of incentive payments" (DOJ business review letter, Jan. 16, 2013).

Here are two simple questions to help ensure pay-for-performance payments are on the right track with regard to FMV:

- > Was the volume or value of referrals taken into account in developing the methodology associated with P4P distributions?
- > Are physicians being compensated for quality and cost savings based on their impact on predetermined metrics?

found that these arrangements to be acceptable when:

- > They focus on reducing waste and increasing efficiency
- > Physicians are required to work with hospitals to evaluate and conduct clinical reviews of various processes
- > Processes include standardization measures based on clinical criteria and recommendations for supply/medication usage
- > No shared savings are paid unless quality criteria are met
- > Objective and credible support for cost reductions are considered as well as historical performance related to the subject cost reduction benchmarks

Recently, the U.S. Department of Justice (DOJ) commented on, and determined that it would not challenge, a gainsharing arrangement whereby the Greater New York Hospital Association sought and received approval for a voluntary gainsharing program. Through this program, 100 hospitals desired to work with participating physicians to account for the use of hospital resources. Physicians who met hospital quality targets while lowering costs could be compensated a portion of the savings (DOJ business review letter, Jan. 16, 2013).

In addition to cost savings, payments for quality alone are being seen in employment agreements as well as larger scale arrangements such as co-management agreements. In such arrangements, CMS and the OIG suggest that quality measures should:

- > Be clearly and separately identified
- > Use an objective methodology that is verifiable and supported by credible medical evidence
- > Be reasonably related to the hospital's practice and consider the patient population
- > Be set with physician and hospital input

These organizations also suggest that incentive payments should:

- > Consider the hospital's historical baseline data and target levels developed by national benchmarks
- > Have thresholds at which no payment will accrue
- > Be based on FMV (and should not consider the value and volume of referrals)

Another recent example of guidance associated with payments for quality and cost savings is the recent favorable OIG advisory opinion, issued Dec. 31, 2012 (oig.hhs.gov/fraud/docs/advisoryopinions/2012/AdvOpn12-22.pdf). In this opinion, a hospital sought and received approval related to an arrangement with a cardiology group that was being compensated for patient service, quality, and cost savings measures. Guidelines found in this opinion reflect the factors listed in this article.

Guidelines from CMS and the OIG should be carefully considered when a hospital is contemplating a pay-for-performance initiative.

How FMV Applies

FMV is an important consideration for all the new compensation models emerging under pay for performance and those that will continue to emerge.

Shared savings. Under shared savings or gainsharing arrangements, in which a hospital shares with physicians savings from cost-savings initiatives, the allocation of savings needs to be reasonable and consistent with current market arrangements. The allocation of savings should ideally consider the effort and impact the physician(s) had on actual savings. In addition, the distribution methodology should not be based on the value or volume of referrals.

Distribution of savings within a physician group.

If shared savings are allocated to a group of physicians, one consideration is how to distribute payments to each physician for his or her efforts. The methodology for distributing the payments may vary among primary care physicians and specialists. The methodology also may vary from the program's first year to the subsequent years based on the availability of actual cost savings and quality score card data. In year one, some hospitals may not distribute savings payments until the second year when more reliable cost and quality information is available (*Contracting for Bundled Payment*, The Mitre Corporation, January 2012). Alternatively, an organization may use a neutral methodology, such as per capita, in year one. From an FMV perspective, the methodology should not consider referrals and should reflect payments for achieving efficiency and quality, rather than productivity.

Quality payments. Payments for improved and superior outcomes for professional services and hospital-based services have been growing in the market. If physicians are instrumental in achieving high-quality outcomes, it may be reasonable and consistent with current market arrangements to compensate physicians for quality. From an FMV perspective, before making quality-related payments, the hospital should

consider comparable payments in the market, historical performance, and benchmarking data.

Patient management. The patient-centered medical home (PCMH) model emphasizes care coordination and communication among physicians caring for a defined patient population. In many cases, the primary care physician becomes the medical home, acting as the care coordinator, typically with the assistance of IT and nurse care managers. In some medical home models, providers are paid a per member per month (PMPM) fee for providing certain patient care management services. This payment is intended to compensate for care management functions, not prepaid healthcare services. From an FMV perspective, the physicians should not participate in payments for patient care management services intended to cover IT and/or nurse care manager if the physicians are not responsible for these costs. Furthermore, the payment should be consistent with the market and reasonable based on factors such as the acuity level of the patients and National Committee for Quality Assurance (NCQA) certification level.^a

Bundled payment. Bundled payment includes financial and performance accountability for an episode of care, with the goal of achieving higher quality at a lower cost through enhanced coordination. If savings are achieved for the episode of care, physicians may be paid a portion of savings from the specific bundle. Similar to the shared savings payments, quality thresholds must be met for savings to be distributed. From an FMV perspective, the payments should be distributed in a manner that prevents allocation based on value or volume of referrals and should compensate physicians based on their services and contribution to actual savings that do not hinder quality.

a. NCQA manages accreditation programs for physicians, health plans, and other medical groups to improve quality standards of healthcare practitioners. NCQA offers a variety of certification programs and has established three levels of PCMH certification based on a point system for the PCMH's work in using data for population management, implementing continuous quality improvement, referral tracking and follow-up, and more.

Success Factors

One critical factor in FMV assessment of pay-for-performance arrangements is data. Because pay-for-performance compensation is based on a physician's influence on cost and quality, establishing FMV requires access to data that demonstrates that influence. If such data is not available, a neutral methodology, such as pro rata, may be a sound starting point for compensation.

Another important consideration is risk adjustment. Adjusting for a patient population's risk—whether age, gender, or acuity—is a challenging, data-intensive task, but also essential in establishing the appropriate degree to which a physician improves quality or lowers cost.

Another important factor is to be aware of any caps associated with the payment type. As seen in CMS initiatives such as the Medicare Gainsharing Demonstration and Bundled Payments for Care Improvement Initiative, to ensure the total payment to a physician for quality or cost savings does not appear excessive, caps are often established. The recent favorable GNYHA letter from the DOJ cited the caps on incentive payments to the physicians that were established by two of the participating hospitals.

Finally, when assessing FMV, it is important to consider as a whole all aspects that affect the amount of compensation. For example, if all of the compensation factors lean heavily in favor of higher physician compensation, the arrangement could be deemed above FMV and problematic from a regulatory perspective. When assessing a pay-for-performance arrangement, consider the following factors that drive the value of the arrangement:

- > Existence and/or size of minimum savings threshold before savings are allocated
- > Savings allocation percentage available to physicians

- > Benchmarks used to measure quality against past performance and/or medical evidence
- > Ways in which quality outcomes are measured and paid for
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An extreme example of what might seem unbalanced, or outside of FMV, would be when physicians are compensated 100 percent of a health system's cost savings without any tangible participation or benchmarking of outcomes.

The Bottom Line

As the healthcare industry struggles to reduce costs while improving quality, performance-based compensation has emerged as a potential tool to influence providers to improve quality and efficiency. However, such arrangements will work only when physicians are fully engaged—which in part requires that the programs be structured to compensate physicians fairly and in a way that will bring about the desired clinical and financial outcomes. ●

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