Physician Compensation: New Paradigms in the Post ACA World - Regulatory Issues in Structuring Physician Payment Models to Achieve Quality, Efficiency and Clinical Integration

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- This presentation:
  - Is the result of collaboration of your panelists
  - Will be an interactive discussion among your panelists
  - Is one of a planned series on this general topic, and will focus largely on clinically integrated networks/ clinically integrated organizations

Factors at Work in the Post ACA World

- Increased awareness and focus on the "Triple Aim":
  - Basis for the ACA
  - Foundation for many ACA provisions
    1. Improve patient experience
    2. Reduce per capita cost of care
    3. Improve health of the population
- Berwick *et al*: *Preconditions for [achieving the triple aim] include enrollment of the an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population."* (*Health Affairs, May 2008)*

Factors at Work in the Post ACA World

- Increased Demand and Funding for Primary Care:
  - Demand:
    - Increase in number of insureds
    - Increase in insurer coverage for primary care services, including screening and preventive care services such as mammograms and colonoscopies
  - Funding:
    - Medicaid reimbursement increases for primary care services (to match Medicare rates)
    - Medicare bonuses (10%) for practitioners who see Medicare primary care patients
    - $150 million in ACA awards to support health centers providing primary care
    - Additional subsidies and incentives to expand the number of primary care providers:
      - Loan repayments for practitioners who focus on primary care
      - Tax breaks for residents and physicians in loan repayment

Factors at Work in the Post ACA World

- Shifting from volume- to value-based payments:
  - Hospital Inpatient Value Based Purchasing Program ("HIVBPP")
  - Expanded Inpatient Quality Reporting Program ("IQRP")
  - Physician Quality Reporting System ("PQRS")
  - CMS Readmissions Reduction Program ("RRP")
  - Medicare non-payment rules (for hospital-acquired conditions ("HACs"), etc.)
  - Medicare Shared Savings Program ("MSSP")
  - Private payors and state Medicaid programs using ACA/Medicare payment rules and incentive programs as a model
  - Increased hospital cost pressures and need for hospital-physician alignment, coordinated care delivery

Factors at Work in the Post ACA World

- HIVBPP:
  - Began in 2012 w/ 1% withhold of baseline DRG payments
  - Hospitals must perform well on key quality indicators to earn back the withhold.
  - The key quality indicators include rates of hospital acquired infections and other complications that are considered “preventable”.
  - By 2016, the withhold will increase to 2%.
  - In addition to the withhold, the HIVBPP provides for a 1% penalty on Medicare payments for hospitals that are in the bottom quartile with respect to “Hospital Acquired Conditions” (HACs) such as infections.

Factors at Work in the Post ACA World

- Expanded IQRP:
  - HACs will be reported and tracked through the expanded IQRP.
    - Information accessible not only to CMS, but also patients and private payors
  - Private payors have example, incentive and mechanism for implementing similar programs to the HIVBPP, and are expected to do so

Factors at Work in the Post ACA World

- Expanded PQRS
  - Relies on incentive payments and payment adjustments ("carrots and sticks") to ensure reporting and tracking of care quality by practitioners
  - Currently allows for additional incentive payments to Part B practitioners who satisfactorily report data on quality measures for covered physician fee schedule services rendered to Medicare beneficiaries
  - Beginning in 2015, adjusts payment (downward) to Part B practitioners who did not satisfactorily report data on quality measures for covered physician fee schedule services rendered to Medicare beneficiaries (2015 adjustment based on 2013 reporting)
  - By 2017, all physicians will be subject to an additional adjustment through value based modifiers that measure the quality of care furnished against cost during a specified performance period (Starting in 2015, will apply only to physician groups with 100 or more eligible professionals; application will expand to all practitioners by 2017)

Factors at Work in the Post ACA World

- ACA introduced new restrictions for Medicare payment for readmissions ("RRP"):
  - Beginning in 2012, hospitals subject to penalties for high rates of readmission within 30 days for patients with an extended list of conditions, including heart attack, heart failure, pneumonia, hip surgery, knee surgery, COPD
  - Hospitals in the worst quartile for 30-day readmission rates lose 1% of baseline MS-DRG payment.
  - In 2014, the maximum penalty for high 30-day readmission rates will increase to 3%.
  - Data suggest that high rates of HACs correspond to high rates of 30-day readmissions.

Factors at Work in the Post ACA World

- Medicare withholds and penalties expected to affect more than just Medicare revenue
  - ACA prohibits Medicaid matching funds to states for care that is subject to the Medicare nonpayment rule = Medicaid may come to mirror Medicare.
  - Private payor policies are expected to gradually mirror Medicare with respect to payments for quality and penalties for poor performance on quality measures.

Factors at Work in the Post ACA World

- ACA introduced the MSSP
- Goal: Improve the quality and reduce the cost of care to Medicare beneficiaries through positive financial incentives (the carrot to the stick of the Medicare non-payment rules)
- MSSP participation requires formation of ACOs:
  - Composed of a combination of Medicare providers working together - *e.g.*, one or more hospitals, physician groups, home health providers, pharmacies etc. - to share responsibility for managing the care of a minimum of 5,000 Medicare beneficiaries for a minimum of 3 years
  - By virtue of entering into an MSSP agreement with CMS, an ACO is eligible to receive a portion of any savings achieved by the Medicare program as a result of managing the care of their assigned beneficiaries, provided that the care meets quality standards.

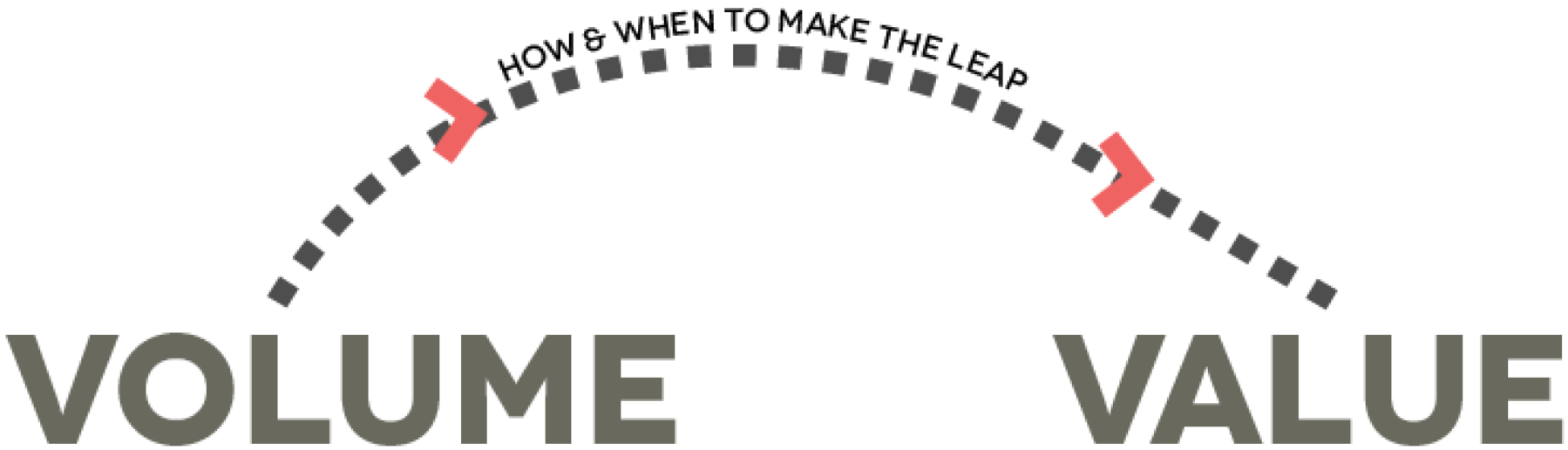
Factors at Work in the Post ACA World

- …the MSSP
- Waivers of existing laws and regulations to allow entities to form ACOS and participate in the MSSP
- Waivers signal government recognition that the goals of the MSSP (the "Triple Aim") cannot be achieved without alignment of incentives and coordination of efforts among healthcare providers.
- BUT… waivers do not apply to organizations that do not participate in the MSSP, even with respect to activities that are nonetheless geared toward achieving the Triple Aim.
- How do organizations address private payor policies that mirror the MSSP and/or other Medicare pay for quality initiatives if they are not in an ACO?

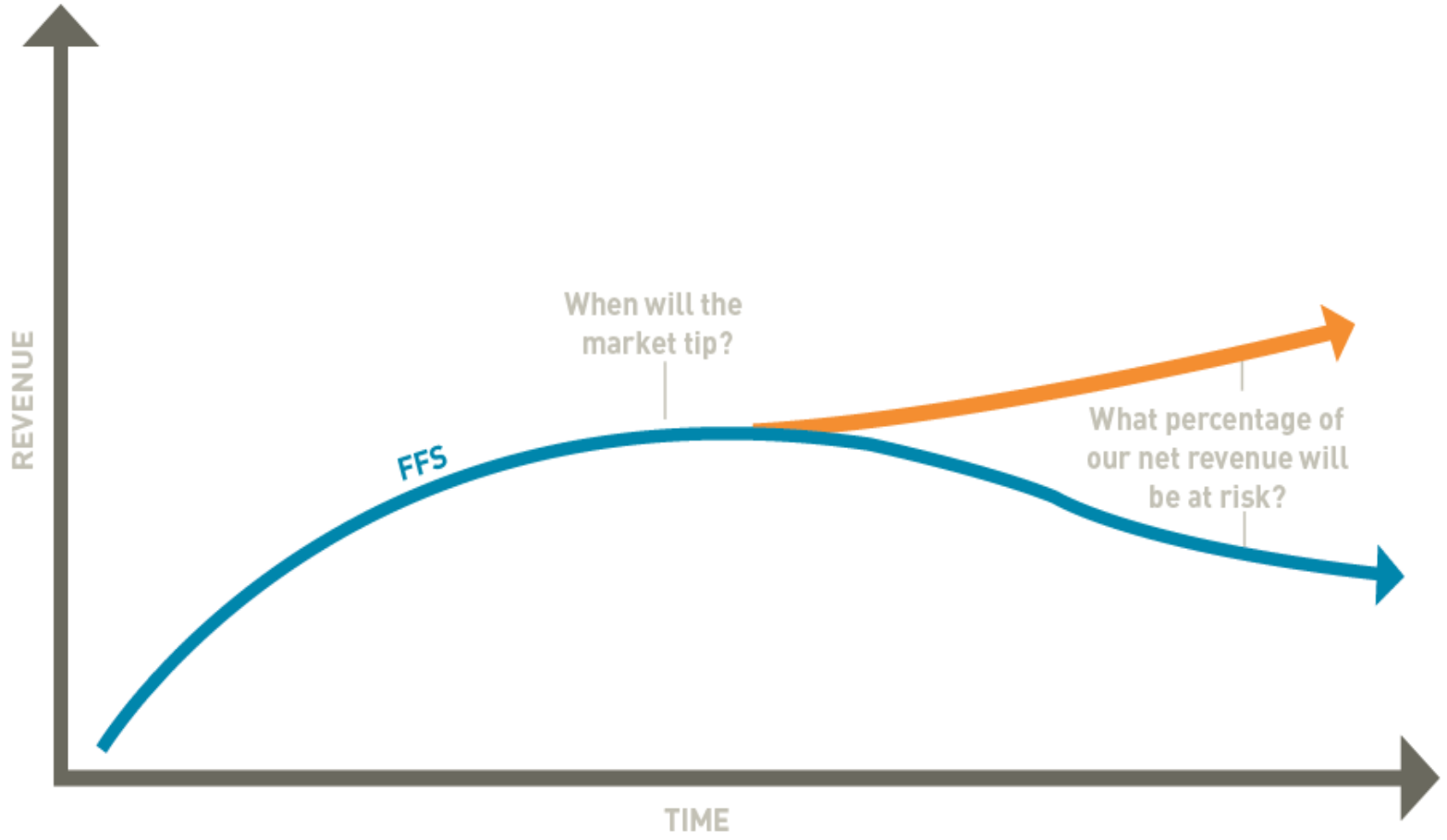
Factors at Work in the Post ACA World

- Achieving the Triple Aim
  - Physician activities are key drivers
    - Physician reporting of data to allow measurements
    - Physician use of data to plan care and guide changes in practice patterns
    - Physician adoption of IT to promote the above
- Trends:
  - Consolidation/Integration
  - Innovative legal structures to align physician incentives to the Triple Aim:
    - Co-management
    - HEPs
    - ACOs
    - "Clinical Integration" – CINs/CIOs
    - Gainsharing and gainsharing-like arrangements
    - Incentive compensation for employee physicians and hospital contractors
    - Combinations of the above

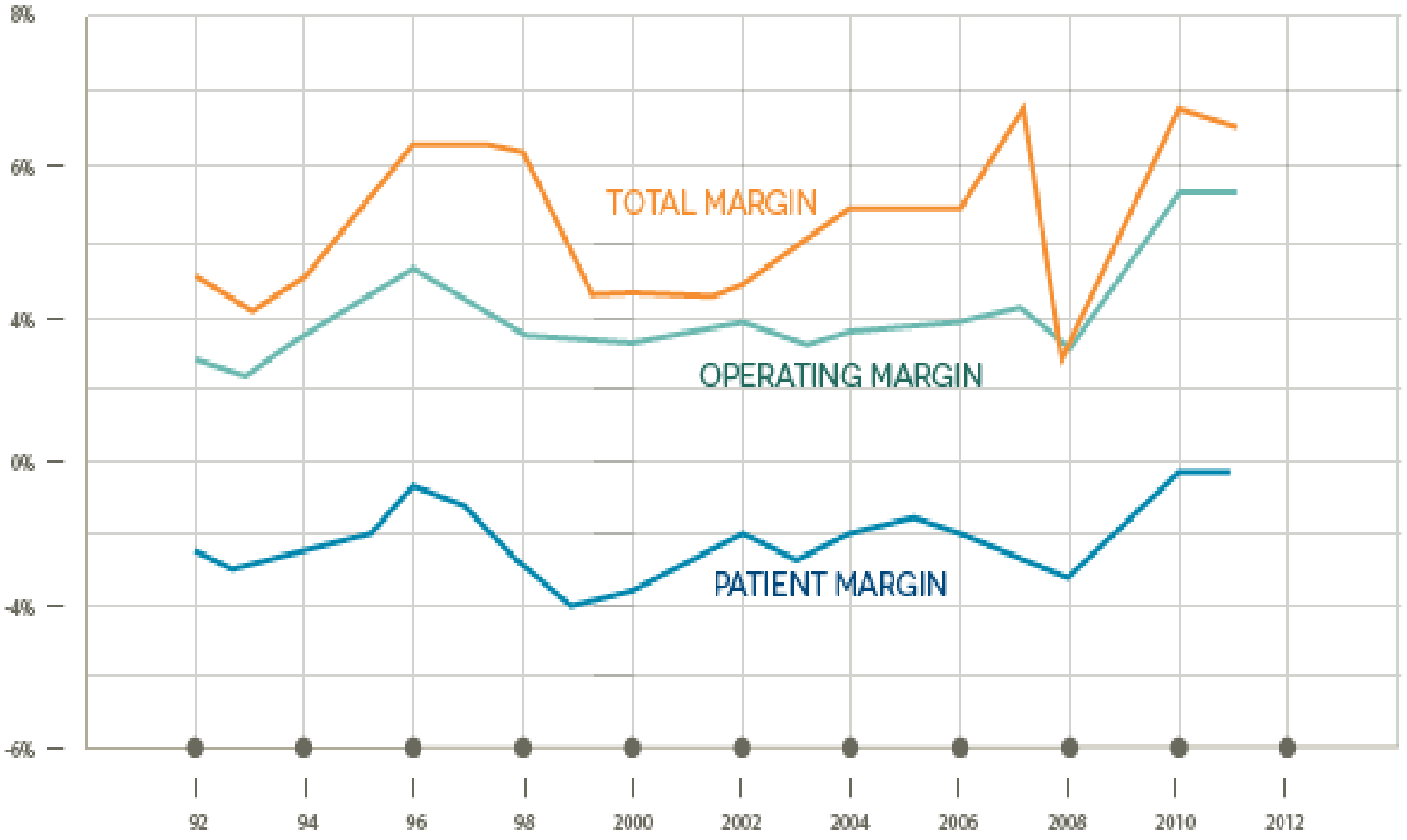
Volume to Value - Sprint or Marathon?



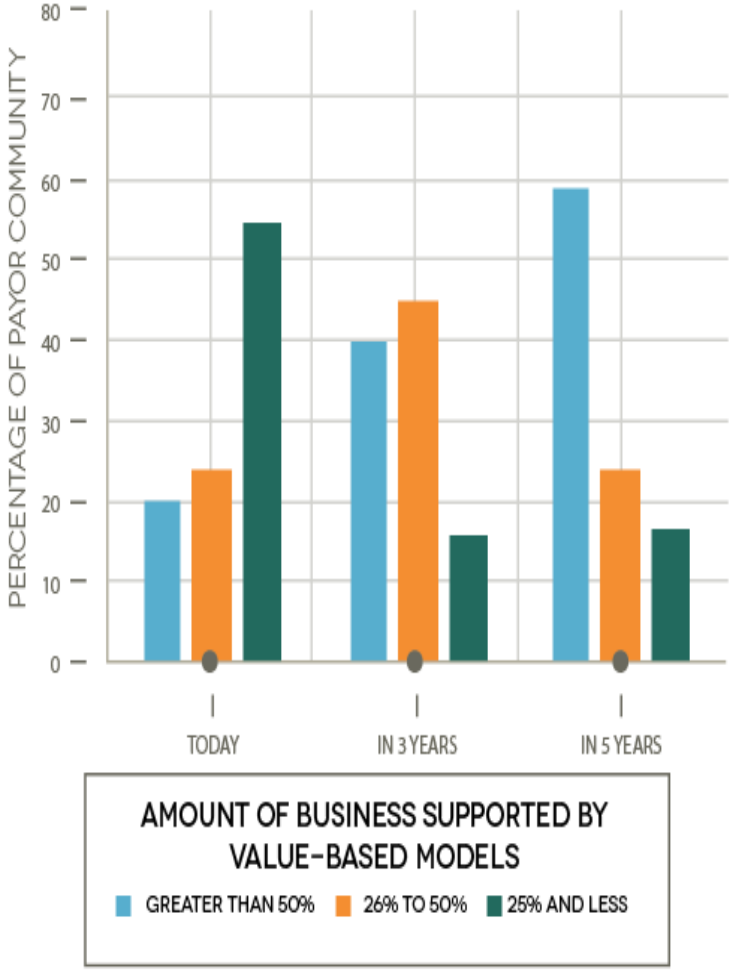
Tipping Point in Sight?

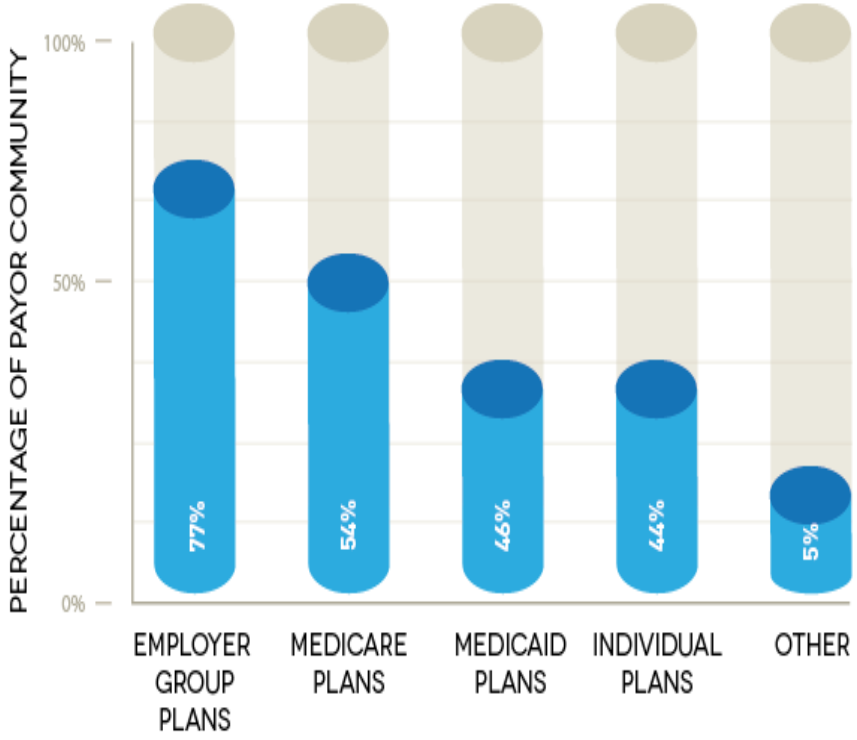


Are Hospital Margins Sustainable?

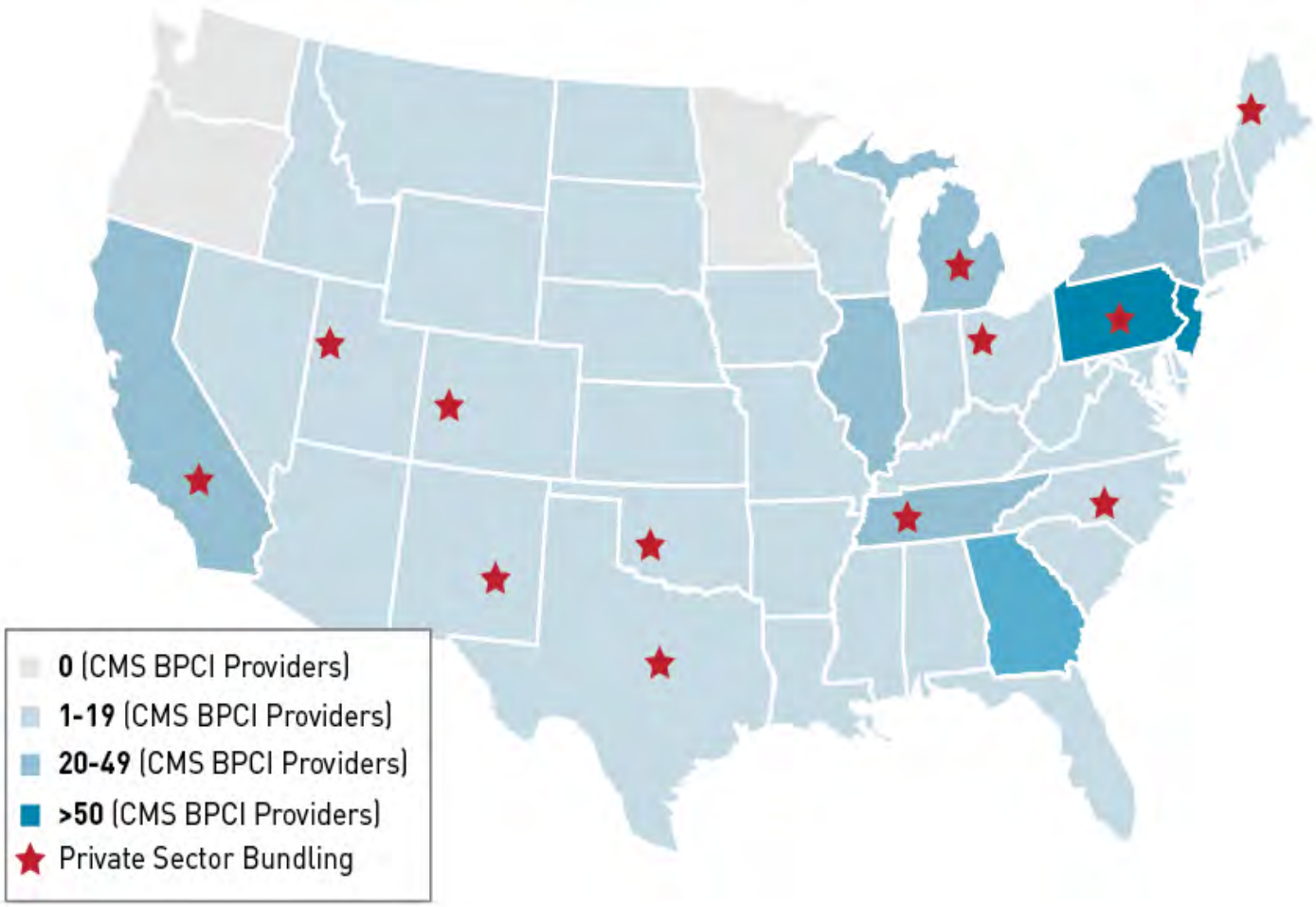


Move Toward Value-Based Payments
A Survey of the Payor Community



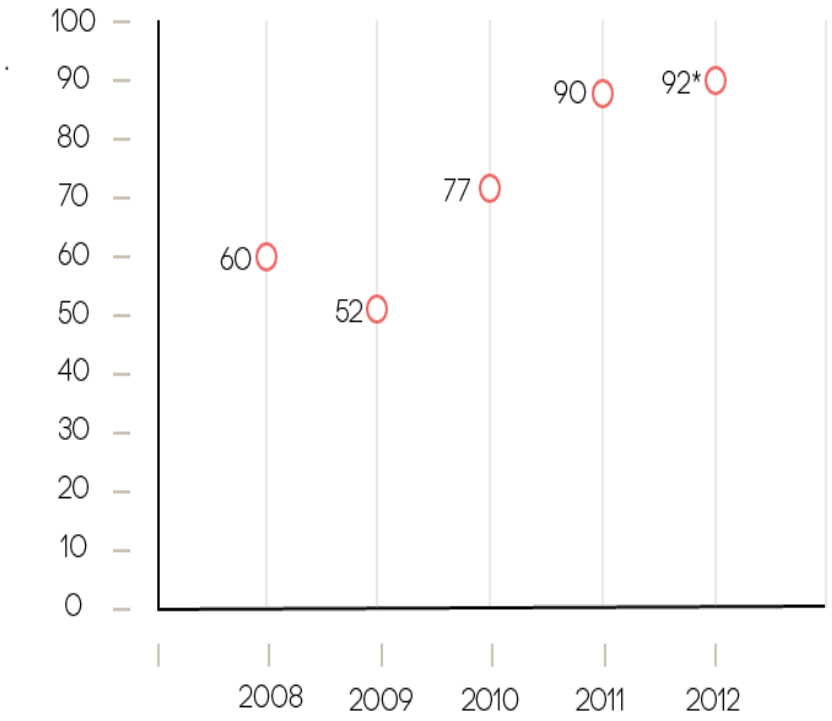


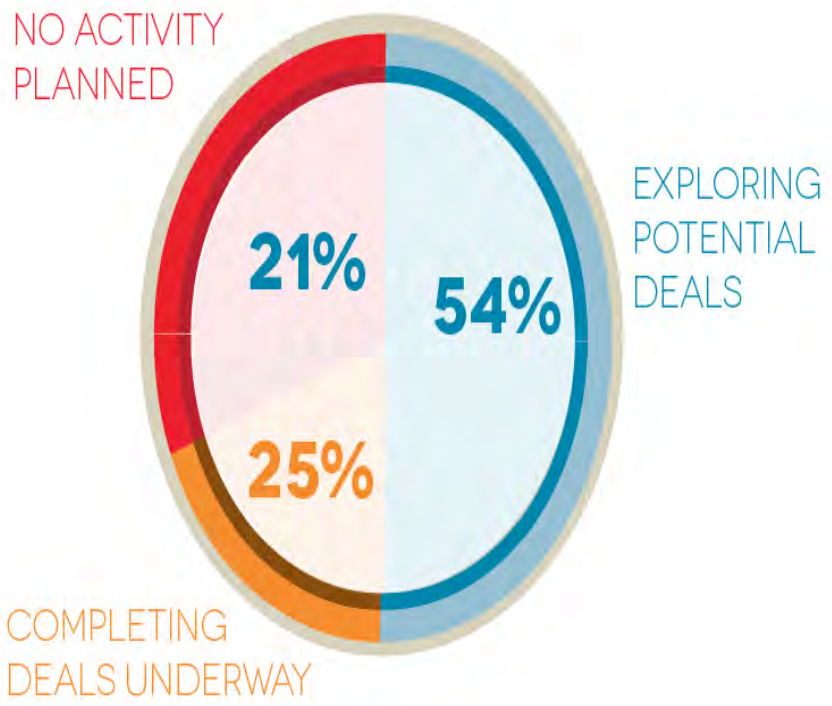
Experimenting with Bundled Payments



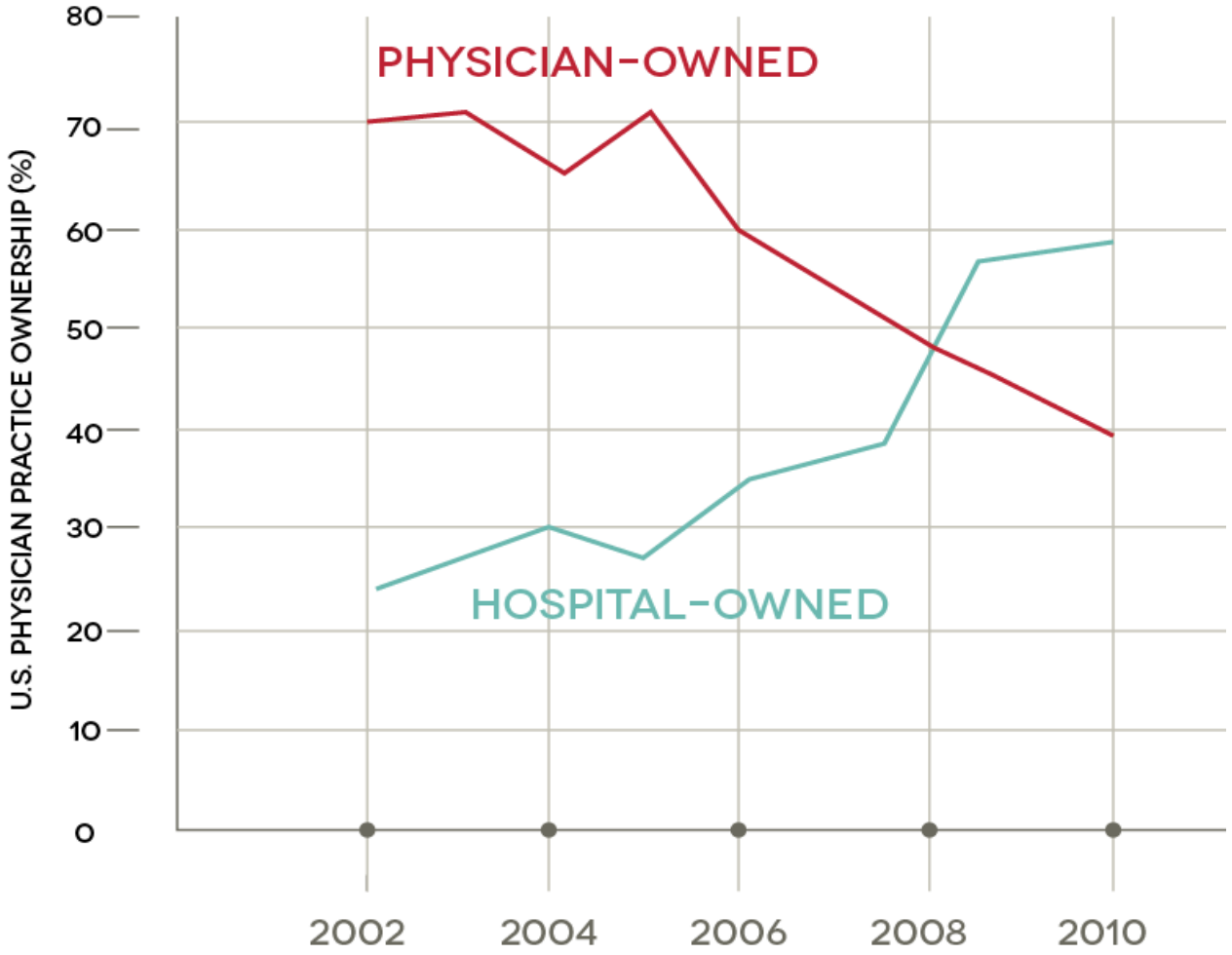
Response: Hospital Consolidation

Hospital M&A Deals: 2008-2012[1]

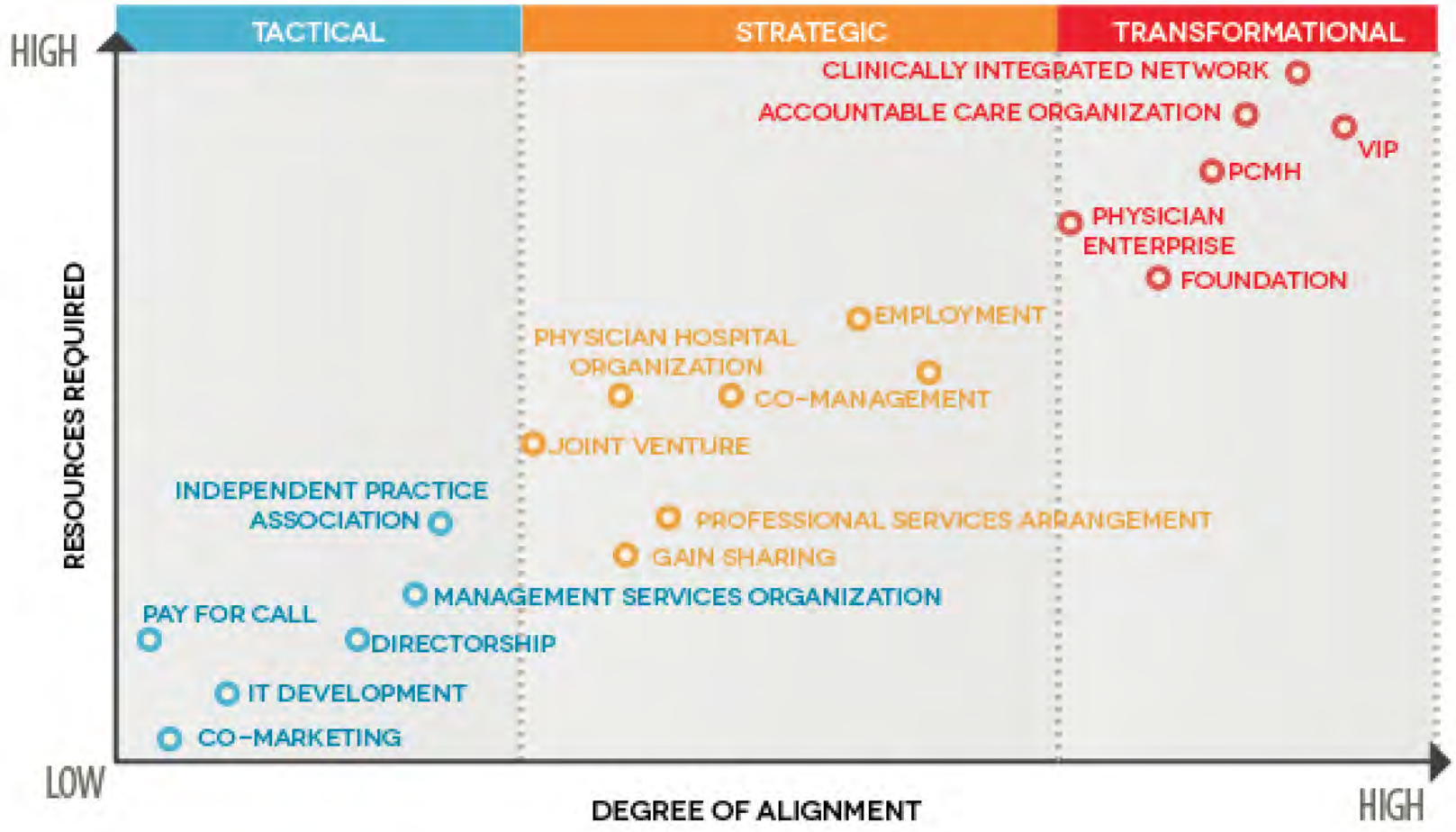




Response: Physician Acquisitions



Alternative Models of Alignment

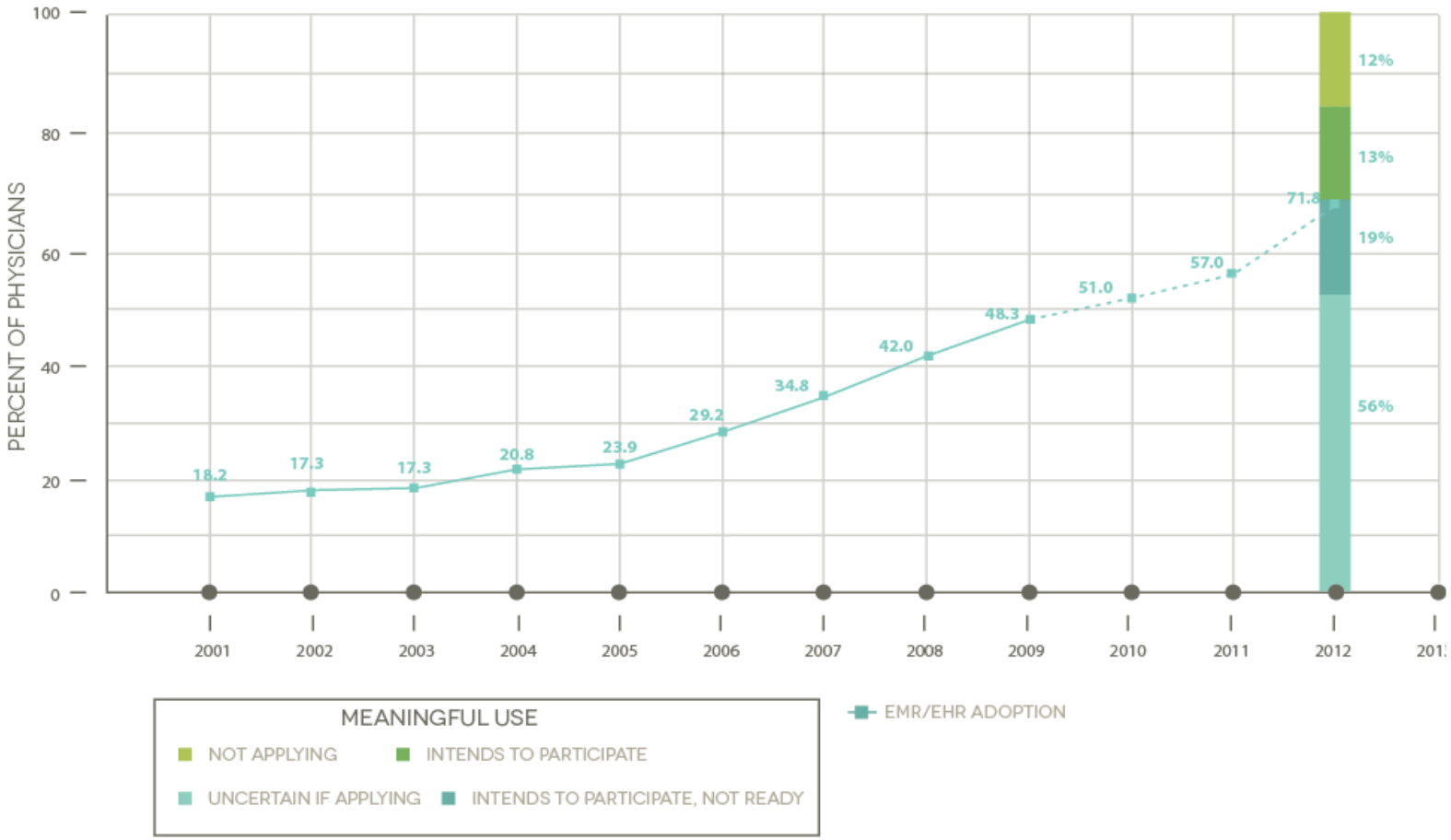


Physicians Reporting Through PQRS

Physicians received a 2% bonus on CMS payments for participation in 2010

CMS Driving Adoption with Incentives

EMR Adoption



Factors in Shifting from Volume to Value

Factors in Shifting from Volume to Value Alignment and Integration: A Model

Structure & Governance	What is the optimal governance model? How do physician leaders participate in governance and decision-making?
Infrastructure & Funding	Is there a distinct entity that has the vision, leadership & infrastructure to truly succeed at creating value for physicians & payors? How will the costs of building the infrastructure be offset? What potential revenue sources exist and what is the plan to capture that revenue?
Participation Criteria	How will you decide which physicians to employ, align or integrate?
Performance Objectives	Do your physicians have experience in leading performance initiatives? How do you plan to proactively enact a cultural change towards value?
Physician Leadership	How do your physicians participate in leadership functions today? What kind of empowerment do they have within the organization? What plans do you have to develop physician leadership competencies?
Information Technology	What IT systems are in place to monitor and track utilization, quality, efficiency, and value? How mature is the technology platform and how effectively is it currently used?
Distribution of Funds	How are providers compensated across the organization? What methodology exists for distributing value-based funds to providers? How does the model mature with the market and organizational capabilities?
Contracting	How urgent and ready is your market (payors and employers) to move toward value-based contracts? How prepared are providers to pursue value-based contracts and/or joint contracting?

CINs/CIOs – Legal/Regulatory Issues

- Antitrust
  - 1996 – "clinical integration" initially discussed legally in FTC Advisory Letters
  - 2010+ – push toward Triple Aim and other post-ACA factors lead to renewed interest
  - Test: improve quality and efficiency

CINs/CIOs – Legal/Regulatory Issues

- Federal Ethics in Physician Self Referral Law ("Stark"):
  - Payments to incent physicians to advance cost and quality goals are at the heart of many CIN/CIO structures
  - Incentive arrangements may constitute a "financial relationship" under Stark, and, if so, must meet a Stark exception.
  - Some potential exceptions:
    - Personal services
      - Physician "incentive plan" exception
      - "Regular" personal services exception
    - Indirect compensation
    - *Bona fide* employment (if physicians are employees of the clinically integrated entity)
      - Incentive bonus may be paid based on personally performed services.

CINs/CIOs – Legal/Regulatory Issues

- Federal Physician Self Referral Law ("Stark") (cont.):
  - With one exception (incentive plan), all of these exceptions have a requirement that compensation not take into account the volume or value of referrals from a referring physician.
  - All of these exceptions require that the incentive payments be "fair market value".
  - All of these exceptions have either an explicit requirement (*e.g.*, in employment, indirect compensation exceptions) or implicit requirement (*e.g.*, in personal services exception) regarding commercial reasonableness.

CINs/CIOs – Legal/Regulatory Issues

- Antikickback Statute ("AKS"):
  - The federal AKS makes it a criminal felony, knowingly and willfully, to offer, pay, solicit, or receive any remuneration to induce or reward referrals for, or the purchase, lease or order of, any item or service reimbursable by a federal health care payment program.

CINs/CIOs – Legal/Regulatory Issues

- Antikickback Statute ("AKS") (cont.):
  - No payments for referrals
  - "One Purpose Test"
  - Statutory exceptions:
    - Payments by an employer to an employee for employment in the provision of covered items
    - Risk sharing arrangement that places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide

CINs/CIOs – Legal/Regulatory Issues

- Antikickback Statute ("AKS") (cont.):
  - "Safe harbor" regulations define conduct that will not be treated as an offense under the AKS
  - Potentially applicable "safe harbor" arrangements:
    - Investment interests
    - Personal services and management contracts
    - Employment
    - Reduced cost-sharing amounts or premiums or price reductions offered by or to health plans
  - Common safe harbor requirements:
    - Compensation not take into account the volume or value of referrals or Federal health care program business generated by the physician
    - Compensation be fair market value

CINs/CIOs – Legal/Regulatory Issues

- Antikickback Statute ("AKS") (cont.):
  - Arrangements that do not meet the requirements of a safe harbor are analyzed case by case: not *per se* illegal
- 2005 OIG Supplemental Compliance Program Guidance for Hospitals -

  The general rule of thumb is that any remuneration flowing between hospitals and physicians should be at fair market value for actual and necessary items furnished or services rendered based upon an arm's length transaction, and should not take into account, directly or indirectly, the volume or value of any past or future referrals or other business generated between the parties. [] Arrangements under which hospitals: (1) provide physicians with items or services for free or less than fair market value; (2) relieve physicians financial obligations they would otherwise incur; or (iii) inflate compensation paid to physicians for items or services pose significant risk. In such circumstances, an inference arises that the remuneration may be in exchange for generating business.

CINs/CIOs – Legal/Regulatory Issues

- Civil Monetary Penalties Law ("CMPL"):
  - Sec. 1128A(b)(1): Creates civil penalties for a hospital that knowingly makes a payment directly or indirectly to a physician as an inducement to reduce or limit services to individuals who are entitled to Medicare Part A or B benefits and are under the direct care of a physician
  - The ACA, perhaps to address this particular issue, included an amendment to the CMP Law to exclude remuneration that "promotes access to care and poses a low risk of harm to patients and Federal health care programs … ." This amendment may be interpreted to permit appropriately structured shared savings programs between hospitals and physicians.

CINs/CIOs – Legal/Regulatory Issues

- IRC considerations for tax exempt entities:
  - General Guidelines:
    - Compensation to physicians should be fair market value for services provided
    - Total compensation paid should be “reasonable” for the market, physician specialty and responsibilities
    - IRC Sec. 162: “reasonable” compensation is the amount that would ordinarily be paid for like services by like enterprises under like circumstances

CINs/CIOs – Legal/Regulatory Issues

- State Law Issues:
  - State physician self- referral laws
  - State antikickback/fee splitting statutes
  - State Medicaid rules (if any CIN/CIO funds will come through state Medicaid)
  - Other state laws and regulations

CINs/CIOs – Legal/Regulatory Issues

- Federal waivers issued simultaneously with issuance of the final SSP regulations
- Office of Inspector General of the Department of Health and Human Services (OIG) jointly released an interim final rule establishing waivers (Waivers) of the application of certain Fraud and Abuse laws in connection with ACOs that participate, or are interested in participating, in the SSP.
- The rules waive certain provisions of the Stark Law, the AKS, the CMP prohibiting hospital payments to reduce or limit services (Gainsharing CMP), and the CMP prohibiting inducements to beneficiaries (Beneficiary Inducement CMP).
- The waivers apply only to the SSP and to ACOs participating in the MSSP. There is no waiver for state fraud and abuse laws.

CINs/CIOs – Legal/Regulatory Issues

- Five Fraud and Abuse Waivers:
  - ACO Pre-Participation Waiver
  - ACO Participation Waiver
  - Shared Savings Distribution Waiver
  - Compliance With the Stark Law Waiver
  - Waiver for Patient Incentives

CINs/CIOs – Legal/Regulatory Issues

- The Federal Trade Commission ("FTC") and the Antitrust Division of the Department of Justice ("DOJ") issued a final *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* ("Policy Statement") in conjunction with the final ACO rule.
- The Policy Statement is intended to provide antitrust guidance for ACOs that intend to engage in joint contracting with private payors.
- Not a waiver: Policy Statement
  - Reduces antitrust scrutiny of providers and suppliers that form and operate an ACO, based upon the individual facts and circumstances
  - Establishes a "safety zone"

CINs/CIOs – Physician Payment/ Fair Market Value Issues

Stark Law: *The term "fair market value" means the value in arm's-length transactions, consistent with the general market value*… (42 USC § 1395nn)

42 CFR §411.351 – For purposes of Stark, *"general market value" means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as a result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.*

CINs/CIOs – Physician Payment/ Fair Market Value Issues

- In re Stark definition of fair market value:
  - Distinct from other definitions fair market value, including IRS definition
  - CMS has explicitly recognized that Stark definition of FMV differs from IRS definition.
  - Qualifying language: “between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party…”
  - OIG publications, including advisory opinions, indicate that the, for purposes of determining compliance with AKS, the definition of AKS is the Stark definition and not the IRS definition.

CINs/CIOs – Physician Payment/ Fair Market Value Issues

- In re Stark definition of fair market value (cont.):
  - A hypothetical concept that may not perfectly match the value to the parties of a particular transaction
  - May be different for a physician's clinical services than the physician's administrative services (see *72 Fed. Reg. 51016 (September 5, 2007) (Stark Phase III Final Regulations*))
  - A distinct but often related concept to commercial reasonableness
  - Not necessarily established through:
    - Earnest negotiations (see *U.S. ex. rel. Kosenske v. Carlisle HMA, Inc.)*
    - What a party has previously been paid (although this may be informative)
    - Opportunity cost or lost opportunity

CINs/CIOs – Physician Payment/ Fair Market Value Issues

- In re Stark definition of fair market value (cont.):

  Stark Phase I Preamble (66 Fed. Reg. 944):

  Fair market value may be established "by any method that is commercially reasonable that provides evidence that compensation is comparable to what is ordinarily paid for the item or service in the location at issue, by parties in arm's length transactions who are not in a position to refer to one another."

CINs/CIOs – Physician Payment/Fair Market Value Issues

- "Commercially reasonable"?

  1998 Stark proposed rule:

  "An arrangement is commercially reasonable if it appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals." (63 Fed. Reg., 1659, 1700 (Jan. 9, 1998))

  2004, Preamble to Stark Interim Phase II final rule (in response to a comment):

  An arrangement will be considered commercially reasonable in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals.
  (69 Fed. Reg. 16054 (March 26, 2004))

CINs/CIOs – Physician Payment/ Fair Market Value Issues

- May use ”any commercially reasonable” methodology to determine fair market value, but:
  - “Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluation fair market value.”
  - “…the appropriate method for determining fair market value for the purposes of [Stark] will depend on the nature of the transaction, its location, and other factors…
  - although good faith reliance on an independent valuation (such as an appraisal) may be relevant to a party’s intent, it does not establish the ultimate issue of the accuracy of the value itself…”

  (72 Fed. Reg. 51015 (September 5, 2007))

CINs/CIOs – Physician Payment/ Fair Market Value Issues

- Accepted approaches for determining fair market value:
  - Market Approach – compares the subject asset or arrangement to those that have been sold/consummated
    - Potential Fair Market Value Pitfall Question: Is the comparable asset transfer or arrangement between parties in a position to refer or generate business for one another?
  - Cost Approach – quantifies the amount of money needed to replace the future service capability of an asset or arrangement
    - Potential Fair Market Value Pitfall Question: Can one reasonably replace the services being valued?
  - Income Approach – relies on conversion of anticipated future economic benefit to a single present amount
    - Potential Fair Market Value Pitfall Question: Will this approach result in compensation that reflects volume or value of referrals or other business generated?

CINs/CIOs – Physician Payment/ Fair Market Value Issues

- CIN/CIO fair market value considerations:
  - CIOs/CINs may or may not participate in the MSSP and be subject to Stark/AKS/CMPL antitrust waivers.
  - Tax-exempt entities must consider private inurement issues regardless of MSSP participation.
  - Potential needs for fair market value (depending on arrangement structure, applicable laws and regulations, waivers)
    - Hospital contributions/distributions
    - Physician contributions/distributions/incentives
    - Operating Costs (if distinct from hospital contributions)

CINs/CIOs – Physician Payment/ Fair Market Value Issues

- Sample CIN/CIO Physician Distribution/ Incentive Compensation Structures:
  - Incremental compensation/bonus ("carrot")
    - % of compensation otherwise payable or
    - Fixed dollar amount
  - Holdback of compensation otherwise payable (to be paid only upon achievement of specified goals) ("sticks")
    - % of compensation otherwise payable; or
    - Fixed dollar amount
  - PMPM payments tied to performance of specific activities
  - Percentage of cost savings achieved ("gain sharing")
  - Others?

CINs/CIOs – Physician Payment/ Fair Market Value Issues

Questions and Steps for Analyzing Physician Payments:

1. Is fair market value required for legal and regulatory compliance?
   - Review structure of arrangement and flow of $$
   - Assess applicable laws and regulations
     - For physician contributions/distributions/payments?
     - For hospital contributions/distributions/payments?
     - For CIN/CIO operating expenses?
2. If fair market value is required, what is the applicable definition of FMV?
   - Stark
   - Other (*e.g.*, IRS?)
3. Define the physician/hospital/other party contributions/services that will trigger payments

Questions and Steps for Analyzing Physician Payments (cont.):

4. What are the potential sources of data for the valuation?
   - Data from independent surveys
   - Other market comparables
   - CIN/CIO financial data and projections
5. What are the potentially applicable valuation approaches?
   - Market, cost or income
   - What are the potential pitfalls of using each
6. Select and appropriate valuation approach and data based on consideration of items 1 to 4.
   - Beware of commercial reasonableness issues
   - Beware of "tainted" data
   - Beware of CMPL considerations

Questions?