Physician Compensation in an Era of New Reimbursement Models

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Agenda

- Background
- New Reimbursement Models
- Trends in Physician Compensation
- Regulatory/Recent Case Law regarding Physician Compensation
- Emerging Alignment Models
  - Co-Management Agreements
  - ACOs
Background

- National health expenditures continue to increase
  - 15.8% of GDP in 2005 and projected to be approximately 18% of GDP in 2014
    - Faster than most any developed nation
    - While, at the same time, lagging on various measures of health
- In 2007, 62% of US bankruptcies were related to medical expenses
- Broad recognition that level of spending is not sustainable
- Issues of whether health outcomes match the spending
- Berwick (2011): Significant percentage of health care spending is "waste"
- Driving shift from fee-for-service to paying for performance/value
Fee-for-service

- We know that fee-for-service (FFS) creates misaligned incentives
  - Incentivizes more services/duplication
  - Less care coordination
  - Less incentive for prevention/preventative care services
  - High quality care is paid the same as low quality care
Paying for performance

- Value-based payments
  - Removes incentives for duplication/increased services
  - Attempts to balance quality and cost
  - Rewards outcomes
  - Rewards removing fragmentation and conflicting incentives
  - Attempts to align provider, payer and patient incentives
We are in a period of transition as the pathway to go from volume-based payment to value-based payment has reached little consensus.
New Reimbursement Models

- Reimbursement policy is driving physician payment reform
- Reform models are increasingly tied to quality and shifting away from fragmented, volume-driven payments
  - Bundled payments
  - P4P
  - ACOs
  - Care Coordination
New Reimbursement Models: Affordable Care Act

- The Hospital Inpatient Quality Reporting Program (IQR), contained in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, laid the foundation.

- ACA attempts through a mixture of incentives and penalties to encourage higher quality, less costly care.

- So far, baby steps along the trajectory from volume-based to value-based payment.
Value-Based Purchasing Program

- Section 3001 of ACA: Hospital Value-Based Purchasing (VBP) Program
  - Authorizes value-based incentive payments to hospitals based upon their achievement and improvement on certain performance measures
  - Targeted thresholds for clinical performance that each hospital will have to meet
  - VBP Program must be budget neutral and all dollars must be released back to hospitals (funded through reductions in base DRG payments)
Value-Based Purchasing Program

- To earn VBP dollars hospital must either
  - Achieve high performer status
  - Show improvements in their baseline scores

- Hospital's performance is available to the public on the CMS "Hospital Compare" website
Value-Based Purchasing Program

Impact on Hospitals

FY2014, reduced payments by 1.25% (this was done in a payment adjustment that applies to each Medicare patient stay over federal fiscal year 2014)

- This created a $1.1 Billion pot for payout to hospitals
- Every hospital is getting something back, more than half not recouping 1.25% payment

FY2014, more hospitals receiving penalties than bonuses in 2nd year of Medicare's quality incentive program

- 1,231 of hospitals receiving bonuses
  - Average bonus was 0.24%
- 1,451 of hospitals receiving penalties
Preventable Readmissions

- Section 3025 Hospital Readmissions Reduction Program
- 20% of Medicare patients are readmitted to the hospital within 30 days of discharge and 34% are readmitted within 90 days
  - MedPac suggests that 76% of these readmissions are preventable
  - Preventing unnecessary readmissions could save Medicare about $12 billion annually
- A "readmission" - when a patient is discharged from an applicable hospital and is then readmitted to the same hospital or another applicable hospital within 30 days of the original discharge
- Hospitals deemed to have excess readmissions for selected conditions will have their payments reduced beginning in FY2013 for discharges on or after October 1, 2012
- Calculate excess readmissions ratio for each hospital and compare to national hospital average (with some adjustment for clinical factors)
- 3 year look back for first year; minimum of 25 cases per condition
- In 2015, CMS will expand the conditions to include COPD and THA/TKA (FY2015 IPPS Final Rule)
Preventable Readmissions

- Penalties are a maximum of 2 percent in FY2014 and 3 percent in FY2015
  - Average penalty 0.63% nationally
  - Number of hospitals penalized rose 17%
- Last data available, approximately 2,600 hospitals with higher than expected readmissions rates
- Getting media attention
  - October 2014, IBJ J.K. Wall article, "More Hospitals Hit with Do-over Penalties"
HAI and Bundled Payments

- Section 3008 Healthcare Acquired Infections
  - 1% reduction

- CMS Innovation Project: Bundled Payment for Care Improvement
  - Began in January 2013-500 providers for 3 years
  - 4 models that providers could choose from:
    - Model 1: Acute care stay; all conditions; discounted payment from Medicare but ability to gain share with doctors
    - Model 2: Acute care stay and 30/60/90 days post-acute care depending on condition
    - Model 3: 30 days post-acute care only for treatment of single condition
    - Model 4: Acute care stay and 30 days post-acute; with prospective lump sum payment

- Have to report quality measures data and maintain or improve performance-CMS to monitor utilization and access
Physician Compensation

- So, what do all these changing reimbursement models/programs mean for physician compensation?
  - Fixed compensation
  - Productivity compensation
  - Risk sharing compensation (based on quality/cost savings)
- Past compensation mainly involved fixed compensation for physicians
- Current compensation reflects some amount of fixed and/or productivity compensation with a small amount of risk sharing compensation
- As hospitals have more of their money tied up in quality programs, physician compensation will track with these changes
  - Higher percentages of physician compensation will be at risk/tied to quality measures
Physician Compensation

- Examples of Quality Incentive Criteria
  - Patient satisfaction
  - Patient outcomes (CMS Core Measures)
  - Development of clinical protocols/processes
  - EHR Meaningful Use
Physician Compensation

- Current regulations are geared towards traditional FFS payment
- As more of physician's total compensation is allocated to non-productivity compensation, the less certain legal compliance becomes
- Regulatory framework:
  - Stark
  - Anti-Kickback Statute
  - IRS
  - CMP
  - Cannot induce to limit or withhold care
Recent Case Law regarding Physician Compensation

Tuomey

- Surgeons announced they would start performing surgeries at their own ASC
- Entered into part-time employment agreement with the surgeons
- Required to perform outpatient procedures exclusively at Tuomey
- Reassigned all rights to professional fees and Tuomey agreed to pay each physician an annual base salary that fluctuated based on the hospital's net case collections for the outpatient procedures
- Productivity bonus of 80% of net collections for personally performed services
- Additional incentive bonus of up to 7% of productivity bonus

- Government took the position that alleged payments took into account the volume and value of referrals
- Found that Tuomey's billing for the technical component of the service constituted a referral for purposes of Stark and that compensation paid to the physicians took into account the volume and value of referrals
Halifax

Filed by member of compliance department

Halifax employed 6 oncologists. Their employment agreements provided they would receive a salary and bonuses.

Bonus based on "15% of the operating margin of the medical oncology program" which was then divided up between the 6 oncologists based on their personally performed services.

Halifax admitted that the revenue at issue included fees for services that were not personally performed by oncologists (included fees related to administration of chemotherapy and outpatient oncology pharmacy charges)

Government contended that the requirements for the bona fide employment relationships wasn't met because the incentive bonus varied based on referrals for DHS.

Halifax argued that the payment of the bonus was based on each oncologist's personally performed services. The Court, however, found that the bonus was not based on services personally performed by oncologists but rather was divided up based on services personally performed by the oncologists.
Recent Case Law regarding Physician Compensation

- All Children's Health System
  - Aggressive recruiting of pediatric subspecialists
  - Compensation plan approved by Board included that the guaranteed salary of the physicians would not exceed the 75th percentile but not be less than the 25th percentile
  - Approximately 1/3 of recruited physicians were paid above the 75th percentile
- Relator alleged that physician salaries were inflated above fair market value to compensate them for their ability to generate additional revenue for Hospital through referrals
- Court found that Stark applies to Medicaid claims through the payment of FFP to Florida and that Hospital allegedly caused the state, in turn, to request the FFP
Recent Case Law regarding Physician Compensation

- Villafane
  - AMC received grants and paid faculty salaries. There was also a contribution to the research fund which flowed to faculty physicians who made referrals to the AMC which were paid by Medicaid.
  - Relator argued that physician compensation exceeded FMV
  - Court found that Hospital met AMC exception noting "[a]ny definition of fair market value that would automatically deem anything over the median, or indeed, anything at the 80th percentile, as necessarily not being fair market value would seem illogical."
  - Court also noted that the chief of staff (a neonatologist) should be paid on the higher end of the ranges due to his duties/responsibilities and experience over other neonatologists.
  - Court also noted that "[a]ny distribution of salaries in a marketplace will show some higher or lower than others. Provided a salary is within a statistical distribution defining the market as a whole, it seems difficult to argue that it is not fair market value."
Other Emerging Alignment Models

- Co-Management Arrangements
  - Aligns clinical, operational and financial incentives within a service line
  - Gives physician "skin in the game" and voice on service line management
  - Reduces silos of care, gets physicians involved and working collaboratively with hospital, staff and other physicians
  - Incentives must be measurable and show improvement in quality and/or efficiency.
Co-Management Arrangements (Non-employed physicians)

- Generally, the hospital and physicians form a management company.
- Hospital engages the co-management company to oversee a service line (orthopedic surgery, cardiology and cardiovascular surgery, etc.) through a management services agreement.
- The compensation paid by Hospital to the co-management company includes:
  - Base fee component
  - Performance incentive fee component
Co-Management Arrangements

- Base management fee
  - Medical Director "on steroids"
    - Budgets
    - Input on purchases, leases, other services
    - Recommendations regarding information systems
    - Documentation
    - Case management
    - Development of programs to reduce adverse events
Co-Management Arrangements

Incentives

- Must be measurable, controllable, realistic, time-boxed with a specified frequency of measurement and payout

Examples:

- Patient satisfaction
- Implant Matching
- First case on-time starts
- Room turnaround time
- Procedure/Protocol Development
- Risk-adjusted readmission rates
Co-Management Arrangements

- Anti-Kickback Statute
- CMP
  - Cannot reduce or limit services
- Advisory Opinion 12-22
  - Recognize that co-management agreements could be used to induce limitations or reductions in case and/or disguise kickbacks
  - Ensure physicians provide actual, substantial, documented services
  - Incentives must show material change not just for maintaining
  - Limit the term of any arrangement so that the need can be re-evaluated and the measures are continually studied and reset to require continued improvement
ACOs: Medicare Shared Savings Program ("MSSP")

- ACA required CMS to create a Medicare "shared savings program" through which groups of providers and suppliers work together to manage and coordinate care for Medicare FFS beneficiaries.
- These accountable care organizations (ACOs) agree to be accountable for the quality, cost, and overall care of those beneficiaries "assigned" to it.
- MSSP intended to:
  - promote accountability for the care of Medicare FFS beneficiaries.
  - Require coordinated care for all services provided under Medicare FFS.
  - Encourage investment in infrastructure and redesigned care processes.
ACOs

ACO Waivers

- Applicable only to MSSP beneficiaries
- ACO Pre-participation Waiver
- ACO Participation Waiver
- Shared Savings Distribution Waiver
- Compliance with Physician Self-Referral Law Waiver
- Patient Incentive Waiver
ACO Investment Model

- October 15, 2014 announced requests for existing Medicare ACOs to better coordinate rural and underserved area care and test pre-payment approaches
- Two types of payments are made:
  - An upfront, variable payment: Each ACO receives a payment based on the number of its preliminary prospectively-assigned beneficiaries.
  - A monthly payment of varying amount depending on the size of the ACO: Each ACO receives a monthly payment based on the number of its preliminary prospectively-assigned beneficiaries.
- Hospitals can't be an ACO participant or an ACO provider/supplier unless the hospital is a critical access hospital (CAH) or inpatient prospective payment system (IPPS) hospital with 100 or fewer beds
Questions?