Incentive Programs that Reward Collaborative Physician Efforts to Improve the Quality and Cost-Effective Delivery of Hospital Care

by
Robert D. Girard, Esq.
Thomas E. Jeffry, Jr., Esq.

Davis Wright Tremaine LLP
Physician Incentive Arrangements We Will Discuss

A. Quality (and Efficiency) Oriented Pay for Performance ("P4P")

1. Government or third party payor sponsored programs
   a) Medicare pilot programs
   b) California and other group programs

2. Provider programs
   a) Focus on hospital or health system sponsored programs
   b) Physician group internal programs
Physician Incentive Arrangements
We Will Discuss (cont’d.)

3. Categories should not be considered mutually exclusive
   a) Government and third party programs generally call for hospital/physician collaboration and contracting commitments
   b) Hospital sponsored programs will generally involve collaboration with either existing or ad hoc physician groups
Physician Incentive Arrangements
We Will Discuss (cont’d.)

B. Gain-Sharing

1. Historical context and rationale for physician incentive programs
2. Advisory Process
3. DRA authorized 3-year CMS demonstration project
P4P Initiatives: Environment and Context

A. Professional and Industry Interest In Improving Quality and Questions re Efficacy of Existing Quality Interventions

B. New Focus on Quality in Compliance Arena

C. Cost Pressures
   1. Disconnect between customary practices, legal restrictions on compensation incentives, and interest in efficiency
   2. Impact of physician practices on hospital and other health system costs
P4P Initiatives: Environment and Context (cont’d.)

3. Relationship between quality and efficiency
4. HIT developments and identification of “best practices”
5. Consultant and other industry expertise in developing systems to assess practice patterns and outcomes. “Evidence Based Practice Management”
6. Constraints on physician income – increased interest in potential incentives
D. Data Mining with Respect to All of These Factors

1. Ability to identify meaningful quality and efficiency indicators

2. Focus on “critical paths”, best practices, and impact of treatment decisions and resource utilization on patient outcomes
Legal Considerations Affecting P4P Structure and Development

A. Physician Incentive Plan Law
B. Stark Law
C. Federal Medicare & Medicaid Anti-Kickback Law
D. Business & Professions Code § 650; PORA
E. Impact of Implicit Presumptions Questioning Provider Intentions
   1. Risk of adverse determinations
   2. Value of third party validation
Legal Considerations Affecting P4P Structure and Development (cont’d.)

F. Non-Profit Tax Issues
   1. Private benefit
   2. Private use

G. Antitrust

H. Corporate Practice

I. Liability Issues

J. Privacy/HIPAA

K. General Contract Law Issues

L. Intellectual Property Considerations
Practical/Programmatic Considerations in P4P Programs

A. Data Intensive
B. Validation of Criteria, Standards, and Incentives
C. Legal Compliance Costs
D. Time and Expense Investments to Develop Programs
E. Recruitment of Appropriate Participants
F. Designing/Monitoring Effectiveness of Incentives
G. Sustainability and Flexibility (may be in conflict)
H. Uncertainty re: Possible “Mega” System Changes
A Short History of Gain-Sharing

A. Programs Focused on Aligning Physician Incentives with Hospital Cost Savings:
   1. Hospitals paid DRGs – at risk for utilization
   2. Physicians paid FFS – no stake in hospital costs

B. Initial Favorable Tax Ruling

C. OIG Special Advisory Bulletin
   1. Physician Incentive Plan Law
   2. Questions under Anti-kickback Law
   3. Stark Law
A Short History of Gain-Sharing (cont’d.)

D. Advisory Opinions and Current Regulatory Status of Gain-Sharing Programs

1. Structure approved in opinions constrains utility

2. Issues to be addressed:
   a) May require significant ongoing third party input and monitoring
   b) Time limited
   c) Incentives limited
   d) Does not address Stark issues
A Short History of Gain-Sharing (cont’d.)

E. CMS Gain-Sharing Study
   1. Designed to improve quality and efficiency of inpatient care
   2. OK if it improves hospital operational and financial performance
   3. Based upon “net savings” for each patient

F. Is Gain-Sharing a Useful Tool or Model?
Medicare and Third Party Payer P4P Plans – Opportunities & Limitations

A. Individual Plan Initiatives
   1. Contractual mandates
   2. Provider tiering

B. Collaborative Initiatives:
   1. Bridges to Excellence (Boston, Cincinnati, Albany)
   2. Leapfrog Group
   3. Integrated Healthcare Association (California)

C. Medicare - Hospital Quality Initiative (DRA section 5001)
Developing Hospital/Health System Sponsored Programs

A. Avoid Physician Incentive Plan Issues.

B. Built Around Quality/Efficiency Standards
   1. Anti-Kickback & Stark considerations
   2. Avoid arrangements that could be construed as providing incentives to refer
Developing Hospital/Health System Sponsored Programs (cont’d.)

3. Be able to document that criteria, standards, and incentives are reasonable and appropriate
   - Use of third party expertise
   - Look to recognized, published standards
   - Payments commensurate with meaningful improvements in quality/efficiency and added value to patients/payors in terms of health outcomes.
   - Adequate tracking, and

C. “Borrow” from Experience and Structure of Medicare and Third Party
## Important Incentive Characteristics

(Commonwealth Fund Study; Views of State Medicaid Directors – 2007)

<table>
<thead>
<tr>
<th>Percentage Believing Characteristic is Very Important for Incentive Plan Performance</th>
<th>Characteristic</th>
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<tbody>
<tr>
<td>78%</td>
<td>Scientifically sound measures</td>
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<tr>
<td>73%</td>
<td>Feasible data collection</td>
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<tr>
<td>70%</td>
<td>Use regularly reviewed and updated measures</td>
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<tr>
<td>62%</td>
<td>Promotes continuous quality improvement, not just target attainment</td>
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<tr>
<td>61%</td>
<td>Developed collaboratively with providers</td>
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<tr>
<td>49%</td>
<td>Incentives are publicly disclosed in an easily understood manner by physicians and consumers</td>
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<tr>
<td>41%</td>
<td>Publicly reported results</td>
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<tr>
<td>35%</td>
<td>Use of nationally recognized measures</td>
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<tr>
<td>28%</td>
<td>Use of measures designed to improve care, but without a requirement of cost savings</td>
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<tr>
<td>24%</td>
<td>Uses measures other than those based on administrative or claims data (e.g., medical record reviews)</td>
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<tr>
<td>14%</td>
<td>Requires cost savings</td>
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Incentive Compensation Features

An Incentive Compensation Plan Should Be Structured to Include the Following Elements:

1. Transparency
2. Objective measures predominate
3. Clear linkages between compensation and individual and practice group goals
4. Simplicity and operational consistency
5. Income stability
6. Legal compliance
7. Shared fiscal responsibility
8. Governance and accountability alignment
Incentive Performance Measure Principles

Incentive Performance Measures Should Be Reasonably Limited in Number and Should:

1. Foster care coordination among providers
2. Affect a significant number of patients
3. Be valid, scientifically sound, and tested before implementation
4. Be developed with physician input and be effectively communicated to physicians
5. Be visible, clinically relevant, and reliably define good care and optimal health outcomes
Incentive Performance Measure Principles
(cont’d.)

6. Relate to factors physicians can impact
   1. Scientific rationale and expected impact should be approved/accepted by participating physicians
   2. The greater the imprecision or “noise” in a measure, the greater the risk of unintended consequences and dampened response by physicians

7. Be measures capable of showing improvement over time

8. Be important and understandable from the patient’s perspective

9. Be aligned with national measures (where feasible)
Incentive Performance Measure Principles (cont’d.)

10. Encourage desired systemic changes over time
11. Be designed to maximize physician participation – both initially and over time
12. Provide adequate and meaningful incentives – where appropriate and feasible, incentives should reflect patient clinical complexity
13. Reward care that is of high clinical quality, patient-centered, and efficient
14. Reward both significant provider improvement and achievement of excellence
Incentive Performance Measure Principles (cont’d.)

15. Be aligned with health system or hospital goals
16. Be based on relevant and appropriate measurement and program evaluation periods
17. Be developed with expectation of and process for review and revision over time