Financial Incentives and Gainsharing: Pay for Performance and Gainsharing Legal Issues

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P4P - A Growing Trend

- Individual Plan Initiatives
  - Contractual mandates
  - Provider tiering
- Collaborative Initiatives:
  - Bridges to Excellence (Boston, Cincinnati, Albany)
  - Leapfrog Group
  - Integrated Healthcare Association (California)
- Medicare

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Bridges to Excellence

- Multi-State Multi-Employer Coalition
- Rewards physicians for--
  - Use of information to implement specific office processes to reduce errors ($50 PMPY)
  - Chronic care management
    - Diabetes care ($80 PMPY)
    - Cardiac care ($160 PMPY)

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Leapfrog Group

- Multi-State Employer Coalition
- Rewards hospitals for--
  - Computerized order entry
  - Evidence-based hospital referral
  - ICU physician staffing
  - 30 safe practices
- Scorecards

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Leapfrog Group

Leapfrog Hospital Ratings

Search Results: **Zip:** 94111 **Radius:** 10 Miles
Below are the results of your search. Click on the "leaps" and the circles for more details.

Survey Info | Scoring Info | Start Over

Click to Compare	Hospital Name	City	Leap1	Leap2	Leap3						Leap4	Results Submitted
			CPOE	ICU	High Risk Treatments						Safe Practices Score	
☐	Alameda Hospital	Alameda, CA	○	○	○	○	○	○	○	○	○	
☐	Alta Bates Summit Medical Center - Alta Bates Campus	Berkeley, CA	◔	●	NA	◕	◔	◔	◑	◕	●	6/23/2006
☐	Alta Bates Summit Medical Center-Summit Campus	Oakland, CA	◔	◑	●	●	◔	◔	◑	NA	●	6/30/2006
☐	California Pacific Medical Center - California Campus	San Francisco, CA	●	NA	NA	NA	NA	NA	NA	●	●	6/25/2006
☐	California Pacific Medical Center - Davies Campus	San Francisco, CA	●	●	NA	NA	NA	NA	NA	NA	●	6/25/2006

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Integrated Healthcare Association

- Health-plan sponsored
- Weighted quality measures for physicians
  - Clinical measures
    - Preventive - screening, immunization
    - Chronic care management
  - Patient satisfaction
  - Adoption of technology
- Payment
  - Incremental PMPM payment (typically < 5%)
  - Often competitive
- Scorecards

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http://iha.ncqa.org/reportcard

★★★★ Excellent
★★★ Good
★★ Fair
★ Poor

Related Links:

About the Physician Group Ratings
IHA Home Page

Compare Overall Physician Group Ratings (San Francisco County)

Physician Group	Rating
Brown & Toland Medical Group	★★★★
Chinese Community Healthcare Association	★★★
Hill Physicians Medical Group - San Francisco	★★
Integrated Medical Group at St. Luke's	★
Northern California Permanente Medical Group - Peninsula	★★★★

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Medicare Pay for Reporting

- **MMA section 510(b)**
  - Hospital payment differential for reporting on 10 quality measures (2005-2007)
- **Hospital Quality Initiative (DRA section 5001)**
  - Larger payment and expanded data beginning this year
- Physician voluntary reporting program

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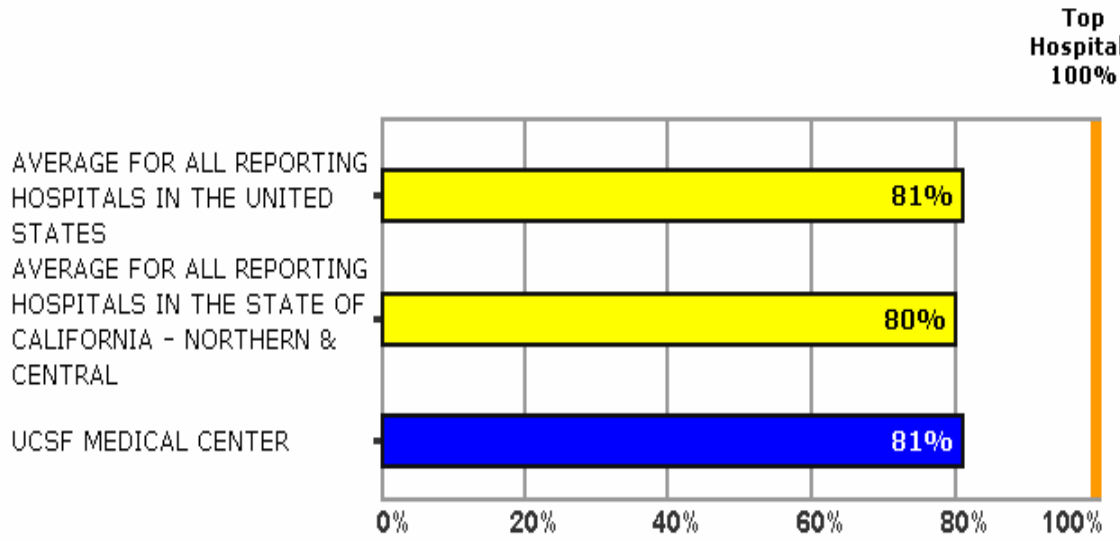
Medicare Pay for Reporting

Graph 1 of 8

Percent of Heart Attack Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)

The rates displayed in this graph are from data reported for discharges April 2005 through March 2006.



Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 100% rate or better.

Why is this Important?

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Health Plan Regulation

- Consumer contracts closely regulated
- Health plans required to ensure coverage
- Provider arrangements flexible

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Antitrust

- Pricing agreements among purchasers resulting in--
  - Increase in premiums
  - Reduction in reimbursement and output

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Antitrust

- The case for collaboration
  - P4P can enhance efficiencies, cost-effectiveness and quality
  - Payor incentives have to be aligned to be effective
  - Enough money needs to be allocated to P4P to drive change
- FTC/DOJ recognizes effectiveness of P4P in improving care – Improving Healthcare – A Dose of Competition
  http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf

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Antitrust

- How far can collaboration go?
  - Agreement on measures
  - Agreement on weighting of measures
  - Agreement on payment for measures
    - Total amount allocated to P4P
    - Allocation among measures
  - Others?

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Antitrust

- Agreements among providers
  - Traditional focus of concern
  - Concerted refusals to participate or to provide information
  - P4P may permit joint price negotiation where provider network is at risk

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Confidentiality

- Protection of individually identifiable health information
  - HIPAA allows use of data for payment
  - HIPAA allows plans and providers to aggregate data
  - HIPAA does not protect aggregated (de-identified) data
- Use of aggregate data
  - Reporting to provider and health plan
  - Other uses
    - Public scorecards
    - Collateral uses

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What incentives to align?

Good:

- Quality
- Efficiencies
- Patient Satisfaction
- Best Practices

Bad:

- Utilization
- Referrals

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Gainsharing: Historical Perspective

- Gainsharing, while not a precise term, typically refers to arrangements whereby a hospital shares cost savings with the physicians who help generate those savings
- Programs generally intended to align incentives:
  - Hospitals paid DRGs-- at risk
  - Physicians paid FFS– no stake in hospital costs

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Gainsharing: Early Programs & Legislation

- In 1980s a Texas Hospital System adopted a program that paid physicians $200 per day for discharging patients early
- Congress, not amused, enacts Civil Money Penalty Law addressing Physician Incentive Plans (PIPs)
- 1990 PIP statute bifurcated between health plans and hospitals (hospital law much more restrictive)

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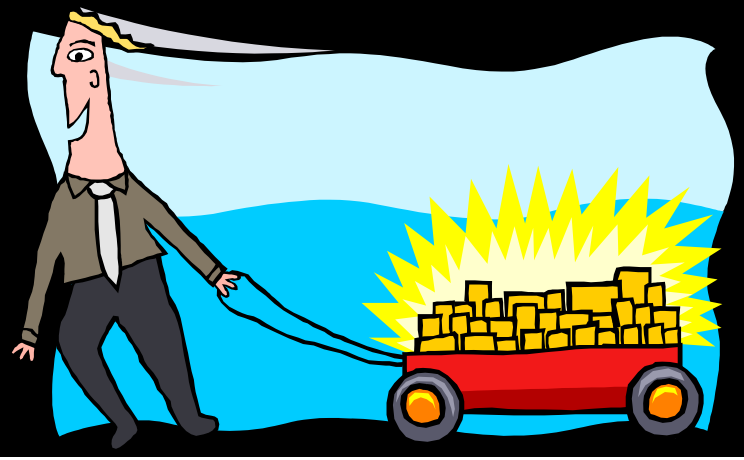
The Gainsharing Bandwagon

- Health care industry in late 1990s began embracing concept
- Focus: Cost per case programs
  - Cardiology leading the way
- Gainsharing spawned its own cottage industry: “a Consultant’s dream”



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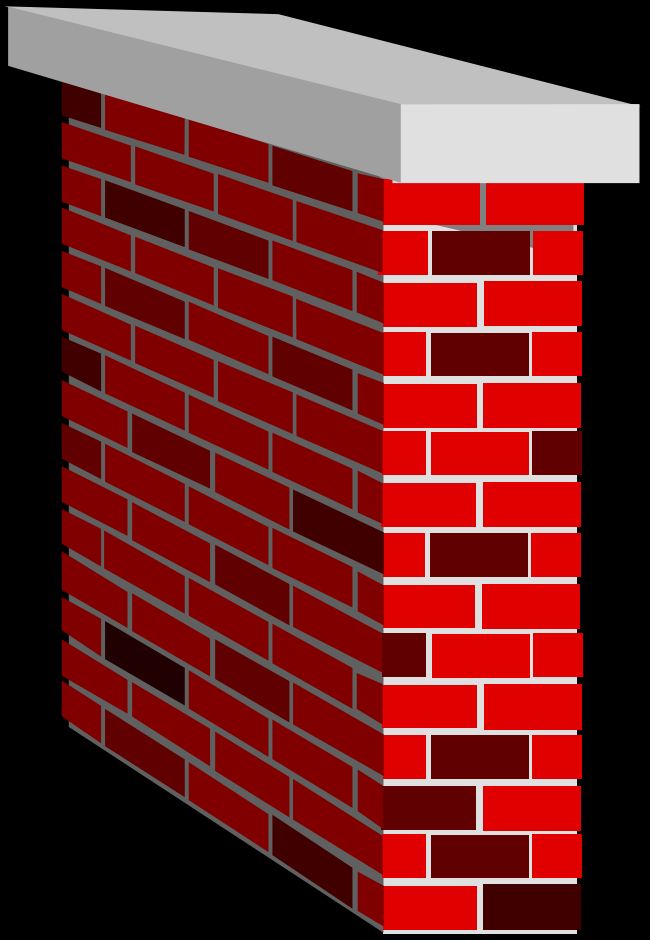
OIG 1999 Special Advisory Bulletin



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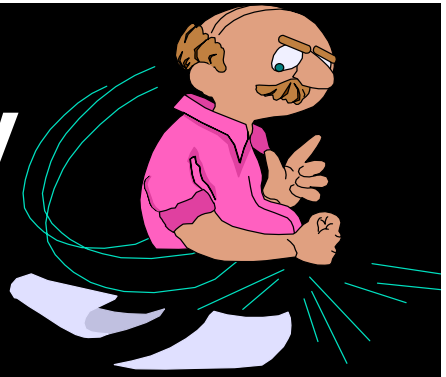
OIG Special Advisory Bulletin (SAB)



- SAB indicates that hospital PIP law: clear prohibition on gainsharing
  - SAB equates incentive to reduce cost w/incentive to reduce care
- OIG suggests Gainsharing Advisory Opinions inappropriate
- Look to Congress for solution?
- Providers instructed to dismantle existing programs expeditiously

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2005: Advisory Opinion Wave

- About Face?
- In rapid succession, OIG issues 6 advisory opinions approving specific gainsharing programs
- All opinions address gainsharing between Hospital and cardiac surgeons or cardiologists
- All involve the same consultant
- OIG position softens but the range of permissible programs very narrow

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Gainsharing Study

- DRA authorized 3-year CMS demonstration project
- Designed to improve quality and efficiency of in-patient care
- OK if it improve hospital operational and financial performance
- Based upon “net savings” for each patient

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Gainsharing Study Requirements

- Cannot limit or reduce medically necessary benefits
- Not based upon value or volume of referrals
- Payments linked to improvements in quality and efficiency
- Payment not greater than 25% of normally what is paid

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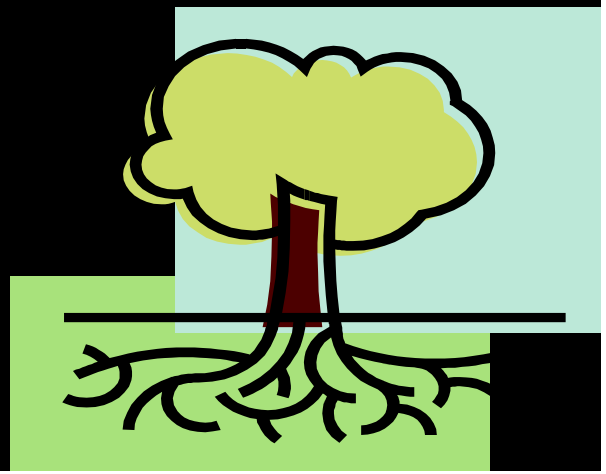
Growth of Physician-Hospital Alliances

- Historical roots:
  - Physician Hospital Organizations (PHOs)
  - Gainsharing Programs
- New risk contracting niche
- Pay for Performance



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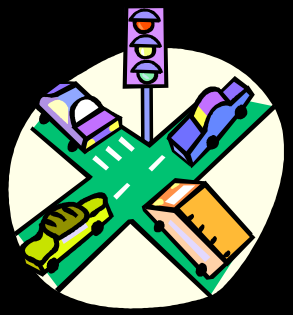
The Rules of the Road



- To be viable, the solution must pass muster under:
  - Federal Physician Incentive Plan Law
  - Stark Law
  - Anti-kickback Statute
  - Tax Exempt Organization rules
  - Antitrust Laws
  - State law restrictions

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New Solution: Provider Specialty Alliances (PSA)

- PSA are hospital-physician service line joint ventures
- Participating Providers contract with health plans to provide specific procedures on a globally priced basis (professional and facility fees combined)

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Provider Specialty Alliances

- PSA members, the hospital and the specialist physicians, share risk
- Typically hospital and physicians agree to fixed base payments for facility and professional services for a procedure
- The remaining funds (including P4P bonus) are placed in a risk pool

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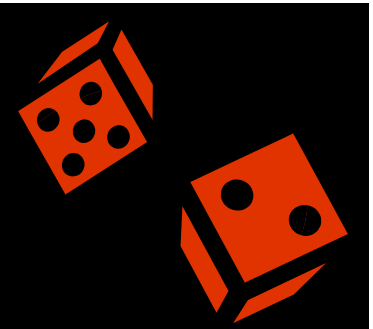
Provider Specialty Alliances



- If over the course of a year the PSA controls costs, the risk pool funds will be available for distribution to the participating physicians and hospital
- Criteria for distribution of risk pool proceeds can be developed by PSA and include P4P benchmarks

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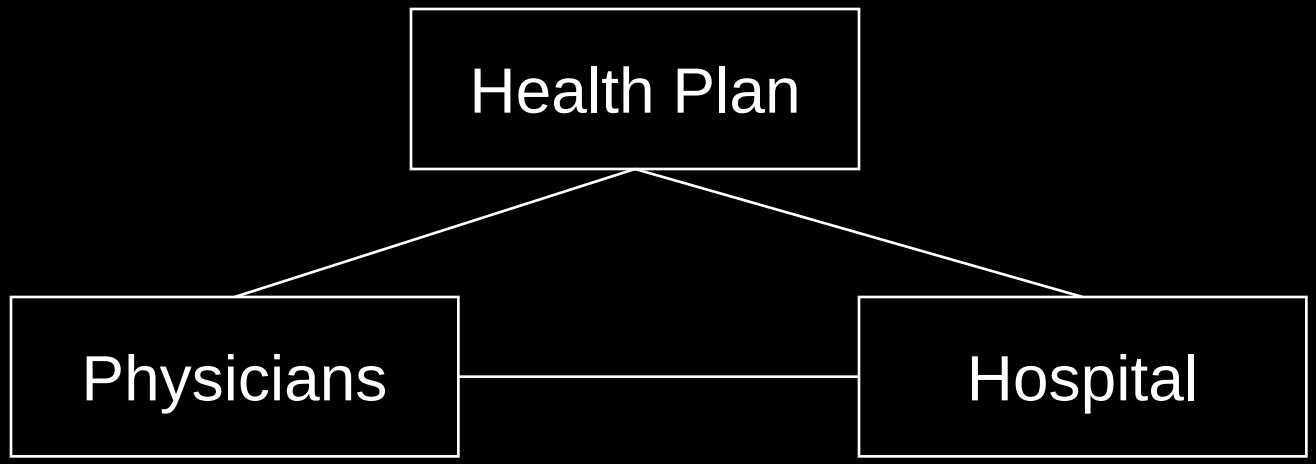
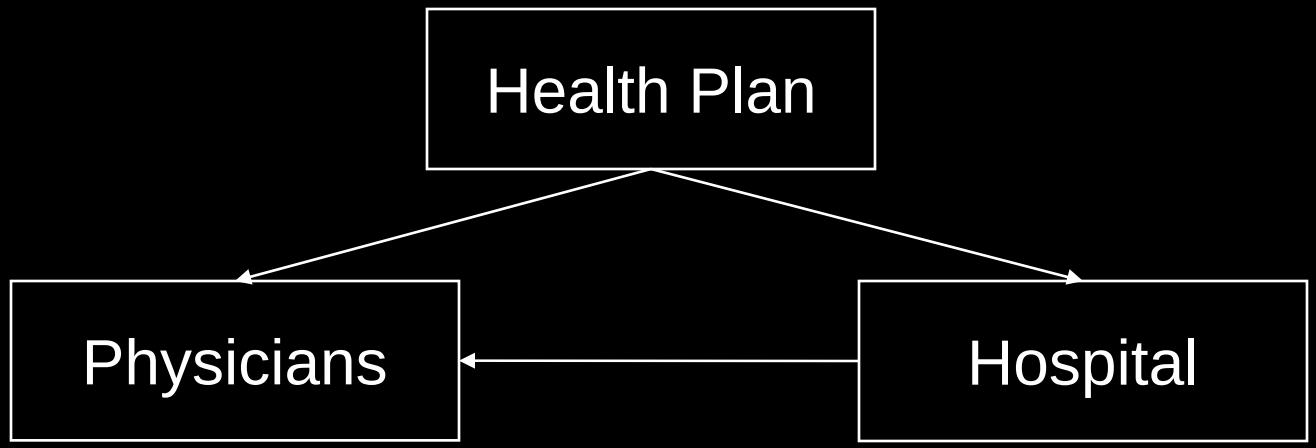
Contracts



Flow of Funds



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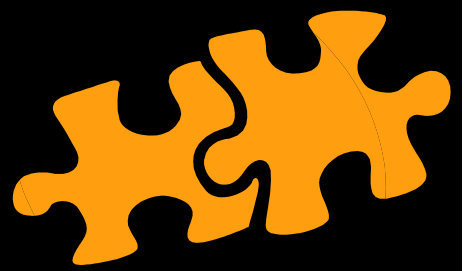
Provider Specialty Alliances

- This structure gives the member physicians and the hospital both an incentive and the flexibility to structure effective measures to ensure quality and promote efficiency
- Care evaluated overall considering the sum of its components



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Does this really work?

- Can PSAs meet all the legal requirements?
- If properly structured the risks appear fairly low–

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Federal Legal Issues

- Hospital Physician Incentive Plan law prohibits a hospital from paying a physician to reduce or limit care
- If PSA enters into risk contracts should be able to avoid Hospital PIP law
- Health Plan PIP law does apply but much easier to navigate

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Federal Legal Issues

- PSAs can be structured to satisfy the risk sharing exception to the Stark Law
- PSAs may be structured to qualify for the risk sharing safe harbor

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Federal Legal Issues

- Antitrust laws designed to protect competition
- Certain arrangements– price fixing, market allocation may be per se violations
- Monopolization or using market power in an anticompetitive way may also violate law
- Antitrust implications of a PSA need to be analyzed but often should be able to structure to avoid problems

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Federal Legal Issues

- Other federal legal issues, tax exempt organization rules, reimbursement regulations, etc.
- PSAs can be structured to address these requirements

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Pay for Performance

- Traditionally reimbursement was based on volume not on quality or outcome
- Perception that the system creates the wrong incentives
- P4P in all of its iterations is an attempt to link payment to quality or to some outcome measure