Co-Management Arrangements
Recent Trends and Valuation Issues

Presented by:

Jen Johnson, CFA

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VMG HEALTH

These slides are not intended as legal or valuation advice and are presented solely to facilitate a general discussion of the issues that may arise in the context of co-management arrangements.

PRESENTATION OUTLINE

- ❑ History of quality incentive arrangements
- ❑ Growth and outcomes of quality incentive arrangements
- ❑ ASCs and co-management arrangements
- ❑ Fair Market Value considerations for quality incentive arrangements

HISTORY OF QUALITY INCENTIVE ARRANGEMENTS

- Critical success factor – the quality of clinical performance
  - Cooperation and collaboration of physicians is essential
  - Many arrangements include an incentive payment ("pay-for-performance program") for the physician's efforts toward helping a hospital service line /outpatient department/ASC achieve high-quality.
- In late 2003, CMS and Premier Inc. launched the Hospital Quality Incentive Demonstration (HQID)
  - Offering financial incentives to improve the quality of health care.
  - By March 2004, research showed approximately 35 health plans representing 30 million members were offering pay-for-performance programs.
- In 2005, CMS developed the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates.
  - Providers that fail to comply with all RHQDAPU program data submission and validation requirements stand to lose 2.0 percent of their annual market basket update.
  - Reporting quality is the natural precursor to a national program for incentivizing quality care.

GROWTH IN QUALITY INCENTIVE INITIATIVES

- The number of private programs financially incentivizing providers for quality care continues to increase exponentially, with more than half of commercial HMOs having programs in place already (2009).
- The trend in paying for quality care spans federal and state healthcare programs as well as commercial payers, examples:
  - CMS awarded incentive payments of $12 million based on 2007 data as part of its Premier Hospital Quality Incentive Demonstration (HQID) project.
  - The top performing hospital in the HQID project received bonuses of approximately $744,000 and $365,000 based on 2006 and 2007 data, respectively.
  - Five physician groups earned a total of $25.3 million in performance payments based on 2007 data under CMS's Physician Group Practice demonstration (PQRI was the precursor to this program).
  - Blue Cross Blue Shield of North Carolina and the State Health Plan for Teachers and State Employees have paid $4.2 million in incentive compensation since 2006 to physicians meeting certain quality standards in diabetes care, heart/stroke care, or physician practice management efficiencies.

GROWTH IN QUALITY INCENTIVE INITIATIVES – EXPECTED TO CONTINUE

- RHQDAPU currently requires hospitals to report 46 quality measures in order to receive the full market basket update for FY 2011.
- Congress authorized the development and implementation of a value-based purchasing (VBP) program to replace the RHQDAPU program.
  - Use financial incentives and reporting to encourage high-quality care
  - Performance would be based on either improving historical performance or attaining superior outcomes compared with national benchmarks.
  - It is projected that these incentive payments would be 2 percent to 5 percent of reimbursement.
  - The VBP program is currently being tested.
- CMS proposes to adopt new claims-based imaging measures.
- CMS proposes 18 new measures related to other clinical topics such as cancer treatment for CY11.
- In 2007, Congress established the Hospital Outpatient Quality Data Reporting Program (HOPQDRP) requiring outpatient facilities to report clinical outcomes
- CMS is expected to expand the scope of VBP programs to cover ambulatory surgery centers in future rulemaking.

RESULTS: QUALITY INCENTIVE ARRANGEMENTS

- CMS and Premier Inc. launched the Hospital Quality Incentive Demonstration (HQID),
  - Raised overall quality by an average of 17 percent over first four years, with total payments in excess of $36.6 million over four years to top performers.
  - Majority of hospitals improved their quality of care across the board with respect to reliable use of scientifically based practices
- In 2008, the Robert Wood Johnson Foundation and California HealthCare Foundation reported results of a national program that tested the use of financial incentives to improve the quality of health care.
  - Tested seven projects across the nation that implemented systems designed to measure the performance of healthcare providers and adjust their compensation based on performance scores.
    - Six projects involved physician incentives and one involved hospital incentives.
    - The seven demonstrations paid out tens of millions of dollars in provider incentives
  - Among the notable findings from the program were that:
    - Financial incentives motivate change
    - Alignment with physicians is a critical activity for quality outcomes
    - Public reporting is a strong catalyst for providers to improve care

ASCs AND CO-MANAGEMENT ARRANGEMENTS

- ASC organizations pushing HHS for similar programs (VBP)
  - ASC Advocacy Committee: ASC Association & ASC Coalition
  - ASC Quality Collaboration (ASC QC): Ensuring quality data is appropriately developed and reported
- Proposal:
  1. Build reliable, voluntary reporting infrastructure for ASCs
  2. Measure performance within ASC setting
  3. Measures of quality should include:
     - Efficiency
     - Outcomes
     - Patient experience
     - Adherence to evidence based processes
  4. Goals:
     - Create competition based on quality and efficiency
     - Drive improvement
     - Recognize highest quality and most efficient providers
     - Recognize improvement
     - Improve transparency
     - Shared savings program, final stage of an incremental VBP implementation

FIRST ASC QUALITY MEASURES

- Developed and implemented by ASC QC
- Endorsed by National Quality Forum
- ASC QC implemented a voluntary public reporting web site for 6 metrics:
  1. Patient falls
  2. Patient burns
  3. Hospital transfer/admission
  4. Wrong site/side/patient/procedure/implant
  5. Administration of intravenous antibiotics for prophylaxis of surgical site infection
  6. Appropriate surgical site hair removal
- Several other new metrics are being considered.
- ASC QC encourages CMS to implement measures for other facility providers of outpatient surgical services (HOPD).

CO-MANAGEMENT ARRANGEMENT STRUCTURES

Engage physicians to manage ASC and/or service line of a hospital

- Quality Management Company
  - Physicians and hospital/ASC invest in management company.
  - Management company engaged to provide management services for hospital service line or ASC.
- Quality Management Agreement with single group
  - Hospital/ASC engages single physician group to provide management services for hospital service line.
- Quality Management Agreements with multiple physicians/groups to participate in Quality Committee
  - Hospital/ASC engages multiple parties to participate in quality committee that is charged with management of service line.
    - All payments must be set at FMV.

FAIR MARKET VALUE GUIDELINES FOR PHYSICIAN COMPENSATION

Based on the anti kickback statute, and other healthcare regulations and guidelines, any transaction between hospitals and physicians must be at Fair Market Value.

•IRS definition - "the amount at which property would change hands between a willing seller and a willing buyer when the former is not under any compulsion to buy and the latter is not under any compulsion to sell and when both have reasonable knowledge of the relevant facts."

•Provides a conclusion which should not reflect consideration for value or volume of referrals.

•Payment must be based on quality outcomes.

QUALITY INCENTIVES: REGULATORY GUIDANCE

OIG & CMS guidelines provide a solid foundation regarding structuring quality care arrangements:

- Quality measures should be clearly and separately identified.
- Quality measures should utilize an objective methodology verifiable by credible medical evidence.
- Incentive payments should consider the hospital's historical baseline data and target levels developed by national benchmarks.
- Thresholds should exist where no payment will accrue and should be updated annually based on new baseline data.
- Hospitals should monitor the incentive program to protect against the increase in patient fees and the reduction in patient care.
- Do not consider the value or volume of referrals.
- Consider an incentive program offered to all applicable providers.
- Incentive payments should be set at FMV.

QUALITY INCENTIVE ARRANGEMENT PAYMENT OBSERVATIONS

- Hospital Quality Incentive Demonstration (HQID). CMS's pay-for-performance pilot program
  - Includes financial incentives for the top 20 percent of hospitals.
  - Top 10 percent of hospitals receive an incentive payment of 2 percent of reimbursement
  - The second decile receives an incentive payment of 1 percent of reimbursement.
- Other commercial payors are shown to reimburse more than 2% for hospitals and as high as 10% for physicians.
- Incentives are paid for superior clinical outcomes.
- Incentives are paid for improvement and performance above the 50th percentile of industry data.
- Some programs also reduce reimbursement for poor performance.

QUALITY INCENTIVE ARRANGEMENTS FMV GUIDELINES

- Structure and terms of the compensation arrangements should be clearly defined before valuing incentive compensation.
- Compensation structure observations for quality care
  - Fixed Fee
    - Time dedicated to meetings designed to improve the overall quality of care for a specific service line, or ASC.
    - FMV based on cost to engage a physician to provide similar services.
      - Clinical and administrative survey data
      - Hourly rate
  - Variable Fee
    - Quality targets are outlined and incentive payments are provided for those responsible for implementing best practices to achieve the predefined targets.
      - Must understand superior quality and improvement
      - Carefully calculate incentive compensation pool
  - Other Add-Ons
    - Base management services (non-physician personnel)
    - Hospital based co-management arrangements may include call coverage payments

QUALITY INCENTIVES: VARIABLE FEE VALUATION CONSIDERATIONS

- First, understand what constitutes superior quality and improvement:
  - Identify key quality metrics for the service line or ASC.
  - Obtain industry-recognized benchmark data for the quality metrics, at the very least to understand the average or median and top or 90th percentile performance benchmarks.
  - Determine the service line's historical performance for the quality metrics.
  - Develop a schedule whereby historical and national data are outlined and levels of improvement and attainment of top quality are clearly identified.
- Second, to calculate the incentive compensation pool:
  - Understand the net revenues for the service line being managed.
  - Determine the appropriate market rates for improving and achieving superior quality care.
  - Understand who is responsible for developing and implementing the strategy to achieve the targets, and allocate the incentive compensation pool accordingly.
  - Create payment tiers for incentives that compensate minimal amounts for improvement over a benchmarked average or median and that compensate higher amounts when the service line is placed in the top tier for quality.

Questions and Discussion