Physician Compensation: New Paradigms in the Post-ACA World, Part II - The 2015 Perspective
Structuring Payment Models for Cost Reduction, Quality Improvement and Clinical Integration

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Today’s faculty features:

Andrea M. Ferrari, JD, MPH, Manager, HealthCare Appraisers, Delray Beach, Fla.
Kevin Locke, Principal, DHG Healthcare, Nashville, Tenn.
Chris E. Rossman, Partner, Foley & Lardner, Detroit

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Physician Compensation: New Paradigms in the Post-ACA World, Part II- The 2015 Perspective on Structuring Physician Payment Models to Achieve Quality, Efficiency and Clinical Integration

Andrea Ferrari, Esq., MPH, Healthcare Appraisers, Inc.
Kevin Locke, DHG Healthcare
Chris E. Rossman, Esq. Foley & Lardner LLP
Disclaimers/Pre-Comments:

- This presentation:
  - Is the result of collaboration of your panelists.
  - Will be an interactive discussion among your panelists.
  - Is a follow-up and update of a prior presentation (February 12, 2014) – some things are the same, some different.
  - Should not be relied upon as legal advice or a legal or fair market value opinion regarding any agreements or arrangements.
  - Is based on personal views of the panelists and may not reflect the views of employers or colleagues.
Factors at Work in the Post ACA World - 2015

- Increased awareness and focus on the “Triple Aim”:
  1. Improve patient experience
  2. Reduce per capita cost of care
  3. Improve health of the population

- Various new and updated state and federal laws and regulations, new government and private payor programs
  - Goal: incentivizing quality and value
  - Focus areas:
    - Improving coordination in care delivery
    - Reducing waste in care delivery
    - Increasing awareness of and adherence to evidence-based guidelines
    - Improving patient outcomes
Factors at Work in the Post ACA World - 2015

- The ACA “combustion engine”

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)
Increased Demand and Funding for Primary Care:

**Demand:**
- Increases in number of insureds
- Increases in insurer coverage for some 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 for practitioners who see Medicare primary care patients
  - ↑ 10%
- 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 - 2015

▪ **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 and coordinated care delivery
### Shifting from volume to value based payments:

<table>
<thead>
<tr>
<th>Medicare Initiative</th>
<th>Description</th>
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<tbody>
<tr>
<td>HIVBPP</td>
<td>Provides for annually increasing withholds and penalties in hospital DRG payments; hospitals earn back the withholds and avoid penalties by performing well on key inpatient quality measures, including rates of hospital acquired infections and other conditions that are considered “preventable”</td>
</tr>
<tr>
<td>IQRP</td>
<td>Expanding reporting requirements for HACs and other inpatient adverse events; reported information will be publicly accessible, including to patients and third party payors</td>
</tr>
<tr>
<td>PQRS</td>
<td>Program of incentive payments (&quot;carrots&quot;) and payment adjustments (&quot;sticks&quot;) for reporting of care quality measures by healthcare practitioners</td>
</tr>
<tr>
<td>RRP</td>
<td>Imposes payment penalties on hospitals for high rates of readmission within 30 days; applies to admissions/readmissions of patients with an expanded list of conditions</td>
</tr>
<tr>
<td>HACs</td>
<td>Non-payment policies (with reduced DRG payments) for inpatient stays that result in HACs</td>
</tr>
<tr>
<td>MSSP</td>
<td>Provides financial incentives (in the form of a share of Medicare’s savings) to groups of Medicare providers who collaborate through an accountable care organization (ACO) to successfully manage the cost and quality of care for an assigned group of Medicare beneficiaries</td>
</tr>
</tbody>
</table>

Factors at Work in the Post ACA World - 2015
Factors at Work in the Post ACA World - 2015

- **Shifting from volume to value based payments:**
  - State Medicaid programs and private payors continue to follow the lead of the Medicare program
    - Corollary Medicaid payment policies
      - ACA prohibits Medicaid matching funds for care that is subject to Medicaid non-payment rules → Medicaid non-payment policies reflect Medicare non-payment policies
      - New Medicaid shared savings programs similar to the MSSP
  - Corollary private payor/health plan initiatives
    - Quality and cost savings incentives in payor contracts
    - Shared savings payments, quality achievement payments
Factors at Work in the Post ACA World - 2015

The Results:

- “What gets measured, gets improved.” (LA Fitness)

- **Short term** - Parties subject to quality and value driven financial incentives are passing on/sharing the incentives with practitioner employees, contractors and other in a position to influence achievement or non-achievement of the incentive triggers.

- **Long term** – At all levels of care, there is more attention to quality and value.
Factors at Work in the Post ACA World - 2015

- The Results:

  - Anecdotal Observations:
    - Physician and midlevel employees – payment bonuses and/or penalties from employers based on measures of quality, cost or value
    - Physician and midlevel contractors – quality, cost or value driven payment bonuses and/or penalties under service contracts
    - Hospital participation in care coordination and integration initiatives
      - Physicians voluntarily participate by executing participation agreements
      - Participation agreements provide financial incentives for individual and/or group achievement of specific cost and quality targets
The Results:

Anecdotal Observations:
- Examples of proposed practitioner incentive payment triggers:
  - Achievement of data reporting thresholds
  - Patient satisfaction scores
  - Performance or non-performance of specific procedures or practices under specific circumstances:
    - Imaging procedures
    - Invasive procedures
    - Risk screening
    - Medication reconciliation
  - Occurrence of HACs and other inpatient adverse events:
    - CAUTI
    - CLABSI
    - Surgical site infections
    - Patient falls with injury
  - Ordering of Drugs or Biological Products that may not be indicated:
    - Antibiotics
    - Blood Products
Summary:

Motivating Objectives
- Practitioner reporting of data to allow measurements
- Practitioner use of data to plan care and guide changes in practice patterns
- Practitioner advancement on key quality and cost savings goals
- Practitioner adoption of IT to promote the above

Trends:
- Consolidation /integration (Is the view from 2015 different?)
- Innovative legal structures to align physician behavior with payor incentives:
  - “Clinical Integration” – CINs/CIOs
  - HEPs
  - Gainsharing and gainsharing-like arrangements
  - Incentive compensation for employee and contractor physicians
  - Co-management arrangements
  - ACOs
  - Combinations of the above
Volume to Value - Sprint or Marathon?
Tipping Point in Sight?

When will the market tip?

What percentage of our net revenue will be at risk?

FFS
Are Hospital Margins Sustainable?

[Graph showing trends in Total Margin, Operating Margin, and Patient Margin from 1992 to 2012]
Move Toward Value Based Payments – A Survey of the Payor Community

Amount of Business Supported by Value-Based Models

- Greater than 50%
- 25% to 50%
- 25% and less

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Experimenting with Bundled Payments

[Map showing states with different numbers of CMS Bundled Payments Initiative (BPCI) providers.]
Response: Hospital Consolidation

Hospital M&A Deals: 2008-2012

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Response: Physician Acquisitions

![Graph showing trends in U.S. physician practice ownership between 2002 and 2010. The graph compares physician-owned and hospital-owned practices. The data indicates a decline in physician-owned practices and an increase in hospital-owned practices over the years.]
Alternative Models of Alignment

- TACTICAL
  - INDEPENDENT PRACTICE ASSOCIATION
  - PAY FOR CALL
  - DIRECTORSHIP
  - IT DEVELOPMENT
  - CO-MARKETING

- STRATEGIC
  - PHYSICIAN HOSPITAL ORGANIZATION
  - JOINT VENTURE
  - MANAGEMENT SERVICES ORGANIZATION
  - PROFESSIONAL SERVICES ARRANGEMENT
  - GAIN SHARING
  - CO-MANAGEMENT
  - EMPLOYMENT
  - PHYSICIAN ENTERPRISE
  - FOUNDATION
  - ACCOUNTABLE CARE ORGANIZATION
  - CLINICALLY INTEGRATED NETWORK

- TRANSFORMATIONAL
  - VIP
  - PCMH
  - PHYSICIAN ENTERPRISE
  - FOUNDATION
Physicians Reporting Through PQRS

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

CMS Driving Adoption with Incentives

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EMR Adoption

MEANINGFUL USE
- NOT APPLYING
- INTENDS TO PARTICIPATE
- UNCERTAIN IF APPLYING
- INTENDS TO PARTICIPATE, NOT READY
Factors in Shifting from Volume to Value
## Factors in Shifting from Volume to Value – Alignment and Integration: A Model

<table>
<thead>
<tr>
<th>Structure &amp; Governance</th>
<th>What is the optimal governance model? How do physician leaders participate in governance and decision-making?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure &amp; Funding</td>
<td>Is there a distinct entity that has the vision, leadership &amp; infrastructure to truly succeed at creating value for physicians &amp; 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?</td>
</tr>
<tr>
<td>Participation Criteria</td>
<td>How will you decide which physicians to employ, align or integrate?</td>
</tr>
<tr>
<td>Performance Objectives</td>
<td>Do your physicians have experience in leading performance initiatives? How do you plan to proactively enact a cultural change towards value?</td>
</tr>
<tr>
<td>Physician Leadership</td>
<td>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?</td>
</tr>
<tr>
<td>Information Technology</td>
<td>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?</td>
</tr>
<tr>
<td>Distribution of Funds</td>
<td>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?</td>
</tr>
<tr>
<td>Contracting</td>
<td>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?</td>
</tr>
</tbody>
</table>
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
Federal Physician Self Referral Law (“Stark”) (cont’d):

- 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.
Antikickback Statute ("AKS") (cont’d):
- 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
- "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; and
  - Compensation be fair market value
Antikickback Statute ("AKS") (cont’d):

- 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 (3) 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.
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 CMPL 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.
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
Federal waivers issued simultaneously with issuance of the final MSSP 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 MSSP.

The rules waive certain provisions of the Stark Law, the AKS, the CMPL prohibiting hospital payments to reduce or limit services (Gain sharing CMP), and the CMPL prohibiting inducements to beneficiaries (Beneficiary Inducement CMP).

The waivers apply only to the MSSP 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

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.”
Stark Law: “fair market value” means the value in arm’s length transactions, consistent with the general market value...(42 USC § 1395NN(h)(3))

• 42 CFR §411.351 – “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 the 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. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.
In re Stark definition of fair market value:

- Distinct from other definitions fair market value, including 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…”

“Usually...where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”
In re Stark definition of fair market value (cont’d):

- A hypothetical concept - may not 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
In re Stark definition of fair market value (cont’d):

**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

- May use “any commercially reasonable” method 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))
“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))
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?
**CIN/CIO fair market value considerations:**

- CIOs/CINs may or may not participate in the MSSP and be subject to waivers of Federal laws; If not, FMV needs arise from:
  - Stark concerns (sometimes)
  - Antikickback concerns (circumstance driven)
  - CMPL (increasingly, but may change)

- Even with Federal waivers, issues may still exist with respect to *state law*:
  - State counterparts to Stark, Federal Antikickback Statute, CMPL, FCA
  - Other state laws and regulations — e.g. provider licensing and practice rules, fee splitting prohibitions

- Federally tax-exempt entities → private inurement issues regardless of MSSP participation

**Depending on facts and circumstances, FMV may be needed for:**

- Hospital contributions/distributions
- Physician contributions/distributions/incentive payments
- CIN/CIO allocations for operating costs
Sample CIN/CIO Physician Distribution/Incentive Compensation Structures:

- Incremental compensation/bonus ("carrot")
  - % of compensation otherwise payable
  - Fixed dollar amount
  - Fixed formula
- Holdback of compensation otherwise payable, to be paid only upon achievement of specified goals ("stick")
  - % of compensation otherwise payable
  - Fixed dollar amount
  - Fixed formula
- PMPM payments tied to performance of specific activities
- Percentage of cost savings achieved ("gainsharing")
- Others?
“Basic” 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
“Basic” Questions and Steps for Analyzing Physician Payments (cont’d):

4. What are the potential sources of data for the valuation?
   - Data from surveys
   - market comparables
   - CIN/CIO financial data and projections

5. What are the potentially applicable valuation approaches?
   - Market, cost and/or income?
   - What are the potential pitfalls of each?

6. Select appropriate valuation approach(es) and data
   - Beware of commercial reasonableness issues
   - Beware of “tainted” data
   - Beware of CMPL considerations
NEW Advanced Questions

Issue: Incentivized behavior is clinically appropriate in 99% of cases – what about the other 1%?

• With respect to the 1%, will the incentive payment interfere with good clinical judgment and undermine the stated goal of quality or value improvements? Does this possibility affect fair market value or commercial reasonableness of the incentive payment? Are the effects mitigated or negated by the existence of safeguards for the 1%?
NEW Advanced Questions

Issue: A hospital or other entity that is in a position to benefit from DHS or other referrals from the physicians is making a “bonus” or other incremental payment for activities that are standard of care, or that a practitioner for some other reason is or should be doing anyway.

• Could the payment be construed as “double dipping”?

• Is there an implication for fair market value or commercial reasonableness of the payment?
NEW Advanced Questions

Issue: The payment model incentivizes cost savings in care delivery, but does not provide specific parameters for how such cost savings may be achieved.

Could the offer of payments reasonably result in cost cutting behavior with disregard for reductions in the quality of care? If so, does this undermine the stated goal of quality and value improvement? Does it affect fair market value or commercial reasonableness of the payments? Can the effects be mitigated or negated by any internally or externally imposed safeguards?
NEW Advanced Questions

Issue: A practitioner payment encourages adherence to practice guidelines, but is also reasonably construed as a payment to:

(a) Reduce some types of services to patients, including Medicare and Medicaid beneficiaries; and/or

(b) Change the volume or value of “referrals” to other providers, including the payor of the incentive payment.

- legal/regulatory issues?
- fair market value implications?
- Are any legal/regulatory and fair market value implications interrelated?
NEW Advanced Questions

Issue: Incentive payments from a hospital-owned or health system-owned entity are substantial and may be earned equally by “employed” physicians and independent community physicians. For some of the employed physicians, the incentive payments may result in total compensation that is well in excess of total compensation amounts reported in published compensation surveys.

• Are the payments still fair market value if the total compensation received by employee physicians from the hospital/health system and related entities will be in excess of total compensation reported by surveys of physicians of the specialty?

• Is there a commercial reasonableness issue/question under these circumstances?
NEW Advanced Questions

Issue: Payment of incentives will directly cause or contribute to an operating loss for the payor of the incentive.

- Does this affect:
  - Fair market value of the incentives?
  - Commercial reasonableness of the incentives?
  - Legal analysis of the incentives?

- Does it matter if the operating loss is short term or long term?
Questions?

Andrea Ferrari, Esq., MPH, Healthcare Appraisers, Inc.
561.330.3488
AFerrari@hcfmv.com

Kevin Locke, DHG Healthcare
330.650.1752
Kevin.Locke@dhgllp.com

Chris E. Rossman, Esq. Foley & Lardner LLP
313.234.7112
CRossman@foley.com