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Pay for Performance: Enhancing Access, Quality & Efficiency

Pay for performance (P4P) programs are gaining traction. Commercial and governmental payors are neither willing nor able to continue to make payments to physicians and hospitals simply on the basis of what is being done to the patient. Studies have shown that as much as 45% of the care that is provided by physicians to patients is not evidenced-based. The lack of coherent standards to measure the quality of care being provided leads to enormous waste. Patient satisfaction with the health care services they receive has also been recognized as an increasingly important element of quality. A paradigm shift is under way that will hold significance for the entire health care industry in the very near term.

The question is no longer **if** P4P will become part of the health care payment landscape. Companies interested in finding ways to save money on healthcare programs for their employees have helped organize quality programs centered on evidence-based medicine in conjunction with payors. The Centers for Medicare & Medicaid Services (CMS) are conducting several P4P demonstration projects involving quality payments to hospitals, physician groups, and chronic care management carve outs.

The P4P concept began in earnest in California in 2003 when seven major commercial health insurers began paying bonuses to physicians based on quality indicators and patient satisfaction responses. The California P4P programs currently involve approximately 6,200,000 lives. While not a large number of lives when compared to the total population of California, there has been tremendous attention paid to this payment experiment by CMS and other payors.

Participating physicians in the California P4P programs are given score cards based on three distinct elements: (1) meeting or exceeding specified patient satisfaction levels; (2) meeting or exceeding specified quality indicators; and (3) implementing computer-based systems to assist in monitoring performance under the specified quality indicators.

Transparency of the performance results to patients is an important feature of the P4P concept. Furthermore, the adoption of uniform quality indicators by the payors is a key to making the provider scorecard acceptable to participants in the P4P program. Prior provider scorecards independently created by each payor led to inconsistent rating and patient confusion. The cooperative efforts in the development of the quality indicators by the health plans are resulting in greater acceptance by physicians.

Very little "new" money exists to pay for participation in the P4P programs; savings may be gained from reducing unnecessary care. However, California physicians reported that they lost money gearing up for P4P.

The bad news for health care providers is that there is little, if any, "new" money to pay for participation in the P4P programs. The expectation is that savings gained from the reductions in unnecessary care will fund the bonuses to encourage quality care. California physicians have reported that they have actually lost money in gearing up for P4P. The costs associated with computer systems necessary for implementation of P4P monitoring can range from \$40,000 to \$70,000. Based on this cost alone, it is fairly clear that P4P programs have a built-in bias for larger physician groups.

The current governmental and commercial reimbursement systems have prospective payment methodologies that may actually discourage quality care. Evidence-based medicine has shown that certain preventive measures by physicians and hospitals may avoid complications of certain conditions. Under current payment methodologies, a hospital receives no additional compensation for preventing complications. In fact, if complications result, the hospital is paid an outlier for providing the additional care. If the reimbursement for taking these quality steps does not appropriately compensate the hospital, revenue could be lost because the hospital does not receive the higher payment for treating the complication. The case for changing the reimbursement system is clearly demonstrated by these types of problems. The difficulty will be operating in the real world while payors go about making changes.

Another concern is the existing regulatory framework. There are significant legal issues that must be addressed in the development of a P4P program. The primary legal issues relate to the following laws and regulations:

- Antitrust (both as to payors and providers);
- Fraud and abuse and physician self-referral (*i.e.*, Stark Law);
- Civil monetary penalties ("CMP"); and
- HIPAA and other privacy issues.

CMP laws restrict the reduction of care by a physician to a Medicare beneficiary. The difference between arbitrarily reducing care and eliminating unnecessary treatments may be a source of debate. The harshness of the penalties associated with the CMP laws makes this more than an academic discussion.

A related example of the change in the government's thinking regarding payment for health care is the recognition that gainsharing may be a useful tool for saving money. Gainsharing is a type of P4P program based on hospital savings generated by physicians (usually surgeons) who agree to

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change historic operating practices such as opening sterile packaged items in the operating room as they are needed rather than opening everything when the surgery begins. The OIG has approved several of these types of arrangements, albeit with extensive restrictions and a limitation on duration. CMS anticipates publishing an RFP in May for a new hospital gainsharing demonstration project pursuant to the authority of the Deficit Reduction Act of 2005.

P4P is here to stay. Commercial and governmental payors are in various stages of program development. Last week, the American Medical Association (AMA) agreed to develop standard measures of performance for physicians. Under the accord between the AMA and Congress, physician groups are to develop a total of approximately 140 physician performance measures covering 34 clinical areas by the end of this year.

Hospitals, physicians, and payors are entering into collaborative efforts to develop P4P programs. While the implementation of a P4P program may benefit patients and the health care system in general, it must be implemented within the existing regulatory environment. The broad reach of the fraud and abuse and Stark laws may impede actions that are truly beneficial to the creation of quality treatment practices. It is important to coordinate the development of a P4P program between the technical consultants who develop the quality indicators and legal counsel with experience in the development and implementation of P4P programs.