

The American Bar Association
Health Law Section
and the
ABA Center for Continuing Legal Education
Present

**Structure and Valuation of Quality Management and
Call Coverage Arrangements**





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**American Bar Association Health Law Section
April 29, 2010 Teleconference Presentation**

**Structure and Valuation of Quality Management and
Call Coverage Arrangements**

presented by:

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

PRESENTATION OUTLINE

Jen Johnson: Overview of Arrangements

- History of call coverage arrangements
- Growth of call coverage arrangements
- History of quality incentive arrangements
- Growth of quality incentive arrangements

Jim Pinna: Legal Perspective

- Key regulatory considerations
- Models for call coverage arrangements and quality management arrangements

Jen Johnson: Valuation Perspective

- Fair Market Value considerations for call coverage arrangements
- Fair Market Value considerations for quality incentive arrangements

HISTORY OF CALL COVERAGE COMPENSATION

- EMTALA (42 USC 1395dd) requires hospitals to provide appropriate medical screening examination within the capability of the ED and maintain a list of physicians who are on call for duty
- In the past, call coverage was typically provided by physicians in exchange for admitting privileges
- Now, more physicians are demanding payments for call coverage due to:
 - Rising Costs
 - Growth in the uninsured patient population
 - Fear of malpractice lawsuits & higher premiums associated with emergency departments
 - Fundamental industry changes
 - Work-life balance
 - Decreasing physician supply
 - Less reliant on hospitals to build practice
 - Seeking equity with other physicians

GROWTH IN CALL COVERAGE PAYMENTS

- ❑ How industry-wide is paying for call?
 - Medical Group Management Association's (MGMA) 2009 inaugural *Medical Directorship/On-Call Compensation Survey Report*.
 - 62% receive additional compensation for call coverage.
 - Sullivan Cotter (SC) 2009 on-Call Survey
 - Approximately one-half (46%) provide on-call pay to their employed physicians.
 - The majority (82%) of survey participants provide on-call pay to non-employed physicians
- ❑ How much are call coverage expenses growing?
 - From 2006 to 2009, the median expenditures reported by trauma centers for physician on-call pay increased by 141% the median expenditures in non-trauma centers increased by 546%. [SC]
 - More than one-half of those surveyed reported their on-call pay expenditures have increased in the past 12 months. [SC]
 - 4% of respondents reported on-call pay expenditures have increased more than 50%. [SC]

GROWTH IN PAYMENTS – EXPECTED TO CONTINUE

- ❑ 80% of survey respondents have experienced difficulty finding physicians to provide on-call coverage [SC]
- ❑ 9% of respondents reported the discontinuation of service lines due to lack of on-call coverage [SC]
- ❑ 20% of the respondents indicate they plan on implementing on-call pay within the next 6 months for physicians not currently receiving pay [SC]
- ❑ As a result, call coverage compensation arrangements are continuing to grow and evolve structurally.

HISTORY OF QUALITY INCENTIVE ARRANGEMENTS

- ❑ Hospitals critical success factors - the quality of clinical performance
 - Hospitals need cooperation and collaboration of physicians
 - Many arrangements include an incentive payment ("pay-for-performance program") for the physician's efforts toward helping the hospital 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.
- ❑ 2006 Tax Relief and Health Care Act required a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries.
 - CMS named this program the Physician Quality Reporting Initiative (PQRI).
 - Reporting quality is the natural precursor to a national program for incentivizing quality care

GROWTH IN QUALITY INCENTIVE INITIATIVES

- ❑ Achieving Quality - 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.
- ❑ 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.
 - 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 30 inpatient measures, CMS has proposed 13 new measures for FY10.
- ❑ In 2007, Congress established the Hospital Outpatient Quality Data Reporting Program (HOPQDRP) requiring outpatient facilities to report clinical outcomes
- ❑ CMS proposes to adopt four claims-based imaging measures for calendar year (CY) 2010.
- ❑ CMS proposes 18 new measures related to other clinical topics such as cancer treatment for CY11.
- ❑ CMS is expected to expand the scope of these programs to cover ambulatory surgery centers in future rulemaking.
- ❑ 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.

FINDINGS OF 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

Key Regulatory Considerations

- Stark Law
- Civil Monetary Penalty Statute
- Anti-Kickback Statute
- Tax Exempt Issues

Stark Law -- Overview

- Prohibits referrals (or billing) of designated health services (DHS) if referring physician has direct or indirect financial relationship with DHS entity unless the financial relationship meets an exception
- Call coverage agreements and quality management arrangements can create direct or indirect compensation arrangements between hospitals and the physicians involved in the arrangements
- Physicians “stand in the shoes” of their physician organizations if they own an interest in such physician organization
 - Agreement with individual physician or physician practice will need to meet an exception for direct compensation arrangements
 - Agreement with special purpose entity (not a physician practice) analyzed as indirect compensation

Stark Law -- Exceptions

- ❑ Direct compensation can meet personal services exception (42 CFR 411.357(d)) or fair market value exception (42 CFR 411.357(l))
 - Signed agreement specifying the services provided
 - Term of at least 1 year or only one agreement entered over course of 1 year period (FMV exception)
 - Commercially reasonable arrangement
 - Compensation set in advance, consistent with fair market value and not determined in a manner that takes in account volume or value of referrals
 - "Set in advance" allows for specific formula set in advance that can be objectively verified and does not vary with volume or value of referrals (i.e. per diem compensation or payments for specific quality measures can be set in advance)

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Stark Law -- Exceptions

- ❑ Indirect compensation analysis
 - Applies if physician ownership in special purpose entity that is not a physician practice
 - Outside of Stark Law if aggregate compensation to referring physician does not vary with or reflect volume or value of DHS referrals
 - Otherwise, need to meet indirect compensation exception (42 CFR 411.35(p)) with respect to closest compensation arrangement to physician
 - Signed agreement specifying the services
 - FMV compensation
 - Commercially reasonable

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CMS Guidance on Quality Arrangements

- ❑ CMS proposed new Stark Law exception for certain incentive payment programs in Medicare Physician Fee Schedule Proposed Rule published on July 7, 2008 (“Proposed Exception”)
- ❑ CMS extended comment period on Proposed Exception in Medicare Physician Fee Schedule Final Rule published on November 19, 2008, but never finalized Proposed Exception
- ❑ CMS acknowledged that incentive payment programs may also meet requirements of existing Stark Law exceptions, such as personal services exception, fair market value exception or the indirect compensation exception
- ❑ Regardless of which Stark Law exception is used to a structure quality management arrangement, the Proposed Exception provides helpful guidance for hospitals

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CMS Guidance on Quality Arrangements

- ❑ Overview of Proposed Exception
 - Aimed at permitting collaboration between hospitals and physicians in two areas
 - Incentive payment programs to meet quality performance goals (the focus of this presentation)
 - Shared savings programs that promote shared cost savings or “gain sharing” (not addressed in this presentation)
 - Concerns about improper incentives for steering of patients, increases in volume, quicker discharges
 - 16 detailed standards listed in Proposed Exception
- ❑ Key focus areas for incentive payment programs
 - Quality measures
 - Structure of physician participation
 - Compensation methodology

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CMS Guidance on Quality Arrangements

- ❑ Quality measure standards
 - Use objective methodology, are verifiable, supported by credible medical evidence and individually tracked
 - Reasonably related to hospital practices and patient population
 - Listed on CMS Specification Manual for National Hospital Quality Measures
 - Targets developed against hospital's baseline historic data and comparing national/regional data
 - Thresholds below which no payments will accrue to physicians
 - Independent medical review prior to commencement and annually thereafter
 - Effective prior written notice to patients affected by program
 - Payment not based on reduction in length of stay

CMS Guidance on Quality Arrangements

- ❑ Physician participation standards
 - At least 5 physicians must participate in each performance measure
 - Participating physicians must be on medical staff of hospital at commencement of program and may not be selected in a manner that takes into account volume or value of referrals
 - Hospital must offer opportunity to participate to all physicians in same department or specialty on same terms and conditions
 - Payments distributed to participating physicians on a per capita basis

CMS Guidance on Quality Arrangements

Compensation Standards

- Signed agreement specifying compensation in sufficient detail to be independently verified and identifying specific performance measures and resulting payments (or formula for payment) to participating physicians
- Term of no less than 1 year and no more than 3 years
- Payment formula takes into account previous payments for performance measures to ensure physicians do not receive payment related to quality improvements achieved in prior period (so called “re-basing”)
- Payment formula set in advance, does not vary during the term and not determined in manner taking into account volume or value of referrals
- Payment formula may not include any amount that takes into account increases in volume or value of referrals
- Payment directly to participating physicians or qualified physician organizations

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Civil Monetary Penalty Statute -- Overview

- 42 USC 1320a-7a(b) prohibits a hospital from knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to a Medicare or Medicaid beneficiary under the direct care of the physician
- No regulations finalized, but OIG issued July 1999 Special Advisory Bulletin, numerous favorable opinions regarding gain sharing arrangements and Adv. Op. 08-16 regarding quality arrangement
- Important to evaluate whether quality incentive measures might create incentive to physicians to reduce or limit items or services and incorporate safeguards to ensure that services are not reduced
 - Avoid measures related to length of stay or cost per patient
 - Focus on reducing complications, readmissions or improper care

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Anti-Kickback Statute -- Overview

- ❑ Prohibits knowing and willful offer, payment, solicitation or receipt of remuneration to induce or reward referrals of services reimbursable by a federal health care program
- ❑ Prohibits arrangements if “one purpose” is the inducement of referrals, regardless of whether there are other appropriate purposes
- ❑ OIG takes position that certain facts and circumstances can support inference that improper remuneration is being paid to induce referrals (e.g. paying greater than FMV)
- ❑ OIG has promulgated safe harbor regulations identifying transactions that will not be subject to criminal prosecution or exclusion proceedings

Anti-Kickback Statute -- Safe Harbors

- ❑ Personal services and management contracts safe harbor requires
 - Written agreement specifying services provided
 - Term of no less than 1 year
 - Aggregate compensation is set in advance, consistent with FMV and not determined in manner that takes into account referrals
 - Commercially reasonable
- ❑ Arrangements with fixed monthly compensation for call coverage or management services may be able to meet safe harbor
- ❑ Arrangements with hourly compensation, per diem call coverage compensation or “at-risk” quality incentive compensation are unlikely to meet safe harbor because aggregate compensation may not be set in advance

Anti-Kickback Statute -- OIG Concerns re Call Pay

- ❑ OIG has noted substantial risk of improperly structured payments for call coverage in OIG Advisory Opinion 09-05 and 07-10, such as:
 - Lost opportunity or similarly designed payments that do not reflect bona fide lost income
 - Payment structures that compensate physicians when no identifiable services are provided
 - Aggregate on-call payments disproportionately high compared to regular medical practice income
 - Payment structures that compensate for services when physician receives separate reimbursement from insurers, or double payment

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OIG Guidance on Call Coverage

- ❑ OIG Advisory Opinions 07-10 and 09-05
 - Burden of uncompensated care and malpractice costs impacted supply of physicians to provide ED call coverage, constraining ability to meet community need and requiring transfers of patients
 - All physicians on staff within relevant specialty offered opportunity to contract for call coverage
 - Agreement specifies call-coverage obligations, including timely response
 - 07-10 used per diem rates for call coverage
 - 09-05 used reimbursement by hospital for services to indigent and uninsured patients
 - OIG concluded that although call coverage arrangements could potentially generate prohibited remuneration, if improper intent were present, OIG would not impose administrative sanctions

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OIG Guidance on Call Coverage

- ❑ **OIG Advisory Opinion 07-10 and 09-05 -- Key considerations**
 - All physicians on medical staff within relevant specialty are offered opportunity to contract
 - Call coverage administered uniformly
 - Per diem rates or reimbursement for services to indigent patients were FMV for services provided
 - Commercially reasonable arrangement to deal with legitimate unmet need for call-coverage

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OIG Guidance on Quality Arrangements

- ❑ **OIG Advisory Opinion 08-16**
 - Hospital shares performance based compensation available from private insurer for meeting certain quality targets with physician-owned entity
 - Services agreement with physician entity whereby hospital will pay entity a percentage of bonus compensation received for meeting quality targets (not to exceed 50% of total bonus compensation)
 - Physician entity distributes compensation earned to its members on per capita basis
 - Hospital to monitor quality targets to protect against inappropriate reductions or limitations in patient care
 - OIG concluded that although arrangement could potentially constitute improper payment to induce reduction or limitation of services and generate prohibited remuneration, if improper intent were present, OIG would not impose administrative sanctions

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OIG Guidance on Quality Arrangements

- ❑ **OIG Advisory Opinion 08-16 -- Quality measures**
 - Credible medical support evidencing potential to improve patient care
 - Quality measures reasonably related to practices and patient population of hospital
 - Performance measures clearly and separately identified
 - Patients notified of quality improvement program
 - Hospital monitors quality targets and implementation to protect against inappropriate reductions or limitation in patient care

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OIG Guidance on Quality Arrangements

- ❑ **OIG Advisory Opinion 08-16 -- Physician participation**
 - Limited to physicians on active staff for at least 1 year so to avoid incentive to attract new physicians to share in compensation
 - Compensation distributed per capita
- ❑ **OIG Advisory Opinion 08-16 -- Compensation**
 - Compensation tied to base compensation in the first year such that increase in patient referrals would not result in increase in compensation to physicians
 - Compensation based on incentive compensation paid by independent private insurer
 - Arrangement limited to 3 year contract

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Tax Exempt Issues

- ❑ Prohibition on inurement or private benefit
 - Requires reasonable compensation consistent with FMV and no payments based on service line earnings
 - Rebuttable presumption of reasonable compensation under intermediate sanctions regulations (26 USC 4958, 26 CFR 53.4958) upon proper review by intermediate sanctions committee
- ❑ Private business use limits for bond financed space
 - Management contract involving space financed with tax exempt bonds can create private business use if contract provides compensation based in whole or in part on net profits
 - Rev. Proc. 97-13 provides safe harbors for management contracts; compliance not mandatory unless required in bond documents

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Rev. Proc. 97-13 Safe Harbors

- ❑ Per-unit fee arrangements
 - Term no greater than 3 years, with termination on reasonable notice without penalty or cause after second year by hospital
 - All compensation based on per-unit fee which is a fee based on unit of service provided specified in the contract or determined by third party (i.e. per procedure payment)
 - Quality fees do not squarely fit within definition of per-unit fee because they are not based on unit of service
 - Separate payments received by on-call physicians from patients or payors may also constitute per-unit fees
- ❑ 50% periodic fixed fee arrangements
 - Term no greater than 5 years, with termination on reasonable notice without penalty or cause after third year by hospital
 - At least 50% of compensation is based on periodic fixed fee (remainder can be per unit fee, quality fee, etc.)
 - Periodic fixed fee would include per-diem fees, hourly fees, monthly fees
 - Quality management arrangements can meet this safe harbor if quality incentive fee is limited to amount of hourly or monthly fixed fee payments (50/50 rule)

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Models for Call Coverage and Quality Management

- What are the primary goals of the hospital?
 - Ensure appropriate coverage of service line consistent with hospital obligations under EMTALA?
 - Engage physicians to manage clinical delivery of care and drive improvements in quality outcomes?
 - Some combination of both?
- Several models for hospitals to consider, based on
 - Specific service line involved
 - Dynamics of physician stakeholders
 - Willingness of physicians to get more involved in clinical management
- Antitrust issues to keep in mind
 - Offered on equal basis to all qualified physicians
 - Justifications for any exclusive arrangement
 - Separate from medical staff credentialing process

Models for Call Coverage Agreements

- Call Coverage Agreement with Single Group
 - Single physician group provides 24/7 coverage for service line for flat monthly payment
- Call Coverage Agreements with Multiple Groups
 - Multiple physician groups engaged to provide coverage for service line in accordance with call schedule and receive payment based on proportion of coverage provided
- Call Coverage Agreements with Individual Physicians
 - Individual physicians on medical staff engaged to provide coverage for service line in accordance with call schedule and receive payment based on proportion of coverage provided
- Call Coverage Agreements with quality and/or management components
 - Portion of call coverage payment at-risk based on quality
 - Engagement to provide administrative or management services

Models for Quality Management Arrangements

- ❑ Quality Management Company
 - Physicians and hospital invest in management company
 - Management company engaged to provide management services for hospital service line
- ❑ Quality Management Agreement with single group
 - Hospital 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 engages multiple parties to participate in quality committee that is charged with management of service line

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.”
- Analysis must be based on unrelated, third party scenario.
- Provides a conclusion which should not reflect consideration for value or volume of referrals.

CALL COVERAGE FAIR MARKET VALUE GUIDANCE: OIG OPINION

- ❑ On September 20, 2007, the OIG issued Advisory Opinion number 07-10 (Opinion), which stipulated several guidelines for healthcare organizations considering compensation for physicians who provided on-call coverage.
- ❑ Specifically, the OIG found a certain arrangement to be low risk for fraud and abuse, based on several factors, including:
 - An independent third-party analysis which concluded that the compensation reflected FMV for the services furnished
 - The per diem rate was designed to compensate each physician for the burden of being on-call and it considered the likelihood that the physician would be required to provide subsequent inpatient services.
 - On-call physicians were obligated to provide continuing care to ED patients, regardless of their ability to pay.
 - Physicians in each specialty received the same per diem payment without regard to the individual physician's referrals to, or business generated for, the hospital.
 - The medical center had a legitimate, unmet need for on-call coverage and indigent care services as demonstrated by the fact that the medical center was previously forced to outsource emergency care and related treatments to other facilities.
 - 18 days of uncompensated call per year was provided by the subject physicians.

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CALL COVERAGE PAYMENT MODELS

- ❑ Daily or hourly rate model - 46% of organizations utilize this compensation methodology for employed physicians and 82% use this methodology for non-employed physicians. [SC]
- ❑ Paying professional fees for uninsured patients
- ❑ Activation fee
 - May not account for specialty or burden of call
 - Can raise regulatory concerns – paid by hospital and payor
- ❑ Combination of the above three models
 - Understand the aggregate compensation
- ❑ Providing payments for “excess” on-call duty
- ❑ Paying the physician's malpractice insurance premium
- ❑ A 457 Deferred Compensation Plan - a supplemental retirement savings program that allows you to make contributions on a pre-tax basis.
 - Generally taxed as ordinary income when paid out
 - 2009 contribution limit \$16,500
 - Unlike 401K
 - No 10% penalty for withdrawal before the age of 59 1/2
 - Allows independent contractors to participate

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OTHER CALL COVERAGE OPTIONS

- Physicians dedicated to on-call coverage and unassigned patients.
 - Typically seen for high volume specialties or time sensitive services.
 - Unassigned patients were not typically covered under an on-call arrangement and are increasingly becoming part of on-call agreements
 - Laborists (obstetricians)
 - Surgicalists / Traumatologists (surgeons and orthopedists)
 - Phone call compensation
- Utilizing residents and physician “extenders” as first responders
- Using locum tenens agencies
- Hospital Inpatient Prospective Payment System final rule for fiscal year 2009 finalized provisions relating to the Emergency Medical Treatment and Labor Act (EMTALA) which outlines community call plan requirements.
 - Permits two or more hospitals to implement a plan to coordinate on-call coverage in a specific geographic area. Must include:
 - A clear delineation of on-call coverage responsibilities
 - A description of the plan’s geographic service area
 - Signed by both hospitals
 - Annual assessment of the plan

MOST COMMON MODEL AND SURVEY DATA AVAILABLE - DAILY / HOURLY RATE

- We will continue to scrutinize the Fair Market Value of arrangements as Fair Market Value is an essential element of many exceptions. Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating Fair Market Value. (STARK II, PHASE III, FR Vol. 72, No. 171)
- Market data sources
 - SC 2009 on-call survey data
 - MGMA 2009 on-call survey data
- Benefits of market data
 - Payments reflect services
- Issues with market data
 - The methodology must exclude valuations where the parties to the transactions are at arm’s length but in a position to refer to one another (STARK II, PHASE II, FR Vol. 69, No. 59).
 - Concern that the survey data may be tainted
 - The data is based upon physician-hospital (referral) relationships
 - The limited number of respondents within the surveys.
 - The large variance in fees reported.
 - The volume of call and payor mix associated with the reported fees are unknown.
 - Details such as whether or not the physician bills and collects is unknown.

DAILY / HOURLY RATE SURVEYS OVERVIEW

- ❑ Sullivan Cotter 2009 on-call survey data
 - 34 reported specialties, 40% of those specialties have less than 20 respondents for on-call compensation.
 - Reliable?
 - Decrease of median per diem payments for specialties such as psychiatry, which dropped 50% to \$200 in 2008.
 - Increase of median per diem payments for specialties such as anesthesiology which jumped 50%, from \$500 to \$750 in 2008;
- ❑ MGMA 2009 on-call survey data
 - 17 reported specialties, 7 have less than 20 respondents for on-call compensation.
 - Reliable?
 - Wide variances in compensation data
 - General surgery shows per diem rates ranging from \$388 to \$2,000 per day,
 - Neurology ranges from \$500 to \$3,105.
 - Invasive-interventional cardiology respondents reported an 80% difference in on-call compensation between single specialty (\$465 per day) and multi-specialty groups (\$2,298 per day).
 - Conclusions do not necessarily support FMV guidelines
 - Unrestricted rates are higher than restricted rates

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CALL COVERAGE: VALUATION CONSIDERATIONS AND METHODOLOGIES

- ❑ Market data – be cautious
- ❑ Alternative to market data: Cost to hospital based on alternatives
 - Adjusted locum tenens rates
- ❑ Alternative to market data: Beeper rates for non-referring providers
 - Reflects cost to carry beeper
- ❑ Reconcile all methodologies
- ❑ Payments may vary based on:
 - Willingness and supply of physicians
 - ED payor mix
 - ED call volume
 - Agreement terms (ie: uncompensated care)
 - Understand aggregate pay
- ❑ Compliance Suggestion: Start tracking volume and payor mix by specialty

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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.
- Quality measures should be reasonably related to the hospital's practice and consider patient population.
- Do not consider the value or volume of referrals. Consider an incentive program offered to all applicable providers.
- 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.
- 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.
- Pay-for-performance programs in the marketplace show incentives as high as 10 percent of reimbursement.
- Incentives are paid for superior clinical outcomes, including improvement and performance above the 50th percentile of industry data.
- Some programs also reduce reimbursement for poor performance.

QUALITY INCENTIVE ARRANGEMENTS VALUATION GUIDELINES

- ❑ Structure and terms of the compensation arrangements should be clearly defined before valuing incentive compensation.
- ❑ Compensation structure observations for quality care: fixed fee, a variable fee or a combination thereof:
 - Fixed Fee
 - Time dedicated to meeting designed to improve the overall quality of care for a specific service line.
 - 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

QUALITY INCENTIVES: VARIABLE FEE VALUATION CONSIDERATIONS

- ❑ First, understand what constitutes superior quality and improvement:
 - Identify key quality metrics for the service line
 - 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