Litigation Support

Payment Models Dictate New Physician Compensation Arrangements

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It is no secret that CMS (Centers for Medicare and Medicaid Services) and private payers are determined to replace health care's volume-oriented fee-for-service payment system with alternatives aimed at promoting quality and value. What is surprising is the momentum that CMS has developed to affect change, as it moves aggressively to implement new payment models.

These new payment mechanisms are reshaping the economic relationship between doctors and hospitals and, therefore, have important implications for the compensation arrangements in physician employment agreements, particularly for doctors employed by hospitals or in practices leased by hospitals.

Payment reforms also pose challenges for health care attorneys as they advise their clients on the new relationships that are emerging and the related compensation issues governed by the Stark and anti-kickback laws.

Physician employment agreements commonly have a five-year term, and CMS has committed to having 30 percent of Medicare payments administered through value-based payment by the end of 2016 and 50 percent by the end of 2018.

Given CMS's goals, it is wise for both doctors and their attorneys to incorporate contract terms that will allow for new compensation arrangements to be worked out as CMS and private payers reshape the payment landscape. A proactive approach will help to avoid the uncertainties of an unanticipated mid-contract renegotiation.

Payers Are Serious

Several recent developments highlight that Congress and CMS are serious about payment reform. Congress has passed the Medicare Access and CHIP Reauthorization Act (MACRA), which authorized CMS to move ahead with new payment models that include financial risk for providers. MACRA also authorizes CMS to unilaterally implement these new payment arrangements and require providers to accept them.

CMS is operating under a framework with four phases in the evolution away from fee-for-service payment:

• Phase 1—fee-for-service with no link of payment to quality.

• Phase 2—fee-for-service with a link of payment to quality.

• Phase 3—alternative payment models built on fee-for-service architecture.

• Phase 4—population-based payment.

CMS is now rolling out payment models in phases 3 and 4. Phase 3 includes models for episodes of care, and phase 4 may include capitation programs. A key element of the models in these two categories is that they introduce downside financial risk. If providers exceed the targeted cost of an episode of care, they may be required to reimburse CMS for the difference. Likewise, if the cost of care for capitated patients exceeds the monthly per–member/per-month payment, providers must absorb some or all of the losses.

The Center for Medicare and Medicaid Innovation (CMMI) is implementing two phase 3 payment models that highlight the need for new performance measures and compensation terms in physician employment agreements. The Oncology Care Model (OCM) is an episode of care payment arrangement for six-month chemotherapy episodes.

The OCM establishes cost targets for virtually all chemotherapy episodes, and those cost targets include all Part A and Part B services, which means that physicians must focus on managing all other providers as well as the cost of chemotherapy drugs. The OCM provides additional payment for enhanced patient management services, but more importantly, the cost targets ratchet down in successive years of the program. If oncologists are able to achieve the targeted cost savings, they will earn an additional performance payment. The third year of the program will allow practices to opt in to a downside risk-sharing arrangement, where providers can receive part of the cost savings, but they must also reimburse Medicare if the cost savings are not met.

The OCM is a voluntary program, but CMMI's Comprehensive Care Joint Replacement (CJR) program is a mandatory financial risk program for hospitals in 67 geographic metropolitan statistical areas. The CJR targets the total cost—Part A and Part B services—of hip and knee replacement episodes beginning with the hospital admission and continuing for 90 days.

CMS is pursuing its ultimate goal of moving to category 4 population-based payment models in the Next Generation ACO Model program. This will be capitation or another predetermined fixed payment model for all care over an extended time period—up to one year, according to CMS.

These new payment mechanisms, especially the mandatory CJR that holds providers financially responsible for the total cost of care, indicate how serious CMS is about achieving cost savings, improving quality, and moving away from pure fee-for-service reimbursement. CMS has taken the lead in payment reform, and importantly, it has opened the door for private payers to participate in its models. The OCM encourages participating providers to recruit commercial health plans to implement a similar payment arrangement for their members.

These developments indicate how important it is for physician employment agreements to include clauses that provide for the possibility of renegotiation of compensation methodologies as conditions warrant.

The predominant basis of compensation for employed or leased physicians is productivity measured by relative value units (RVUs), or more specifically, work RVUs (WRVUs). WRVUs are objective, consistent and easily tracked. WRVUs have worked up until now because compensation can be easily determined and administered. Equally important, WRVUs are a means to ensure productivity and promote growth.

The challenge that both hospitals and physicians face in creating workable compensation arrangements is to ensure that an emphasis on productivity is maintained while also aligning doctors with new incentives and providing compensation for the new responsibilities they face, such as rewarding their efforts to control costs and improve quality.

The study "Effects of Healthcare Payment Models on Physician Practice in the United States" by the American Medical Association and the RAND Corp. reported that practices are having difficulty in balancing these complex and contradictory requirements: "In several practices, leaders acknowledge the presence of inconsistency between financial and nonfinancial incentives (e.g., applying RVU-based financial incentives simultaneously with admonitions to contain costs)."

Thus, there is the possibility that it may be difficult for doctors and their employers to develop mutually agreeable and easily administered compensation arrangements. Likewise, there may be challenges in ensuring that new compensation arrangements comply with the fair market value and commercial reasonableness provisions of the Stark and anti-kickback laws. There is helpful federal guidance on current compensation arrangements with supporting OIG advisory opinions covering current compensation arrangements, but the new payment models introduce new terms and incentives that should be incorporated in physician employment agreements. These new terms go beyond the current guidance and precedents. They need to be evaluated in detail by experts who have the experience to determine how they fit into the existing laws and regulations.

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