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OIG Ruling Sets Stage for Aligning Incentives to Improve Quality

Borgess Medical Center in Kalamazoo, Mich., will be the first hospital in the country to engage, with OIG's approval, in a quality-improvement program that calls for splitting with physicians an insurer's rewards for better patient care.

In a ground-breaking advisory opinion (08-16) issued last month, OIG gave the green light to a hospital-wide quality improvement program that allows hospitals to reward physicians for achieving quality targets. That's taking things in a different direction than the OIG-approved gainsharing plans that distributed a percentage of cost savings to physicians based on efficiencies but were limited to departments or service lines, according to attorneys Janice Anderson and Nathaniel Lacktman, both with Foley & Lardner LLP.

"This is all pretty much new territory," says Anderson, who requested the OIG opinion with Foley & Lardner colleague Charles Oppenheim. "Hospitals and physicians are aligning with each other around quality, which is a shared goal."

In the advisory opinion, Borgess asked OIG whether its plan to share with physicians certain performance-based compensation from an insurer would trigger civil monetary penalties (CMPs) that bar kickbacks and forbid hospital payments to physicians to limit services to Medicare or Medicaid beneficiaries.

Borgess participates in an insurer's pay-for-performance program. On top of the base compensation the insurer pays the hospital for treating patients, the insurer would pay Borgess a bonus if it meets certain standards of quality and efficiency. The bonus is a percentage of the base compensation from the first year of the program. The max in 2008 will be 4%.

Part of the bonus hinges on whether the hospital meets certain quality standards. For 2008, these standards relate to six conditions or procedures from CMS's Hospital Quality Initiative (e.g., heart attack, heart failure, pneumonia, surgical infection). The hospital has to report data for only two of them; the hospital must achieve certain performance standards on the other four, the opinion states. Because the conditions are drawn from CMS's Health Quality Initiative, hospitals know what they need to do to get the quality-based payments, Lacktman says. The insurer will base the bonus on the hospital's performance with all patients, including Medicare and Medicaid beneficiarie, and not just patients covered by the insurer.

Borgess told OIG it needs medical staff to help meet the quality targets. So the proposal envisions forming an entity composed of physicians who have been on the active medical staff for at least one year. The physicians will each make an equal capital contribution to fund the entity and must agree to adhere to the quality targets.

The plan is to forge a "quality enhancement professional services agreement" between the hospital and the physician entity. Physicians will help the hospital achieve the quality targets by, for example, developing policies and procedures, participating in quality reviews, conducting peer review and auditing medical records. As a reward, the hospital will pay the physicians a percentage of the insurer's bonus compensation.

OIG: Enough Safeguards Exist

In the advisory opinion, OIG said it would not seek sanctions against the hospital for its payments to the physicians under the pay-for-performance program even though it might violate the CMP law that bars incentives to limit care. *The reason*: OIG says there are enough safeguards to prevent any reduction in services.

For example, physicians get paid for behavior designed to improve patient care. The performance measures are "clearly and separately identified," which promotes public scrutiny and physician accountability for adverse events, OIG says. And the hospital has pledged to monitor implementation of the quality targets to keep an eye out for inappropriate limitations of patient care.

The advisory opinion also said the pay-for-performance program would violate the CMP law against kickbacks if there were an intent to induce referrals, but OIG will not pursue sanctions because of additional, relevant safeguards. For example, it's unlikely the hospital is using the payments to lure physicians' business because only physicians who have been on the medical staff for a year can participate (by joining the new en-

tity). And their additional referrals won't help drive up the bonus compensation because it's calculated according to the base compensation of the first year of the deal, which can increase based on inflation but not based on volume. Also, participation is open to all physicians, not just the big referral sources. If any physician's referral patterns change significantly because of the program's rewards in a way that benefits the hospital, OIG says the hospital will terminate the physician from the program.

Anderson and Lacktman say a lot of hospitals are showing interest in this model. Although fraud-and-abuse laws are a common stumbling block, the advisory opinion should help clear the way, they say.

Government Pushes Quality-Payment Link

Meanwhile, the link between quality and payment continues to get a big push in the public sector. Anderson says the government is working to ensure that Medicare gets a quality bang for its buck. To promote that goal, CMS and other government agencies have employed a three-part approach:

(1) Payment reform. This includes the Hospital Quality Initiative, which docks hospitals' DRG payments if they fail to report to CMS on a number of designated quality measures (which will reach 42 by fiscal year 2010). Congress is also expected to enact a bill authorizing value-based purchasing, which is a step beyond reporting *(RMC 12/10/08, p. 2)*.

(2) Public reporting through Web sites like Hospital Compare, which is where CMS reports the results of the Hospital Quality Initiative. With more consumers educated through the Internet, providers feel the pressure to improve quality, Anderson says.

(3) Enforcement actions. False claims cases have been built on substandard quality. And though so far the failure to comply with Medicare conditions of participation (CoP) doesn't give rise to a false claim (cases have been built only on failure to comply with the conditions of payment), Anderson says "that could change once it becomes apparent to the courts through value-based purchasing that quality is required for payment. Even now, failure to comply with the CoP may trigger False Claims Act lawsuits."

Contact Anderson at janderson@foley.com and Lacktman at nlacktman@foley.com. ✧