Legal Corner

Pay-for-Performance Programs in the Private Sector

By *Daniel T. Roble*

There are more than 110 pay-for-performance (P4P) programs in the United States today. Most of these programs reward doctors for improving the quality of care being delivered or the processes by which care is delivered. Other programs reward hospitals, whereas a handful of programs attempt to reward hospitals and doctors for undertaking P4P programs together. In most cases, the payments being made serve as bonuses because the doctors and the hospitals are not placed at risk for losing any of the fees being paid to them for delivering the required care. These bonuses take the form of cash lump-sum bonuses, fee schedule adjustments, or per-member, per-month adjustments. Other programs do not involve payment, but rather give public recognition to outstanding achievements with respect to improving quality or controlling costs.

Most P4P programs use provider reimbursement models that link performance to compensation. This is done by embedding performance measurement rewards in the areas of quality, utilization (total medical expense trends), patient access and satisfaction, information systems, prescribing, and actual outcomes into provider contracts. The hope and expectation is that these programs will promote improvements in the quality of care and better control health care cost trends. The quality measures may include such items as waiting times for appointments, number of complaints and grievances, peer and staff reviews, and patient turnover. In addition, the measurements also include physician and/or hospital performance in managing chronic diseases such as asthma, diabetes, or hypertension, and adherence to screening guidelines for breast, cervical, and prostate cancer.

An example of a physician-oriented P4P program is Bridges to Excellence (BTE). Employers who participate in BTE agree to pay physicians who participate in a cardiology program, a diabetes program, or a physician office technology program. In each case, a physician is rewarded up to a maximum amount of money for following specific best practices for caring for patients with cardiac problems or diabetes or for bringing technology that should improve the care being rendered by that physician into that physician's office. BTE collects the relevant data and shares the results to substantiate that care is being improved.

The Hospital Rewards Program (HRP) is an example of a hospital-oriented P4P program. HRP is being sponsored by The Leapfrog Group (Washington, DC), a coalition of

employers, and is based on a series of best practices in a number of clinical areas. To receive a financial reward from an employer or a managed care plan, a hospital has to score well both from a quality and efficiency standpoint. A hospital that provides excellent care on the basis of measured and monitored outcomes but is expensive on a severity-adjusted basis will not be rewarded to the same extent as a hospital with excellent outcomes produced in a cost-effective manner.

With respect to the larger insurers, in January 2004, Aetna (Hartford, Connecticut) launched new networks of doctors who the company believes have better outcomes in high-cost specialties. Aetna believes that the program could reduce health care costs for employers, improve care of patients, and possibly increase volume and income for physicians. The team includes specialists in cardiology, cardiothoracic surgery, gastroenterology, general surgery, orthopedics, and obstetrical gynecology, which are some of the highest cost drivers for Aetna.

The Integrated Health Association (IHA) initiative involves Aetna; Blue Cross/Blue Shield of California; CIGNA Healthcare of California, Inc.; HealthNet (Woodland Hills, California); and PacifiCare Health Systems, Inc. (Cypress, California). Under the IHA plan, physician groups will receive a consolidated performance scorecard. The annual score will be evaluated by an independent firm and made public. The scorecard covers three areas: clinical quality, patient satisfaction, and investment in information technology. Clinical measures quantify performance in treating three chronic conditions—asthma, diabetes, and coronary artery disease—and providing three preventive services—breast cancer screening, cervical cancer screening, and childhood immunizations. Patient satisfaction is based on communication with the physician, specialty care received, timely care and service, and overall rating of care. Information technology investment is evaluated on the physician group's ability to integrate data at the group level or provide physicians with data at the point of care.

In the oncology area, there are at least 11 programs in the country that base their programs in part on preventive care involving breast, cervical, and prostate cancer screening. In most of these programs, the physicians are rewarded financially for following best practices related to these three screenings.

When putting together P4P programs, it is important to be aware of four legal issues that must be satisfied. These are the

Anti-Kickback Statute (payment for referrals), the Stark Law (payments to physicians for referrals), the Civil Monetary Penalties Law (payments by hospitals to physicians to reduce or limit services), and tax laws (payment of more than fair market value for services rendered). In most P4P programs, these legal parameters can be quite readily satisfied. However, great care must be taken if a hospital is using cost savings to reward physicians under a so-called “gainsharing” program. Also, if a payer is involved in the P4P program, a different, easier-to-satisfy Civil Monetary Penalties Law is applicable. Several additional safe harbors exist under the Anti-Kickback Statute, and several exceptions exist under the Stark Law. The

bottom line is that legal requirements must be carefully considered but generally can be satisfied.

Although P4P programs are an interim step toward reimbursement systems based on evidence-based protocols and outcomes measures, they will generate meaningful insights with respect to appropriate and beneficial methods to incentivize providers to furnish higher quality, less costly care.

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