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COPING WITH MERGING STREAMS;

LEGAL ISSUES IN PHYSICIAN COMPENSATION

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COPING WITH MERGING STREAMS:

LEGAL ISSUES IN PHYSICIAN COMPENSATION

Alice G. Gosfield, Esq.

For many years, the trumpet cry of regulators and payers regarding the inexorable rise in health care costs has been the need to shift payment for health care services from a system that rewards volume to a system that rewards value. Since most of what happens in health care emanates in some measure from a physician order, referral or prescription, what motivates physicians in their behavior is an essential aspect of how the system might change and in what ways. [1]

The role of physician compensation in the challenge of a changing system has interested me for a long time. Beginning almost fifteen years ago during the debates over health reform and the frequent citations to high performing health systems, many of which were managed by their owning physician practices (e.g., Mayo, Cleveland Clinic, Billings Clinic etc.), I wondered the extent to which the incentives in physician compensation they received was relevant. When the results of the early pay for performance programs were so tepid, I wondered whether the reason was because the extra money never made it into the physicians' wallets. In all this work, including physician practice surveys, I learned that some high performing groups had no incentives and paid physicians a fixed salary, others had begun to introduce incentives, but there was no single driving approach present in any of the high performers.[2]

Still, it was undeniable that the purpose of changing external payment models was to create incentives to produce value – increased quality at lowered cost.

> *"The essence of incentive contracting is the effort by one individual or organization (the principal) to induce and reward certain behaviors by another (the agent)...the structure of payment,... is designed to provide the highest reward to the agent at the lowest cost to the principal."*[3]

How these designed incentives can motivate changed physician behavior is still a challenge in the system. This article looks at how much change there really has been so far. It

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[1] Much of the initial thinking for this article was developed for the handouts for presentations to the AHLA Physician and Hospital Institute 2022, and the Pennsylvania Bar Institute Health Law Institute 2022.

[2] See, Gosfield, "Physician Compensation for Quality: Behind The Group's Green Door", HEALTH LAW HANDBOOK, 2008 edition, pp. 3-44; Gosfield, "The New Value on Provider 'Value'", HEALTH LAW HANDBOOK (2011 ed.) West Group; Gosfield, "Compensating Physicians for Quality and Value: A Changing Landscape", Group Practice Journal (Sept 2011), pp. 16-26; Gosfield, "Bolstering Change: Physician Compensation for Quality and Value", HEALTH LAW HANDBOOK (2012 Ed.) all available at https://www.gosfield.com/read/publications

[3] Robinson, "Theory and Practice in The Design of Physician Payment Incentives", Milbank Quarterly (2001) pp 149-77 at 151 ; https://www.milbank.org/quarterly/articles/theory-and-practice-in-the-design-of-physician-payment-incentives/

considers the multiplicity of changing payment models in terms of what they are intended to generate, citing to contractual pitfalls that lurk in each. It looks at the real impacts from the changing revenue streams and then considers a range of legal issues lawyers will confront in drafting the contracts that solidify the physician compensation model. These include the tangle of Stark internal compensation models as well as voluntary repayment requirements and effects from external audits. We will see that the multiplicity of external payment models, some applied simultaneously within groups, confounds the issues in developing effective physician compensation models and supporting them in contract terms.

"The best compensation system is the one you will introduce next."

---sophisticated practice manager, 2007

1.0 *How much are new external physician reimbursement models actually in play now*

1.1 Federal and Commercial Initiatives

The call for changed models began to exacerbate with the expiration of Medicare's sustainable growth rate (SGR), which had been a cap on the rise of payment to physicians predicated on what had been historically usual and customary charges.[4] The effect of the SGR was so draconian according to physician advocates that it was punted by Congress multiple times to avoid its effects. It was not until 2015 that it expired completely and finally. In 2015 then DHHS Secretary Sylvia Burwell announced the intention to have 85% of all payments in traditional Medicare tied to quality or value and 90% would be value based by the end of 2018. The government planned to tie 30% of Medicare payments to all providers to alternative payment models by 2017. In reality, by 2018, among all payors, 34% of payments were tied to value, almost all upside only, shared savings and care management fees paid to patient-centered medical homes. [5](See 2.8.2 below)

By 2021, 41% of US health care dollars involved alternative payment models (APMs), including shared savings, shared risk, bundled payment and more -- a 23% increase over 5 years. .[6] America's Health Insurance Plans with the Blue Cross Blue Shield Association surveyed 79 payers covering 80.2% of the insured US populationThese models were predicated on Fee for Service (FFS) 39.3%; and Pay for Performance (P4P) (see below at 2.6) 19.8%. APMs were most prevalent in Medicare Advantage plans (58%), traditional

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[4] For a history of the SGR and how many times it was punted, see https://en.wikipedia.org/wiki/Medicare_Sustainable_Growth_Rate

[5] See, Terry, "Slow Walking to Value Based Care: Why Fee for Services Still Rules," Aug 26, 2020, The Health Care Blog; https://thehealthcareblog.com/blog/2020/08/26/slow-walking-to-value-based- care-why-fee-for-service-still-rules/

[6] See, Moran, "Use of Alternative Payment Models Up 23% over 5 years, report finds" (December 16, 2021) https://www.beckershospitalreview.com/payer-issues/use-of-alternative-payment-models-up-23-over-5-years-report-finds.html All succeeding data in tis section comes from this article

Medicare (42.8%), commercial (35.5%), and Medicaid (36.4%). Half of Medicare Advantage plans (29.3% total) used 2- sided risk meaning not only would physicians be paid bonuses, but they were at risk of having to repay money or losing withheld funds for failure to perform effectively. When asked their views of the changing landscape, 87% of responding payers expected more growth in APMs. They further stated that the results of these new programs improved care coordination (93%); improved quality (92%); and yielded more affordable care (85%). We shall see further that their views are not shared by the subjects and targets of the incentives. (See 3.7, below).

Those data were health plan focused. Turning their attention more specifically to physicians, the AMA had even more striking findings.[7] In 2020, 32.3 % of physicians were in practices that participated in medical homes and another 43% worked in a practice that belonged to a commercial ACO, 36.7% to a Medicare ACO, and 29.% to a Medicaid ACO. Although participation in commercial and Medicaid ACOs increased slightly from 2018, participation in Medicare ACOs decreased and participation in medical homes remained roughly the same.

> "*Nonetheless, 54.9% of physicians reported participation in at least one ACO type, compared to 53.% in 2018 and 44.0% in 2016. The data also show that 44.5 percent of physicians received at least some payment based on pay- for-performance for care that they provided, 40.1 percent received bundled payments, 23.8 percent received capitation, and 21.5 percent received shared savings. Sixty-seven percent of physicians worked in practices that received at least some revenue from an APM for care they provided (up from 63.1 percent in 2018). FFS, however, was still the most prevalent payment method with 88.1 percent reporting at least some payment from this method in 2020. Further, an average of 70 percent of practice revenue came from FFS and 30 percent from APMs*."[8]

1. 2 State-based Initiatives in Medicaid

While Medicare Advantage plans are apparently staking out the leading edge in new payment models, over five years until 2019, the number of states and territories implementing value-based reimbursement increased by 7 times.[9] Six states had been at it for four years or more; 34 states had been doing it for at least two years. A state focused report indicated that 22 states had or were considering adoption of Accountable Care Organizations (ACOs) (see 2.8.1 below); and, 16 had or were considering adopting Episode of Care payments. Interestingly half the programs are multi-payer initiatives. The

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[7] AMA, "Payment and Delivery in 2020: Fee-for-Service Revenue Remains Stable While Participation Shifts in Accountable Care Organizations During the Pandemic, " AMA Policy Research Perspectives (2021); https://www.ama-assn.org/system/files/2020-prp-payment-and-delivery.pdf

[8] Id at p.1.

[9] For state-by-state data, see, Change Healthcare, "Value-Based Care in America: State-by-State", 2019, https://www.pcpcc.org/sites/default/files/resources/%7Ba7b8bcb8-0b4c-4c46-b453-2fc58cefb9ba%7D_Change_Healthcare_Value-Based_Care_in_America_State-by-State_Report.pdf

reporters found that the states that were most advanced in their programs were New York, Pennsylvania and Vermont. In 2019, Medicaid insured about 16% of Americans, overall.[10] But the impact of Medicaid varies widely by state, so on a state-by-state basis, Medicaid as a payer has vastly different significance to the physicians depending on where they practice.[11]

Taken together, there is no question that new payment models are playing a significant role in physician reimbursement. The various models and their impacts are different, however. To understand the role of physician compensation within groups receiving these payments, it is essential to understand how they work, their intended purposes, and what perverse incentives lurk within them. To the extent they have incentives at all, it is useful to consider the view that "The incentives that matter most are those closest to the clinical decision-maker".[12] Here, we also consider briefly the contracting pitfalls they present for lawyers who represent physicians or those seeking to engage them for their delivery of care in this transitional period.

2.0 *The External Payment Models, Their Intended Purposes, Perverse Incentives and Contractual Pitfalls*

2.1 Fee for Service

As we have seen when we focus our lens more specifically on physician reimbursement models, traditional fee-for-service (FFS), now denigrated as contributing to rising health care costs, persists and often is part of the basis for some APMs. FFS has been described as retrospective piece work payment. Robinson says it is well designed to incentivize two desired aspects of physician performance: physician productivity and risk acceptance meaning willingness to accept sicker patients.[13] The primary perverse incentive it generates is potential overuse of services and delivery in high cost settings. As a payment model it offers no support for collaboration with other clinicians, either in the practice (e.g., mid-levels) or outside (other clinicians and unless explicitly recognized with separate payment for such coordination services (which is increasing[14]). It does nothing to induce

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[10] https://www.statista.com/topics/1091/medicaid/#dossierKeyfigures

[11] The ten highest Medicaid population states as of 2019, in descending order, were 1.California (10,860,126); 2. New York (5,863,440); 3.Texas (4,034,937); 4. Georgia (3,805,520); 5. Pennsylvania (2,980,867); 6. Indiana (2,787,617); 7.Ohio (2,687,107); 8. Michigan (2,476,774); 9. Arizona (1,791,620); 10.Washington (1,779,628). Seven of them expanded their Medicaid programs as a result of new monies made available by the Affordable Care Act. https://worldpopulationreview.com/state-rankings/medicaid-enrollment-by-state#:~:text=Here%20are%20the%2010%20states%20with%20the,highest%20Medicaid%20enrollment%3A%20California%20%2810%2C860%2C126%29%20New%20York%20%285%2C863%2C440%29

[12] Quinn, "The 8 Basic Payment Methods in Health Care," Annals of Int Med, 2015, pp 300-306 at 303

[13] See Robinson at fn 3 *supra.* He has long observed, analyzed, studied and written about physician payment and compensation. He is one of the most articulate and literate economists any lawyer could read.

[14] See, Gosfield, "Beyond Face Time: The Evolution of Fee For Service In A Value Driven World", HEALTH LAW HANDBOOK, (2016 ed.) WestGroup, pp. 1-30

more efficient communication (e.g., telehealth, email, etc). The model is completely agnostic regarding evidence-based medicine, which does not matter in this model unless the program explicitly reviews for it after care delivery with denial of payment. FFS care can be of mediocre quality and will still be reimbursed.

The primary contractual pitfall in FFS contracts is from where the data comes from to pay in commercial programs (e.g., medical record or CMS 1500). It is unusual to see (although we now include this in our agreements) a representation that the data will be drawn from a specified source. In the current environment where electronic heath records are increasingly linked to billing systems, drawing the report of what is to be paid from the medical record itself is preferable to being limited to the claim form as submitted. There is many a slip twixt the service delivered and its claim. CMS itself has long quantified the error rate in claims submission using its Comprehensive Error Rate Testing (CERT) program. In 2020 and 2021, the error rate just for Medicare was more than 6%.[15] Increasing payment for non- face-to-face time can help avoid some problems; but these payments can create their own problems as well, including billing for services that have not met time expenditure requirements or insufficient documentation to substantiate the claimed time, not to mention simply billing for the wrong code given the plethora of new codes. All of this is compounded by the challenges in the new Evaluation and Management codes.

2.2 The Challenge of The New Evaluation and Management (E&M) Codes

The importance of E&M codes in physician payment cannot be overstated. In Medicare, "E/M visits billed using CPT codes comprise approximately 45% of allowed charges for PFS services. Office and outpatient E/M visits comprise approximately 25% of allowed charges for PFS services."[16] When the Resource Based Relative Value Scale (RBRVS)[17] was created, it introduced the now long-standing emphasis on three aspects of a visit – the extent of the history and physical examination, the complexity of the visit (medical decision-making), and in some instances the amount of time spent with the patient.[18] The quantification of the

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[15]CMS, "Improper Payment Rates and Additional Data", reviewing 2012-2021 https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/AdditionalData

[16] See, AMA, "Medicare Physician Payment Schedule Detailed Summary" (2020); https://www.ama-assn.org/system/files/2020-12/2021-pfs-qpp-final-rule.pdf

[17] I used to refer to the acronym as standing for 'really bad reimbursement very soon'; but over time Medicare has come to be seen as one of the better payment sources for physicians.

[18] For a historical review of the problems created by the advent of the E&M codes, among other physician reimbursement issues, see the following articles all by Gosfield, "Unintentional Part B False Claims: Pitfalls for the Unwary", HEALTH LAW HANDBOOK, (1993 ed.) Clark Boardman Callaghan, pp. 205-230; "Slouching Toward the Millennium: False Claims in Medicare Physician Billing", HEALTH LAW HANDBOOK, (1997 ed.) Clark Boardman Callaghan, pp. 51-86; "Avoiding Fraud and Abuse in Medicare Claims: What FPs Need to Know", Family Practice Management, (September 1997) pp. 73-82; "Assessing the Risk of Physician False Claims Enforcement", Journal of Healthcare Compliance, (Jan/Feb 1999) pp. 52-53; "Getting The Team Paid:

cognitive power brought to bear in treating the patient is the essence of what the varying E&M code levels signify -- from barely any physician involvement in the visit to level 5s, which represent the most acutely ill patients, the most complex decision-making and the greatest quantity of information to review to determine a course of treatment. Contrary to popular belief, the designation of visit levels was not created by the government, but rather by the AMA itself in its coding system which the federal government adopted when it introduced the Physician Fee Schedule based on RBRVS. The administrative burden of documenting increasingly voluminous bullet point requirements regarding the specific patient, to move from one level of code to another, was part of the motivation in CMS's shift to a simpler version of the codes.

Beginning in 2021, CMS collapsed the E&M codes into fewer payment variations resulting in higher weights for wRVUs for visits and substantially increased dollars for some physicians.[19] This represented a significant increase ($40 per visit) for some visits. But because of required budget neutrality, the conversion factor (the dollar amount which is the multiplier of the wRVUs to determine the payment amount), which drove the actual amount that would be paid, was reduced from what it would have been without budget neutrality. Only office and outpatient visits were included, so the E&M descriptors for hospital, skilled nursing facility or emergency department visits remain the same. In a major shift to relieve administrative burden, CMS changed the required documentation to remove history and physical exam as required elements, focusing exclusively on complexity of medical decision-making (MDM) and time spent to determine which code applies. MDM itself is still determined by number and complexity of problems addressed; the data the provider must review and analyze; and overall risk of the patient. The amount of data reviewed drives part of the determination of MDM for the level of code (e.g., which of 99202-99215); but if the interpretation and report of a diagnostic study are paid separately they cannot be included in the determination of the visit level.

The government added codes for prolonged services (99417) when the level 5 visit time is exceeded in 15 minute increments. They also added a visit complexity code (GPC1X) which applies to Medicare only unless a commercial payor explicitly adopts it. Then, in regulations which had not existed before[20], for 2022 split/shared visits were reincorporated after having been removed from availability to bill because they were not initially published in the Federal Register. Still further, unlike the former version, only the

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How Medicare Physician Payment Policies Impede Quality", HEALTH LAW HANDBOOK, (2009 ed.) WestGroup, pp.35-78;

[19] See, CMS Fact Sheet, "Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits" (Jan 11, 2021); https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdfl and Stone and Rock, "E/M Changes Are Here – What Health Lawyers Need to Know about the Compliance and Reimbursement Issues," (Oct. 19. 2020) AHLA Archive, https://www.americanhealthlaw.org/content-library/ahla-daily/article/915d0578-dba7-4327-87dc-cb282caaa302/From-AHLA-s-Enterprise-Risk-Management-Task-Force-

[20] See 42 CFR §415.140 (2022)

practitioner (NP, PA or MD/DO) who performed more than half of the non-duplicated total time can bill the service. A modifier must be added to the claim to indicate it is split/shared regardless of who bills for it. Full implementation is not expected until 1/1/2023. For the year before that, either time or performing one of the three key components can be used to determine who bills.

Medical necessity is still an over-arching concern; e.g., was the level of service medically necessary for the patient. Merely spending a lot of time would be an issue on audit unless the documented time was medically necessary. The guidelines are not very clear, and commentators expect audit issues to arise. For many practices, the prior design of their productivity based compensation models turning on wRVU volumes may end up out of whack with what the practice is seeking to motivate. The compliance risks lie predominately in not meeting MDM standards or misstating or under-documenting time spent, using add on codes for which the service or documentation does not qualify, and choosing a level of code which is not medically necessary. The impact of these changes alone would motivate a close look at existing physician compensation models, not to mention complexities under the Stark law. (See 4.1and 4.2 below)

2.3 Capitation and Percent of Premium

At about 24%[21] of all payments, a smaller volume of payment is made to physicians in the form of capitation. That said, most of the physicians who are paid capitation are primary care physicians; and the intensity of capitation varies regionally.[22] Almost all sources agree that the services included in the payment per member per month are typically routine screenings for vision and hearing; preventive, diagnostic, and treatment services; in-office health education and counseling services; injections, immunizations, and medications administered in-office and outpatient laboratory tests conducted in-office.[23] The amount of payment is based on insurance principles since the payment is the same no matter whether the patient is healthy or sick. Payment is typically made prospectively irrespective of the volume of work that actually gets performed.

As Robinson observes[24], capitation incentivizes the physician's desire to treat only healthier patients and undertreat those who are sicker by not referring to specialists. Others, he claims, seek to offload the risk of sicker patients by sending them to specialists. Whether this is a decent strategy depends on whether the primary care physician is at risk for the volume of referrals he makes. In the heyday of capitation in the 1990s, physicians were typically at risk by a withhold of capitation monies that would only be paid if they did not order or refer for too much care. Risk from specialist and hospital referrals was common. Robinson finds that capitation motivates

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[21] See fn 7, *supra.*

[22] Emanuel, Mostashari and Navathe, "Designing a Successful Primary Care Physician Capitation Model", (May 2021) JAMA The Journal of the American Medical Association 325(1) and see n. 23 *infra*

[23] https://www.aafp.org/about/policies/all/capitation-primary-care.html

[24] See fn 3, *supra*

more physician attention to population based epidemiological outcomes supported by evidence-based protocols.

Despite complaints about its implementation in the past, there are modern versions of the prior complaints that commentators cite to warn of problems in some of today's capitation.[25] They counsel about problems from inaccurate assignment of patients to the physician's panel for whom he is responsible and for whom he will be paid the same amount whether they ever show up in his office or not. They caution that it is essential to pay attention to carve outs – services or items that are paid for outside the capitation rate, but for which it is often beneficial to include those charges (as for vaccines or other screening tools) in a fair rate, large enough so the physician can manage other services more effectively. New data submission requirements are also singled out as problematic for physicians new to capitation.

Against those laments, there are those who have argued that capitation is the best step toward ameliorating the hamster wheel incentives of more work, more money, more waste.[26] They argue that capitation is the only payment model that fully aligns the providers' financial incentives with the goal of eliminating all major categories of waste. "It fundamentally shifts the role of managing the amount, form and cost of care from insurers to medical practitioners."[27] All of that is only fair if the payment rate is properly designed. Poorly designed capitation is inadequate to pay for the legitimate medical 'loss' (services rendered) a capitated practice might experience. These proponents also admit that the former widespread version of capitation was imposed with a host of bureaucratic hassles ---from gatekeeping physicians to prior authorizations for specialty services. In addition to primary care capitation, a far smaller volume of capitated payments goes to specialists. Typical carve outs for specialty capitation include radiology, diagnostic imaging, physical therapy and others.[28] Contractual pitfalls for all forms of capitation rest primarily on clear definition of what is in the rate and what is outside as well as how any withholds (sometimes characterized instead as bonuses) are calculated and imposed along with appeals mechanism to challenge the plan's approach.

Finally, another form of capitation is global capitation. Under this mechanism, the primary care physician is paid a far larger amount of money from which he must pay for all the specialty and other care, including the patients' overall health care costs. All of the risks of a well designed rate, plus the contractual challenges of stating the complete mechanisms of payment, arise in this context as well. That said, United Healthcare has argued that global capitation produces the

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[25] Chipsblog, "The 2021 Capitation Fun and Games," (Nov. 29, 2020) https://chipsblog.pcc.com/the-2021-capitation-fun-and-games

[26] See James and Poulsen, "The Case for Capitation," Harvard Business Review (July-Aug 2106) https://hbr.org/2016/07/the-case-for-capitation

[27] Id.

[28] Nelson, "What Are Capitation Reimbursement Models, Key Strategies?", RevCycleIntelligence, (Feb 16, 2021) https://revcycleintelligence.com/news/what-are-capitation-reimbursement-models-key-strategies

highest quality results for seniors in Medicare Advantage plans.[29] They concluded this by examining preventive care screening, treatment of diabetes by two services, and managing chronic conditions based on two issues (functional status assessment and medication review). They touted five benefits from the approach, stating that paid this way physicians: (1) spend more time engaging with patients; (2) prioritize preventive services and care management programs; (3) invest in and use data analytics and information technology; (4) avoid unnecessary interventions that increase risk and complications for patients; and (5) focus on keeping patients healthy and out of the hospital.

Closely related to, but not exactly the same as global capitation, is percent of premium payments. Here, literally, a percentage of the premium paid by the subscribers is allocated to the physicians. This is not very much practiced today since some of its failures were quite spectacular. At the Allegheny Health System, which at one time represented the largest not for profit health care bankruptcy in American health care system history, the precent of premium strategy, combined with aggressive acquisition of physician practices (among other factors), led to massive losses when the 80% of premium they were paid failed to cover the cost of the services rendered.[30] The contractual risks in percent of premium deals are less than in other forms of capitation because the risk for all of the services-- the complete menu of what will be provided-- rests on the providers. Whether the payment is sufficient turns on the structuring of the premium payments as well as close management of the delivery of services. There are many reasons these payment models are so difficult to find extant.

2.4 Case Rates or Episode of Illness Rates

Surgeons have been paid on case rates for years: a single payment is made to cover the procedure and all related services rendered during the same day as the procedure, the subsequent 10 day period or 90 day period. These timeframes are the "global period" within which all services rendered by the surgeon or his group related to the procedures are covered in a single case rate. The same principles can be applied to any services, and increasingly are. These rates can be bundled with other providers. Bundled payment, which combines remuneration to multiple providers in one payment, is typically either based on a case rate or an episode payment. The AMA found that about 40% of physicians surveyed were paid a bundled payment.[31]

Like capitation, in the structuring of these payments one of the critical issues is which type of risk the physician is given: *probability risk* is a risk the physician cannot control for. How healthy was the population to whom the product was sold? What utilization did the rate designer contemplate in bundling services together into a single budget for the defined episode of care or case? Was that utilization based on best evidence regarding how to treat the patient or on past behavior? None of those is anything the physician can control and all

[29] UnitedHealth Group, "Global Capitation Payments Result in the Highest-quality Primary Care for Seniors" (Aug 2020); https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2020/UHG-Global-Capitation-Research.pdf

[30] Massey," Anatomy of a Bankruptcy," Part 4, Pittsburgh Post-Gazette (Jan 21, 1999) https://old.post-gazette.com/aherf/part4.asp

[31] See fn 7 *supra*

of them are relevant to whether the rate is equitable. *Technical risk* is the physician's risk for managing care effectively within the rate. It is fair to devolve this risk onto the physician if the budget that creates the rate fully accounts for the needed care, from all providers included in the budget. How those budgets are constructed is what differentiates risky case rates from those that are effective.[32] Unfortunately, not all case rates are constructed on foundations that reflect good medicine or an evidence base. In contrast, PROMETHEUS Payment® created the budget for the case rate from clinical practice guidelines.[33] In addition, a salient distinction in that model was that the budget included money that historically had been spent on potentially avoidable complications. The theory was that this money would typically be spent anyway, so to put it into the providers' budgets would help them deliver care to avoid those complications. These are not "never events", but for a condition like diabetes would include admission to the hospital for diabetes, diabetic eye procedures, diabetic amputations and more. PROMETHEUS Payment® also had the ability to pay providers individually for what they did within the budget, rather than have the payment devolve to one provider to distribute to others.

Case rates may be bundled or not, but almost all bundled payments involve some definition of a case rate or an episode of illness. Many people believe that bundled payment cannot work other than in a hospital context. They are wrong. PROMETHEUS Payment® was designed specifically to be applicable to primary care and, in fact, to revitalize the patient centered medical home.[34] (See 2.8.2 below). When the case rate pertains to primary care or chronic conditions, it is typically stated in terms of a timeframe over which it will be applicable – three months, six months or a year, depending on the nature of the condition and its acuity.

The incentive in the bundled or case rate payment is to provide a financial basis for providers, and particularly physicians, to work together effectively with other providers within the defined budget for the defined condition. If the case rate is for only one provider, then there is less to focus on in terms of overall costs. When episode payments are bundled, it is critical to be able to assure the recipients that the budget is sufficient to cover what is necessary to treat the patient within the defined budget. The contracting pitfalls lie in clear definitions of what triggers the case rate, what breaks the case rate and when it expires. If

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[32] Gosfield, "Bundled Payment: Avoiding Surprise Packages", HEALTH LAW HANDBOOK, (2013 ed.) WestGroup, pp. 279-307

[33] I was one of the members of the original design team that created PROMETHEUS Payment® and was also the first chairman of the board of PROMETHEUS Payment®, Inc, a not for profit organization that sought to expand the implementation of the model. I was also the Chair of the Health Care Incentives Improvement Institute (HCI3) into which PROMETHEUS Payment® merged and continued to support the implementation of the model. See, Gosfield, "The PROMETHEUS Payment® Program: A Legal Blueprint", HEALTH LAW HANDBOOK, (2007 ed.) WestGroup, pp. 79-129; and http://prometheusanalytics.net/deeper-dive/history-prometheus-payment%C2%AE

[34] See, Gosfield, "Making PROMETHEUS Payment® Rates Real: Ya' Gotta' Start Somewhere", (June 2008) 15pphttps://www.gosfield.com/images/PDF/MakingItReal-Final.pdf; and Gosfield, de Brantes, Emery, Rastogi, and d'Andrea, "Sustaining The Medical Home: How PROMETHEUS Payment® Can Revitalize Primary Care", (2009) http://nccd-crc.issuelab.org/resources/11349/11349.pdf

the money will not be allocated directly to the participating providers, who has the authority to disburse it and how any errors there get challenged are also important. Clarity regarding what is outside the case rate is also essential. That can be managed by being specific about what is inside the case rate and covered by it.

2.5 Gainsharing

Gainsharing is not actually a payment model but more precisely a payment principle. It's application is present in a range of programs where the providers are paid in the ordinary course, whether FFS or DRGs or capitation; and then, if they save money, they share in some percentage of the savings. Some bundled payment programs are bundled only in the sense that multiple providers share in the savings they all generate. Gainsharing is present in many ACOs and in several of CMMI's innovative payment models. (See 2.7) The perverse incentive in gainsharing is the provider, physician or not, will do what is measured for payment to the detriment of other services. It is a long-standing truism that 'what gets measured gets done' with its corollary 'so be careful what you measure.' When bonuses are available for performance that generates savings, in some instances it is what is not done that will be measured. The contracting pitfalls in any gainsharing program are the definition of the bucket of available money, what determines whether payment will be made and how much will be paid to which provider for what performance, as measured in what scores turning on what data. Without all of these specified in the basic payment agreement, troubles can easily arise.

2.6 Pay for Performance (P4P) - Commercial

The advent of P4P programs goes back to around 2004-5.[35] Typically, the earliest forms of payment were not even documented in contracts; they were simply offered by the payor on a 'take it or leave it' basis. They typically focus on one clinical condition and pay extra for meeting standards. Some are absolute (HgbA1c of X = $10); some are relative within the class (the top 5% will each get $X or all will share $Y). The contracting pitfalls are defining the source of data to determine eligibility, making known the performance of the entire class to assure payments have been made properly and how challenges to data may be mounted. Since, as we have noted, what gets measured gets done, the perverse incentives here are that physicians will do what is necessary to earn the bonus to the detriment of other necessary services.[36] In addition, they can only be transitional programs. When the entire class at risk performs to earn the bonus, what next? Does the payer keep paying for maintaining performance?

2.7 The CMMI Models

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[35] See, Gosfield, "P4P: Bold Leaps or Baby Steps?", Patient Safety & Quality Healthcare, (Oct/Dec 2004), pp. 30-35; Gosfield, "Contracting for Quality: Then, Now and P4P", HEALTH LAW HANDBOOK,2004 Ed, WestGroup; Gosfield "P4P: Transitional At Best", Managed Care, (Jan. 2005) pp. 64-69

[36] Gosfield, "The 10 Biggest Legal Mistakes Physicians Make in Pay-for-Performance Programs," Babitsky and Mangraviti ed., "The Biggest Mistakes Physicians Make: And How to Avoid Them", SEAK (2005) https://seak.com/blog/uncategorized/10-biggest-legal-mistakes-physicians-make-pay-performance-programs/

Many of CMMI's initiatives may generate additional revenues to their participants, but it is beyond the scope of this presentation to delve into how they work. This article offers a summary of the key physician-relevant provisions in these models.[37] CMMI has had other programs to instigate improved quality.[38]

2.7.1 *Merit Incentive Payment System (MIPS) or Alternative Payment Models*[39]

The MIPS program was Congress' answer to the eternal dilemma of how to fix the problem of the sustainable growth rate, which had been adopted in 1997. That was enacted to limit the rate at which physician fees would increase, but each year it was about to take effect, Congress forestalled its implementation.[40] Finally, in 2015, the MIPS program was adopted. Essentially it provides that for Medicare participating eligible clinicians payment adjustments will be made (up and down) based on performance on quality, cost and other measures. Low volume clinicians (e.g., too few Medicare patients or too little Medicare payment) are exempt. It is mandatory unless the practice or group is exempt or is participating in an alternative payment model.

Medicare FFS payment can be reduced by specified percentages for failure to report and perform effectively, as applied to either individual clinicians or by or with payment to their group. The fees can also be adjusted upwards for good performance. Payment is made based on performance that occurred two years earlier as measured over a minimum 90 day period up to through the entire performance year. There were initial transition periods through 2018. The weights of the metrics that determine the payment can be adjusted annually. For Calendar Year (CY) 2022, the cost category measure weights will increase to 30% from 20%; quality category is reduced to 30% from 40% and quality improvement activities (15%) and promoting interoperability of EHRs (25%) remain the same as for CY 2021. There are literally hundreds of metrics organized by specialty, from which a physician can choose which to report. A minimum of six quality metrics is required, for example.

Clinicians and groups participating in MIPS must earn at least 18.75 points in 2022 to avoid a Medicare payment penalty of up to 9% in 2024. For those who surpass the exceptional threshold of 89 points, the maximum performance bonus is in addition to maximum

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[37] I address physician payment only and not completely, For example this summary does not include dialysis, or radiation therapy, for example.For a very good presentation of the history of the range of CMMI initiatives, see, Cooperrider, Corner and Hertzog, "Innovation in a Nutshell: Key Recent CMS Payment Initiatives, Where They Came From and What You Should Know", AHLA Archive, Institute of Medicare and Medicaid Payment Issues (March 2019)

[38] For more information on the range of payment programs related to quality which are provided by CMS see the Quality Payment Program page at https://qpp.cms.gov/

[39] P.L 114-10, §101(c)(1); 42 U.S.C. §1395w–4; 42 CFR §414.1300 et seq

[40] See, Hirsch et al, "Sustainable Growth Rate Repealed, MACRA Revealed: Historical Context and Analysis of Recent Changes in Medicare Physician Payment Methodologies," American Journal of Neuroradiology February 2016, 37 (2) 210-214; DOI: https://doi.org/10.3174/ajnr.A4522

possible positive payment adjustment of 9%. During the COVID-19 public health emergency (PHE), the complex patient bonus (for a maximum of 10 points) was doubled for the performance year 2020/payment year 2022. This will continue for 2021 performance year/2023 payment year. These are substantial payment effects which turn on reporting performance as well as the actual performance itself. Clinicians participating in Advanced Alternative Payment Models [41] can opt out of MIPS reporting and be paid a 5% increase in their payment if they meet appropriate thresholds. CMMI has stated it is moving toward requiring participation in other models like ACOs to participate in some of these programs. Such efforts include Patient Centered Medical Home payments for primary care physicians as well as specialists who can qualify, with CMS support through the Primary Care Collaborative.[42]

The point of this story is not to explain the complexity of the operation of MIPS. Merely describing it raises a host of issues; and the effort it takes to comply is not only clinical, given the emphasis on reporting. Medicare explanations of benefits (EOBs) to patients report separate codes for various activities reported by the practice but which are irrelevant to the patient and have no claim-by-claim impact.

As early as March 2018, MedPac, which advises Congress on physician payment, recommended its repeal.[43] Three years later, well respected commentators called for its transformation and movement closer to the Alternative Payment Models CMMI was also offering.[44] Their primary criticisms are telling in terms of challenges to physician practices. First, MIPS evaluates quality and cost performance independently and potentially, because of physician choice of measures, on different bases not clinically relevant to each other. Second, the financial rewards are tied to FFS payment which almost all commentators view as a critical problem in Medicare generally. Finally, they believe the program should be redesigned to move clinicians through it in a more explicit, predictable fashion to assume more risk. In sum, MIPS is predicated on a long-denigrated payment model which does little to change health care by physicians or for patients. Much of the blame can be placed at the feet of Congress which adopted the program by statute. A different failed model was created by CMMI for oncology care.

2.7.2 The Oncology Care Model

[41] https://qpp.cms.gov/apms/advanced-apms

[42] https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/benefits-support/macra/

[43] "Should MIPS be Repealed and Replaced? Several Industry Leaders Weigh in on MedPAC's Published Proposal", https://www.hcinnovationgroup.com/policy-value-based-care/article/13029967/should-mips-be-repealed-and-replaced-several-industry-leaders-weigh-in-on-medpacs-published-proposal

[44] Liao and Navathe, "Medicare Should Transform MIPS, Not Scrap It," Health Affairs (March 2, 2021) https://www.healthaffairs.org/do/10.1377/forefront.20210226.949893/abs/

During its implementation this voluntary program included 126 practices nationally and 5 commercial payers. It ends in 2022. It created net losses to Medicare over the five years of its operation to the tune of $315 million.[45] Some referred to it as a debacle.[46]

As stated by the government itself, "The Model, launched on July 1, 2016, combines attributes of medical homes (patient-centeredness, care coordination, accessibility, evidence-based guidelines, and continuous quality improvement) with financial incentives for providing services efficiently and with high quality."[47] Two fundamental payment mechanisms were in play: (1) Monthly Enhanced Oncology Services (MEOS) payment of $160 per month per patient for the duration of the treatment episode which was defined to last six months, whether that was the actual treatment time or not. (2) The potential for a performance-based payment for episodes of chemotherapy care was also available. "If practices meet performance quality goals, they can receive a bonus that CMS calculates by comparing all expenditures during an episode (including MEOS payments) to risk-adjusted historical benchmarks, minus a discount that CMS retains."[48] Initially the payment model provided only bonuses (upside only). Then after some participation, the physician could choose to accept downside risk as well. In the last performance period, acceptance of downside risk was required. While the program ends in 2022, CMS will surely propose something else given how much is spent on cancer care.[49]

2.7.3 Bundled Payments for Care Improvement (BPCI)

Originally announced as a voluntary program for replacement of hips and knees, over time this expanded into a model which involved four different approaches to bundling payment for care for inpatient and outpatient procedures as well as including long term and skilled care.[50] Initially focused solely on procedures, it was later expanded to include medical conditions. The program was found to have had little effect on Medicare expenses for

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[45] "Oncology Care Model Leads to $315 Million Net Loss to Medicare", The Medical Progress, November 24, 2021; https://themedicalprogress.com/2021/11/24/oncology-care-model-leads-to-315-million-net-loss-to-medicare/

[46] Wherwein, "Oncology Care Model is a "debacle," says healthcare policy expert" (March 1, 2021) Managed Healthcare Executive, https://www.managedhealthcareexecutive.com/view/oncology-care-model-is-a-debacle-says-healthcare-policy-expert

[47] "Evaluation of the Oncology Care Model, Performance Periods 1-5", (Jan 2021) https://innovation.cms.gov/data-and-reports/2021/ocm-evaluation-pp1-5

[48] Id

[49] In 2019, CMS proposed a new Oncology Care First program about which many commented. CMS issued a Request for Information (bit.ly/2Ca1Sjd), but as of this writing, no announcement of the implementation of a new program has been made and Oncology Care First is not on the CMS website as a program in operation.

[50] https://innovation.cms.gov/innovation-models/bundled-payments

medical conditions.[51] It was revamped in 2018 to launch October 1 and run through December 31, 2023.

This time there is physician-focused information because physician groups can be the recipients of the benefits of the payment model.[52] Incentive payments are available. In the initial years of the program there are 29 inpatient episodes, and 3 outpatient episodes. The physicians to be involved are hospitalists and 11 other specialties. The program is not available in Medicare Advantage plans. For the initial years, all quality measures tied to payment in the program are derived from administrative claims, intended to reduce burden on physicians. CMS explicitly acknowledges that practices may participate in multiple bundled payment models of other CMS models at the same time.

From a financial perspective, eligible physicians who meet threshold levels of participation in BPCI Advanced for a year will receive a 5% APM Incentive Payment under the Quality Payment Program for 2019-2024. FAQ 19, lightly touches on the downside risk that applies in this program. CMS has established a Target Price for each episode. To make life even more confusing, Target Prices will be adjusted during the year.

> *Participants may receive payments from CMS under the Model for providing and coordinating efficient care, but may owe payments to CMS if costs are higher than the Target Price. Payments from CMS to Participants and payments to CMS from Participants will be subject to a stop-gain and stop-loss policy, which is 20 percent of the Target Price for an Episode Initiator. Both Negative Total Reconciliation Amounts and Positive Total Reconciliation Amounts will be subject to an adjustment based on quality performance. For the first two Model Years, performance on quality measures may adjust these reconciliation amounts by up to 10 percent.*

The Target Price is established by fixing a Benchmark Price for the Physician Group Practice, and then deducting a discount. A convoluted reconciliation process will determine the ultimate payment.[53] Participation in the program is now closed so no new physician groups will join. The issue for lawyers is whether your client participates and if so, how they are handling receipt of these funds.

2.7.4 Medicare Shared Savings Program – Accountable Care Organizations

The flourishing of Medicare ACOs is fairly surprising in that they were not a fully formed concept when they were introduced by the Affordable Care Act. They were not even espoused as a pilot project but merely an opportunity. Their inception came from a Health Affairs blog posting by Elliot Fisher and Mark McClellan who wrote that hospitals should be held accountable for the performance and outcomes of their physicians on staff and this

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[51] Maddox, et al, "Evaluation of Medicare's Bundled Payments Initiative for Medical Conditions", NEJM (July 19, 2018) N Engl J Med:260-269; doi: 10.1056/NEJMsa1801569.

[52] See, "Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model Physician-Focused Frequently Asked Questions (FAQs),"(January 2018) https://innovation.cms.gov/files/x/bpciadvanced-physicianfaqs.pdf

[53] See, "BPCI Advanced Fact Sheet", https://innovation.cms.gov/files/fact-sheet/bpci-advanced-generalfs.pdf

could form a payment model[54]. The early regulatory iterations of the program were modeled primarily on the now defunct group practice demonstration model that mostly didn't work, even when adopted by old line AMGA type groups (e.g., Mayo, Cleveland Clinic, etc.). There, the problem was that most of the participants were so highly performing at the inception of the demonstration that there was little more to demonstrate to achieve any incentive payments.

Today, the program has evolved significantly. There are 477 ACOs providing care to 10.3 million beneficiaries.[55] The participating entity must have at least 5,000 assigned beneficiaries to play. The rules do not specify any pre-determined organizational structure. ACOs may be like a PHO (governed by hospital and physicians jointly), driven by a health system, or driven by a physician group. The varieties of compensation arrangements to physicians in these structures is virtually limitless and the gainsharing mechanisms that are deployed to incentivize them also vary widely. Again, the point here is to recognize these arrangements as yet another stream of revenues with which the physician practice must cope. As to whether they work, in 2015 it was found that 205 operating ACOs saved Medicare about $169 per patient.[56] Other proprietary organizations claimed far more impressive results with the use of their platform, for the Medicare ACOs to generate savings of more than $500 million in 2020 and more than $1.5 billion from 2014 through 2021.[57] Again, the internecine machinations of governance and payment within MSSP ACOs vary; but the point is that they can introduce additional revenue streams as well as risk for the physician practice.

2.8 Organizational Structures That Are Not Themselves Payment Models

2.8.1 *Non-Medicare ACOs*

There are a host of commercial ACO models that have sprung up around the country. They often entail only upside risk, meaning more money can be earned, but performance does not create financial risk of repayment or withheld monies. That said, more advanced larger ones are taking on downside risk. They continue to expand nationally, but more slowly.[58]

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[54] The record will reflect that I actually used the formal concept of accountability in payment before they did in a paper I wrote for the AMA in 1998. See, Gosfield, "Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations", (1998) https://www.gosfield.com/images/PDF/AMA.quality_culture.022510.pdf

[55] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

[56] https://www.americanhealthlaw.org/content-library/ahla-daily/article/f9fea75d-050f-45dd-a295-a29f195891aa/CMS-Says-ACOs-In-Revised-Medicare-Shared-Savings-P

[57] See, LightBeam Solutions, "Over $1.5 Billion In MSSP Savings Generated by ACOs Using LightBeam Platform" (Sept 21, 2021) https://lightbeamhealth.com/news/over-1-5-billion-in-mssp-savings-generated-by-acos-using-lightbeam-platform/

[58] See, Muhelstein et al, "Spread of ACOs And Value-Based Payment Models In 2019: Gauging the Impact of Pathways to Success", Health Affairs Blog (Oct 21, 2019). https://www.healthaffairs.org/do/10.1377/hblog20191020.962600/full/

There are contracting risks to the physician practice depending on where the money will land if bonuses are earned. Some ACOs do not negotiate their arrangements when they are system driven rather than physician driven. Who governs the ACO and how it relates to the payer are variably addressed in ways that physicians can access. Still, they are a developing model, depending on the applicable market. [59]

2.8.2 *Patient-Centered Medical Homes*

The Patient-Centered Medical Home (PCMH), is also not a payment model but is recognized by some payers for additional payment. CMMI led a Primary Care Collaborative around PCMH but it ended in 2021.[60] The concept of PCMH was touted as a way to organize care delivery so patients are far more engaged with a primary care practice, to produce better outcomes. The concept was spearheaded by American College of Physicians with support from Academy of Family Physicians.[61] Qualifying as a PCMH was recognized initially by NCQA, and then by others, as the predicate for additional bonus payments from commercial payers. There are many articles about commercial PCMH programs online, often by insurers (e.g, CareFirst)[62]. Some PCMH initiatives have been state sponsored, including Arkansas[63]; Pennsylvania[64]; and Rhode Island.[65] These typically involve a bonus payment on top of capitation rates. The concept has been expanded to patient centered medical 'neighborhoods' to include specialists. I represented the first specialty group to be designated a PCMH by NCQA.[66] Some programs have been instituted for heart and stroke care, irritable bowel syndrome and other specialty focused care.[67]

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[59] For more information on these issues see, available at https://www.gosfield.com/read/publications: Gosfield & Shay, "What to Ask if an ACO Comes Calling," Dermatology World, Mar. 2014, pp 17-20; Gosfield, "Avoiding Food Fights: The Value of Good Drafting to ACO Physician Participants", AHLA Physician Practice Group (June 2012) pp. 10-11; and Gosfield and Shay, "ACOs: Myths and fables debunked," Dermatology World (March 2012) pp. 13-15

[60] https://innovation.cms.gov/innovation-models/comprehensive-primary-care-initiative

[61] See ACP resources: https://www.acponline.org/practice-resources/business-resources/payment/delivery-and-payment-models/patient-centered-medical-home/understanding-the-patient-centered-medical-home/what-is-the-patient-centered-medical-home;

[62] https://www.member.carefirst.com/members/patient-centered-medical-home/pcmh-about-the-program.page

[63] https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/pcmh-pccm/

[64] https://www.health.pa.gov/topics/programs/Pages/Medical-Home-Program.asp;

[65] http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php

[66] Sprandio, "The Oncology Patient Centered Medical Home", J of Onc Practice (May 2012) https://ascopubs.org/doi/10.1200/JOP.2012.000590

[67] See CDC resources: *https://www.cdc.gov/dhdsp/policy_resources/pcmh.htm*

2.8.3 Value-Based Arrangements

In the 2020 massive overhaul of the Stark regulatory exceptions and the OIG's safe harbors, both sets of regulations addressed arrangements that without protection would raise compliance issues under both statutes. With the intention of providing for ways in which multiple providers who remained independent could come together and share financially in the rewards for producing better value, the Stark regulations, by the statutory restrictions that define them, focus on financial rewards to physicians. The OIG regulations are far broader and address other types of participants in these programs, including physicians. As is always the case, because the Stark exceptions provide safe haven or the arrangement violates, any review of this source of money into the physician practice must start there. Both sets of regulations address increasing (or decreasing) levels of financial risk from no risk, to meaningful downside financial risk, to full financial risk. Strangely, they address them in reverse order. Stark begins with full financial risk It is beyond the scope of this article, which is focused on individual physician compensation, to address the details and nuance of either regulatory scheme, but it is worth reviewing how these financial streams may come into play in determining individual compensation.

The regulations address definitions of value-based activities, value-based arrangements (VBAs), value-based enterprises (VBEs), value-based purposes, value-based participants and target patient populations (TPP). All of these are in play to claim the protections that the regulations offer, in their three iterations.

The Stark regulations addressing full financial risk[68] provide that for protection the participants must be at risk for all the costs of items and services covered by the payer. For each patient in the TPP there must be risk for a specified period of time beginning no more than 12 months from the commencement date. The OIG regulations are similar but address participants other than physicians and state that the payer can be a value-based enterprise participant but not the entity assuming risk.[69] Stark regulations require prospective payment only, including capitation and global budgets as examples. The remuneration to the participants must be for or result from value-based activities undertaken by the recipient for the TPP. Gainsharing and shared savings distributions are enumerated as qualifying. Under Stark, the value-based enterprise in which the participants act need not be a separate legal entity although the OIG says it must be separate.[70]

Under Stark for meaningful downside financial risk to the physician, the physician is responsible to repay or forego no less than 10% of the total value in cash or in kind of the remuneration he receives.[71] The OIG characterizes this as substantial downside financial

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[68] 42 CFR §411.357(aa)(1)

[69] 42 CFR §1001.952(gg); at 85 Fed Reg 77776 (Dec 2, 2020)

[70] Id

[71] 42 CFR §411.357(aa)(2)

risk to the VBE[72]. Under Stark the methodology must be set in advance and remuneration may not reduce or limit medically necessary items or services to any patient whether in the TPP or not. The OIG's rules are different, focusing on 30% loss on expenditures, prospectively or retrospectively, under shared savings and losses, and 20% of savings and losses where a defined episode of care methodology is used.[73] The VBE participants must take on at least 5% of what the VBE is at risk for.

Where no financial risk is assumed, remuneration flowing to he physician must be from value-based activities for the TPP, using a contract among the parties describing the arrangement.[74] Outcomes standards for measurement and payment must be applied and must be objective, measurable and based on clinical evidence. The benchmark used must quantify improvements in or maintenance of quality or reductions in cost to or reductions in growth of expenditures of payors, while maintaining or improving quality of patient care. The OIG version is called the "care coordination arrangements" safe harbor[75] which protects remuneration exchanged between a VBE and its participants or between VBE participants. The remuneration need not be fair market value. There must be legitimate outcomes measures used with written documentation of what is going on.[76]

The VBA regulations have a somewhat theoretical quality to them, because they are describing arrangements that could not have existed previously without violating the law. The point in reviewing both the incoming multiple streams of revenue to a group practice and the organizational structures that might be in play with no specific financial format, is to emphasize the difficulty in designing a compensation structure within a group practice, when neither the quantity, risk nor scope of the revenues is very predictable. All of these influences have generated a host of impacts and responses in physician groups.

3.0 **Impact of Current Systems**

The myriad streams of revenue have varying incentives at work and offer widely variant contracting methods as well as financial risk. What have been the impacts of this apparent move toward more value, but with greater cacophony?[77] In the mid-20 teens, the AMA and RAND together did surveys to examine the impacts of the then burgeoning diversity in

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[72] 42 CFR §1001.952(ff)

[73] 85 Fed Reg 77757 (Dec.2. 2020)

[74] 42 CFR §411.357(aa)(3)

[75] 42 CFR §1001.952(ee)

[76] See 85 Fed Reg 77728, 77734, 77729 and 77749-50.

[77] See, Friedberg et al, "Effects of Health Care Payment Models on Physician Practice in The United States," RAND-AMA, (2015) https://www.rand.org/pubs/research_reports/RR869.html; and the follow-up study Friedberg et al, "Effects of Health Care Payment Models on US Physicians Practices in The United States: Follow-up Study October 2018 (Nov, 2018) AMA-RAND https://www.rand.org/content/dam/rand/pubs/research_briefs/RB10000/RB10039/RAND_RB10039.pdf All the reports of RAND and AMA findings in this section come from these reports.

physician payment models. Their findings were not encouraging; and they cut across a host of parameters which were assessed. One would think they might have informed real change. We shall see that is not so much the case. Initial reports came from the 2015 and 2018 surveys. At the same time, while the calls for different incentives have not waned at all, a RAND study in 2021 reported that in the major consolidation of physicians leaving private practice to work as employees of health systems, for more than 80% of employed primary care physicians (PCPs) and 90% of specialists their compensation was based on volume.[78] For only 9% of PCPs and 5% of specialists were there any financial incentives in their compensation based on quality or value.

3.1 Organizational Impacts

Practices as a whole responded to new models in several ways. New models typically were found to encourage practices to merge or become affiliated with hospitals and large provider organizations. This phenomenon is so rampant that it is a truism; and the FTC has announced an investigation into it.[79] There have been mostly negative effects on cost as a result.[80] They also, however, encouraged practices to develop team approaches to care, new access options for patients, and new referral patterns to more like-minded specialists. For all practices, new payment models increased the importance of data and data analysis and highlighted data deficiencies and inaccuracies. Because payment models sometimes conflicted with each other, they were found to complicate the practices' abilities to respond in a constructive manner

3.2 Individual Impacts

If the idea of alternative payments' impact was to motivate individual physicians, it was surprising to me when I did my own surveys ten years earlier[81] that pay for performance monies did not make their way into the physicians' pockets. In 2015 and 2018, RAND and the AMA found that alternative payment models were not passed through to individual

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[78] RAND Corporation, "Most physicians paid by volume, despite push for quality and value" (Jan 28, 2022) https://medicalxpress.com/news/2022-01-physicians-paid-volume-quality.html

[79] Press Release, "FTC to Study the Impact of Physician Group and Healthcare Facility Mergers" (January 14, 2021) https://www.ftc.gov/news-events/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers

[80] Yang, "Hospital mergers and acquisitions leading to increased patient costs", citing a study by James Robinson, Ph.D in 2014, Berkely News, (Oct 21, 2014) https://news.berkeley.edu/2014/10/21/hospital-mergers-acquisitions-patient-costs/; Seven years later, things had not improved. Kacik, "Rising costs, low-value care linked to hospital-employed physicians, studies show Modern Healthcare (May 05, 2021)

[81] See, Gosfield, "Physician Compensation for Quality: Behind The Group's Green Door", HEALTH LAW HANDBOOK, (2008 ed.) WestGroup, pp. 1-44; Gosfield. "Compensation for Quality: The Next Inevitable Step", Group Practice Journal, (May 2008) pp. 10-15; adn Gosfield, "Compensating Physicians for Quality: A Changing Landscape", Group Practice Journal, (Sept. 2011) pp. 16-26

physicians, none of whom faced financial incentives to contain costs.[82] Rather, groups used non-financial incentives and interventions to encourage cost containment.

3.3 Problems with Implementation

As new payment models were introduced, survey respondents reported continuing problems with data integrity and timeliness of data. There were reports of errors in payment model execution, from inaccurate measures specification and patient attribution. The incentives themselves were deemed incomprehensible, which calls into question whether they qualified as incentives at all, according to Robinson's definition in the opening of this article.

By the 2018 survey the complexity of models had increased, with MACRA and QPP specifically cited as complex. Given their experiences, practices are more risk averse seeking less downside risk including being willing to forego some upside bonus potential to reduce downside risk. Data issues still persisted including timeliness and accuracy problems. And still there was the "cacophony of measures" at work.

3.5 Coping Strategies

To respond to the group incentives the new payment models created, primary care practices became more comprehensive. The recurring theme of the role of data in managing heightened forms of practice led participants to develop new informatics capabilities, with more investment in data and analytics. Over time, apparently, incentives were modified within practices so that quality incentives were passed through to individual physicians, but only after modification by the group itself. Cost incentives, by contrast, almost never pass through as physician financial incentives, calling into question both the design of the models and their implementation.

3.6 Continuing Challenges

By 2018, the pace of change in payment models (most unproven as we have seen) was so fast that expertise was not even available timely for practices to hire to assist them in responding and changing. Physicians have stated repeatedly that they crave a pause in the pace of change. They lament sudden and unexpected changes in payment models due to discontinuities in administrations. The effects have impacted practice investments, finances and other relationships. In two of the six markets surveyed in 2015 and 2018, by 2018 there was a return to FFS. Some of this was believed to relate to the advent more broadly of high deductible health plans where the patients are incurring a far larger initial portion of their health care costs than in years past; but the surveyors could not state with certainty the connection between FFS payment and high deductible health plans. Physician risk aversion continues with strategies of shifting care which could count against them as costly (e.g., SNF care) out of the risk model; and in some instances this shift has devolved more risk onto device manufacturers. Still further, physicians seek to shift risk back to payers by forgoing bonuses to get protection from downside risk. All of this belied as of 2018, essentially failed experiments. More recent data is not much more sanguine.

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[82] See n. 77 *supra*

3.7 Continuing Complaints

From the effects of the COVID-19 crisis to the ongoing demands of an essentially inefficient system, physician burnout has become a major problem.

3.7.1 Burnout

Burnout is the sense of complete frustration that leads physicians not only to dissatisfaction, but increasingly termination of their professional careers. Physician burnout has been a subject of alarm for almost fifteen years. It is such a significant problem in terms not only of the availability of a work force to deliver necessary care, but also as a major contributing factor to mistakes and malpractice. The Agency for Health Care Research and Quality (AHRQ) maintains a website devoted specifically to this problem. [83] More recently, commentators have stated the problem succinctly: "The six driving factors of workplace burnout are a chaotic work environment, loss of control, insufficient rewards, breakdown of community, the absence of fairness and conflicting values."[84] COVID-19 has only made matters worse, particularly in primary care. Combine these already existing problems with ineffective payment models and the result is inflammatory at best. It is combined with another aspect of new payment models

3.7.2 Administrative Burden

In a survey in 2021 conducted by the Medical Group Management Association, physicians stated that administrative burden was increasing and troublesome.[85] Prior authorizations were most frequently cited, but Medicare's Quality Payment Program ranked #2.

- 73% of respondents participated in MIPS; of them, 93% said the payment adjustments do not cover costs, time and resources,
- 90% said CMS feedback is not useful to either reduce costs or improve clinical outcomes.
- 79% said CMS implementation of value-based policies increased administrative burden

In yet another recent survey[86], of 420 practices responding, 91% said in 2021 that the overall administrative burden had increased. In addition, the annual cost per-physician to

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[83] https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html

[84] Strategies to combat physician burnout lead 2021 practice management coverage, Ocular Surgery News, Dec 18, 2021; https://www.healio.com/news/ophthalmology/20211217/strategies-to-combat-physician-burnout-lead-2021-practice-management-coverage

[85] See, Mensik, "Regulatory burdens strapped medical practices over the past year, MGMA finds", (Oct 27, 2021) https://www.leapzine.com/regulatory-burdens-strapped-medical-practices-over-the-past-year-mgma-finds.html

[86] See, Khullar et al, "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System", JAMA Health Forum (May 14, 2021) https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

participate in Medicare's QPP models was $12,811 and physicians and staff spent 201.7 hours annually per physician on MIPS-related activities. Physician time counted for the greatest proportion of overall MIPS-related costs. So, while the new payment models are many, they also are not succeeding in their principal goals and are making physicians dissatisfied with their work. Lawyers have yet another tangle of concerns to throw into this bubbling, troublesome brew.

4.0 Legal Issues

4.1 Stark Productivity Bonuses

In December, 2020, the regulators published new rules under Stark addressing compensation issues for physicians, notably productivity bonuses and profit sharing. Because what they published differed substantively from what had been in place, they delayed implementation until January 1, 2022. The new rules are now the current rules.

While many features remained in place, several entailed major change which has to be incorporated into compensation formulas and agreements. The statute itself allows bonuses to be paid for personally performed services or services “incident to" the physician's personally performed services[87]. It should be noted that there is no requirement of paying physicians for "incident to" services, but if ancillary DHS that are incidental are to be allocated to physicians, that must be as productivity dollars or in profit sharing. In determining how to allocate dollars, the essential question is whether they can qualify as productivity dollars which can be allocated directly to the treating physician, or profit sharing dollars which can only be allocated on bases that indirectly reflect the ordering of DHS. The power of the rules on productivity and profit sharing lie in the fact that they are part of the definition of a group practice. To make use of any of the exceptions that permit activities such as referrals to a physician in the group[88] or in office ancillary services,[89] the constellation of physicians billing for the services must qualify as a group practice; so these financial rules come into play.

For those services that the physician personally performs, including DHS, the revenues or the profits are directly allocable to the physician who renders them. Personally performed means there is no other person involved in producing the service –e.g., no technician, no nurse, no medical assistant. There are services which sometimes entail additional personnel, but in some instances physicians perform directly themselves. If the physician performs her own ultrasound, for example, with no technician manipulating the wand and the physician interpreting the images herself, she can be given credit for the interpretation and the technical component-- the global fee.

"Incident to" services turn on an ancient provision in the Medicare rules. When Medicare was enacted, most physicians worked in small practices of one or two physicians supported

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[87] 42 USC §1395nn(h)(4)(B)(i)

[88] 42 USC §1395nn(b)(1)

[89] 42 USC §1395nn(b)(2)

by some ancillary personnel. They might have been a vo-tech school trained laboratory technician, a medical assistant, a registered nurse, and often the physician's wife. These people did everything from taking histories, to reception, to venipuncture, to taking vital signs and more. If Medicare had only agreed to pay for the services of the physician, no one would have participated. Instead, they agreed to pay for those services which were "an incidental although integral part of the physician's personal professional service to the patient."

When the Stark regulations were finally published in 2001, the regulators explicitly recognized the legitimate allocation of the revenues for "incident to" services to the treating physician. Although I personally had written comments that argued that by its very terms "incident to" services do not constitute a referral because they are an integral part of the physician's services, they rejected that position and instead said it is a referral but the statute allows credit for those dollars to go to the treating physician.[90] To whom "incident to" allocation is made has nothing to do with who the supervising physician is when that physician's identification is required on the claim form. To bill for "incident to" services, there must be a physician on premises in the office suite (not somewhere else in the building) and immediately available to assist at all times that the services are being rendered; so that physician's number is listed as the supervisor. Still further, it is important to remember than in a major change in 2007-8, the regulators, for no discernible reason, suddenly decided that diagnostic testing (which had been billed "incident to" for 41 years) could then and now 'never' be billed "incident to". So, unless the treating physician performs the diagnostic test completely himself, the technical component dollars of DHS have to float up into a profit-sharing pool if they are going to be shared.[91]

Taken together, then, DHS "incident to" billing permits dollar for dollar allocation of revenues from DHS that is itself "incident to" the physician's services. This includes services and supplies, so both drugs and the infusion of them can be allocated directly to the ordering physician. Similarly, physical therapy (PT) and occupational therapy (OT) can be allocated "incident to", if they meet the "incident to" requirements. Since both of them may be billed without a physician on premises, a potential pitfall is not assuring that some physician in the group was on premises when the PT/OT services were rendered. If not, those dollars can float up into a profit-sharing pool if profits from them are to be allocated at all. Likewise, revenues generated by 'care team' members who are not performing DHS themselves can also be allocated directly to the treating physician. Non-physician practitioners themselves (e.g., NPs, PAs, LCSWs, etc) are not subject to Stark, but the revenues they generate could be if they entail DHS.[92]

4.2. Stark Profit Sharing

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[90] See 66 Fed Reg 909, (Jan 4, 2001)

[91] There is no requirement that incident to services be allocated as personal productivity. Those revenues or profits could be included in profit sharing; or they might be retained in the practice to defray other expenses.

[92] 85 Fed Reg 77566, (Dec 2, 2020)

Compensation to physicians for their productivity and "incident to" services are often referred to as dollars that represent the fruits of the physician's own labors. Profit sharing, on the other hand, by definition is not personal productivity, so it represents the fruits of others' labors, including technical components of diagnostic services which cannot be allocated 'incident to' even if they are not DHS (e.g., EMGs, EEGs, EKGs, much cardiac monitoring and more). Generally, amounts paid to a physician as compensation may not be determined in any manner that takes into account the volume or value of the physician's referrals. By contrast, profits from DHS may be distributed to group practice members and physicians in the group (e.g., independent contractors when they are working on the premises of the group) in accordance with methods that indirectly *take into account referrals.*[93] The regulators have maintained the 5%/5% rule which means a group need not concern itself with the profit sharing rules if DHS represents less than 5% of the practice's total revenues and less than 5% of the allocated portion to each physician. The difference is that they reemphasized that the exception cannot pertain if the group as a whole has less than 5% DHS revenues, but only some of the physicians have only 5% of their revenues from DHS. The exception requires that all of the physicians may not have more than 5% DHS revenues in their total compensation from the group.[94] They have removed references to Medicaid.[95]

Going back to the 2001 publication, the regulators have said profits to be shared must be a share of the total profits. Many lawyers, including me, advised that a share of the overall profits could be limited to modality specific profits –e.g., profits from CT, infusions, PT/OT, MRI, all in different pools. In the 2020 publication, they picked up this issue yet again. First, they emphasized that their focus was on profits and not revenues. The rules on profit sharing address what remains after expenses are paid rather than revenues which "could serve as an inducement to make additional and potentially in appropriate referrals to the group practice. They clarified, claiming it had always been their intent, that any portion of profits from DHS that might be allocated to physicians had to include all the profits from DHS (presumably excluding those that could be allocated as "incident to"). The dollars to be allocated must be "the profits from all the DHS of any component of the group...a physician practice that wishes to qualify as a group practice may not distribute profits from DHS on a service-by-service basis."[96] They referred to the modality specific allocations as 'split pooling' and prohibited it.

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[93] *(Emphasis added (*66 FR 862 and 908, Jan 4, 2001)

[94] 85 Fed Reg 77562, Dec 2, (2020)

[95] The statute as enacted provided that it applied to Medicaid in a manner which simply cannot be implemented. At 42 USC §1396b(s), the statute says no federal financial participation (FFP) will be available to a state Medicaid program for any service that was subject to a referral for which the payment would be denied under Medicare on account of the Stark anti-referral provision. FFP for Medicaid is paid to the states often in the form of many millions and millions of dollars. There is no mechanism that exists or could exist to deny FFP for any single service that violates the anti-referral prohibitions.

[96] 85 Fed Reg 77563 (Dec 2, 2020)

They continued to allow subsets of at least five physicians in a group to share profits as they always have, but the basis to establish subsets is not specified but could be "physicians with similar practice patterns, who practice in the same location, with similar years of experience, with similar tenure with the group or who meet other criteria determined by the group practice."[97] The reference to similar practice patterns impliedly means that historical ordering patterns could be taken into account for current allocation formulas. In a slightly backhanded reference to commercial payment, for purposes of calculating what portion of the overall profits from DHS a physician might be paid they stated we will "deem the payment of a share of overall profits not to directly take into account volume or value of a physician's referrals if overall profits are distributed based on the distribution of the groups revenues attributed to serves that are not DHS and *would not be considered DHS if they were payable by Medicare."*[98] So, while they acknowledged that their jurisdiction extends only to Medicare DHS, a proper Medicare allocation formula could not include commercial DHS to establish the physician's piece of the profit pie.

4.3 Value-Based Arrangements and Enterprises

Going back to the multiple sources of revenues in a physician practice, there is now the possibility of money arriving from a VBA or VBE. Notwithstanding the general prohibition, on profit-sharing from referrals, profits from DHS that are directly attributable to a physician's profit sharing related to participation in a VBA, as defined at 42 CFR §411.351, may be distributed to the participating physician. Because an individual in a practice may be compensated directly for referrals within a VBA, "they may be encouraged to participate in a VBA with providers and suppliers outside of the physician's own group practice even when the group practice does not participate as a whole in the VBA."[99] The regulators explicitly cited the permissibility of allocating within the group to an individual physician, profits from DHS he refers himself within a VBA.

5.0 External Audits and Voluntary Repayments

5.1 External Audits

For many years there have been a litany of agencies within the federal government who engage in post-payment audits, sometimes requiring the return of monies based on their findings on samples, which may then be extrapolated across a number of years. Commercial insurers also often engage in post-payment audits to confirm compliance with their coverage requirements. When the audit finds overpayments have been made to the group, there is always a concern over how the overpayment got generated. If the billing function was inadequate or negligent, that is a different set of problems from an overpayment created by an individual physician's failure to document effectively, or meet

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[97] 85 Fed Reg 77565, (Dec 2, 2020)

[98] 85 Fed Reg 77562 (Dec 2, 2020)

[99] 85 Fed Reg 77559 (Dec 2, 2020)

coverage requirements that pertain to the services he rendered which generated the overpayments.

The demand for repayments from the group that received the monies lies in the effect of the reassignment by the individual physician to the group under Medicare or often a commercial insurer as well. Under Medicare the reassignment requires joint and several liability between the individual physician and the group for overpayments. Unless there is clear contract language which sets forth the obligation of the offending physician to contribute to the repayment that is demanded, that physician who may have caused the problem, would have received unjust enrichment by keeping those monies which the group now has to repay. In addition, the findings of an external audit are explicitly considered to be credible evidence to motivate a group to engage in a deeper inquiry as to the nature and extent of the errors under the voluntary repayment rules.[100]

5.2 Governing Documents

In the context of physician compensation, because improperly submitted claims require repayments, some of the money to be repaid will reflect compensation made to the physician himself. Unless the obligation to contribute to such repayments is made clear in the documents governing the physician's relationship with the practice, it can be difficult to recoup those monies or withhold them from ongoing compensation.

The relevant guiding agreements, whether in shareholder or partnership documents or employment contracts, should address the physician's obligation to contribute to overpayments they caused. While we have written many agreements that provide for this obligation to pertain even post-termination, we have not had an occasion to see those documents enforced. Still further, what if the problem arises when the physician is post-retirement? We have no answer for that; and physician practices will have to determine their approach to these recoupment problems.

5.3 Voluntary Repayments

The obligation of groups receiving Part B dollars to engage in voluntary repayments of monies improperly received was made real with regulations published in February, 2016.[101] The obligation is on-going and provides that improperly received monies must be returned within 60 days of identifying and quantifying the amount that is owed, or the claims generating those dollars convert to false claims: available for the government or whistleblowers to attack. I have written extensively on the implications of these rules both practically as well as in the context of false claims liability.[102]

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[100] See Gosfield, "Heightened Peril From Physician Audits," Compliance Today, (January/February, 2020); https://www.gosfield.com/images/PDF/AGG.Heightened_peril._JHCC_0102_20_Gosfield.pdf

[101] 42 CFR §401.303

[102] See, Gosfield, "Voluntary Repayments: The Physician Perspective", Compliance Today, (Jan/Feb 2017) pp. 5-9; Gosfield, "The Oxymoronic Landscape of Voluntary Repayment", HEALTH LAW HANDBOOK, (2017 ed.) WestGroup, pp. 71-99; https://www.gosfield.com/images/E-bulletins/JHCC_0102-

Unlike results from an external audit where the group itself is not establishing the scope of the repayment, where the matter is purely internal and based on the group auditing itself, questions may arise regarding the determination: how it was made, what the evidence was, how the dollars were calculated, and, then, which portion of those dollars were paid to the physician at issue. If a physician, for example, is paid 50% of the revenues she generates, then she should only be responsible to pay a commensurate portion of the repayment to be made.

We believe that some level of dispute resolution should be available for these problems. In our approach, we have the parties sign a non-disclosure agreement, since the fact of the repayment ought to be kept confidential and handled as an ongoing business responsibility. The physician should be provided the basis for the determination and the calculation of the amounts to be imposed, typically through on-going withholds of compensation so as not to completely jeopardize the physician's income while the repayment is resolved. The group should permit the physician to bring in an outside reviewer to challenge the determination, if appropriate, within a specified timeframe. If the parties cannot agree as to whether the overpayment findings are legitimate, we think mediation might be the appropriate road to take. That said, if the practice is functioning effectively, the likelihood that their findings are correct ought to be very high. As to whether mediation should even be available we think might rest on a standard of materiality. Depending on the specialty, that number might vary. For a family physician a matter of $2500 may be sufficiently challenging so as to permit additional review. For a hematologist-oncologist that number might be $5000 or $10,000. These are matters for the group to determine; but the basis for garnering any of the overpayment from the physician has to be established in the contract that governs the relationship if there is any hope of recoupment. That said, we think the presumption should be in favor of a properly functioning organization so no additional review ought to be necessary. If agreed to by the physician upon her engagement with the group, we think courts might well defer to the group assessment if it is done fairly using a credible consultant.[103]

6.0 Conclusion

There are many varied revenue streams generating dollars into a physician group based on the work those physicians do. Many of the current models purport to veer toward incentivizing value. Few have demonstrated much success. In the health system context, physician compensation remains mostly volume driven. With the mad rush to consolidation, the likelihood of producing improved value seems low. Today, if value-based payment is present, it has become increasingly difficult to predict with any specificity, the revenues upon which to base any physician's compensation. Physicians themselves tend to

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17_Gosfield.pdfhttps://www.gosfield.com/images/Publication_Files/AGG.TheOxymoronicLandscape.Final.122116.pdf; Gosfield "Understanding The New 60-Day Overpayment Rule", Family Practice Management, (May/June 2016) pp. 12-14 https://www.gosfield.com/images/PDF/FPM.60dayrules.pdf

[103] There are many implications to the voluntary repayment process which should be considered carefully as an ongoing matter for all physician practices receiving Part B dollars; most of the details of that process are beyond the scope of this consideration, but available at our website: www.gosfield.com

want security in their compensation models. It is becoming more and more trying for any group to be certain what their revenues will be given the disparate payment models at work and their varied incentives. Against the problem of determining and predicting revenues, there are also the compliance issues from the Stark statute as well as the new value-based arrangements.

The purpose of this article has been to raise the consciousness of attorneys who either work on these issues with physician groups or advise physicians reviewing their compensation contracts to understand the very significant challenges that will remain in play unless something supersedes the current cacophony of payment models into a single driving principle. I have zero expectation that will happen any time soon. In the meantime, providing the legal basis in contract language and policies to pay physicians fairly will remain an interesting and important aspect of delivering better quality, lower cost care to American patients everywhere.