

## PAY-FOR-PERFORMANCE IN THE NEW HEALTHCARE ENVIRONMENT:

# Why Incorporating Clinical Best Practices and Compliance Strategies is More Important Than Ever

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Pay-for-performance – the idea that healthcare providers should be compensated based on the quality of care provided rather than the fact that care has been provided – is not a new concept. What is new is the level of intensity aimed at implementing a national strategy for quality improvement, embodied in public and private initiatives around the country. This inexorable shift to outcomes-based reimbursement makes implementation of data-driven clinical best practices and effective compliance strategies essential to success under these new payment models.

In its June 2010 “Report to the Congress: Aligning Incentives in Medicare”, the Medicare Payment Advisory Commission (MedPAC) reiterated its support of reformation of the design of the traditional Medicare fee-for-service benefit stating: “A primary goal of this approach is to improve quality.” In this same report, MedPAC also recommended that Medicare revisit its conditions of participation to align them with current quality improvement efforts and to incorporate performance on outcomes measures as a criterion for providers to be eligible to perform certain procedures.

The Patient Protection and Affordable Care Act of 2010<sup>1</sup> (PPACA) has a wide array of provisions aimed at improving the quality of the U.S. healthcare system. Some, such as the Patient-Centered

Outcomes Research Institute and the Center for Quality Improvement and Patient Safety<sup>2</sup>, focus on the research and development of outcomes, effectiveness and practice guidelines.

Other provisions of PPACA focus on new reimbursement models designed to reduce fee-for-service medicine. Perhaps the most talked about of these is the Accountable Care Organization<sup>3</sup> (ACO). In shared-savings model, an ACO is intended to hold groups of providers collectively accountable for meeting cost and quality targets with the expectation that internal peer review and peer pressure will drive the identification and implementation of best practices systemically, thereby leading to better cost controls and outcomes. Although, at the time of this writing the ACO regulations have not yet been released by CMS, we anticipate that a key component of ACOs will be effective implementation and measurement of clinical quality benchmarks. In other words, in order to participate in shared savings, ACO par-



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ticipants will have to demonstrate both improved quality and decreased costs.

PPACA also provides a number of possible performance-based care coordination models.<sup>4</sup> These innovative payment and delivery arrangements include the promotion of various models of integration that reduce or eliminate fee-for-service payment systems, for example, patient-centered medical home models, coordinated care models, direct contracting with provider groups, and other models that transition healthcare providers away from fee-for-service based reimbursement and toward risk-based comprehensive payment or salary-based payment. Under these models, physicians earn a bonus for curtailing growth in the cost of health services by better managing treatment across care settings and by pursuing quality targets. A care-coordination model may be structured differently from an ACO and may also use different methods to calculate shared savings.

Pilot programs on payment bundling, grouped by provider and/or patient and based on episodes of care, are viewed as having the potential “to improve the coordination, quality and efficiency of healthcare services...”<sup>5</sup> The United States Government Accountability Office (GAO) recently advised the Congress that “[t]o the extent that bundled payment arrangements encourage providers to become more efficient in the delivery of care, these arrangements can also benefit providers financially. Any reductions in unnecessary care that result from bundling can improve the quality of care.”<sup>6</sup>

Beginning in 2015, PPACA also mandates implementation of a value-based payment modifier under the CMS Physician-Fee Schedule that will provide for differential payment to a physician or a group of physicians based upon the quality of care furnished compared to cost. This program will contain risk-

adjusted measures that reflect health outcomes.<sup>7</sup>

The earliest and largest pay-for-performance programs were developed as testing grounds for many of the reforms contained in PPACA. Whether these programs resulted in demonstrable improvements in quality of care remains an open question. According to a recent study, the MassHealth Pay-for-Performance program, implemented in 2008, did not result in measurable improvements in quality of care for pneumonia treatment or surgical infection prevention. On the other hand, studies of the largest hospital pay-for-performance program, the Premier Quality Incentive Demonstration (PHQID), implemented in 2003, found evidence that it was successful in effecting quality improvements.

Private payors have jumped on the quality bandwagon as well. While a comprehensive survey of private initiatives is beyond the scope of this article, illustrative of these efforts is Blue Cross Blue Shield of Massachusetts, Inc.'s Alternative Quality Contract (AQC), a modified global payment model designed to encourage cost-effective, patient-centered care by paying participating physicians and hospitals for the quality, not the quantity of the care they deliver. The AQC was implemented in 2009; first-year results demonstrated significant progress in improving the quality and outcomes of patient care while significantly slowing the rate of growth in healthcare spending.

The GI and endoscopic communities have been active in the development of quality guidelines for nearly two decades. According to Peter B. Cotton, MD, FRCP, FRCS, Professor of Medicine; Digestive Disease Center, Medical University of South Carolina, the issue is compliance: "...[D]ata collection [has not been a priority]...follow-through is anecdotal and not [done] in

any structured way. The laxity of quality control, despite the guidelines, [is due to] no enforcement."<sup>8</sup>

This heightened focus on quality, the establishment of clinical quality standards, and the call for compliance with "best practices" will significantly affect the liability exposure of physicians. The greater the availability of real outcomes data, the greater the likelihood of comparisons between an individual provider's outcomes and the measurable outcomes of other providers. The development of "practice recommendations" and clinical practice guidelines begins to sound like "standard setting", putting a heavier burden on physicians to justify deviation from what could be argued is the new "standard of care". Physician performance information will be available to consumers through website information. Narrowing practice variation and medical uncertainty will result in a "double whammy" for physicians: the physician who does not keep up with new research will not only suffer income loss; he or she will also suffer a higher risk of liability for failing to conform to what becomes the new standard of care.

Patient satisfaction will be an essential ingredient in the development of quality standards. PPACA includes demonstration of patient-centeredness as an essential attribute of an Accountable Care Organization.<sup>9</sup> As Dr. Cotton noted, patients must be educated to ask questions about performance and quality effectiveness. Indeed, patients may well be involved in scoring care and treatment, making service excellence more important than ever as a strategic tool to positively impact both economics and liability risk.

The result: strategic and effective implementation of data-driven clinical best practices blended with best practices in risk management is more important than ever. Providers that understand their practice's clinical quality data will

be in a strong position to develop quality strategies to improve quality and reduce risk. Ongoing performance analysis coupled with strong compliance efforts and effective feedback tools will boost providers' ability to achieve quality standards. Those organizations and providers that meet certain benchmarks or that come within a top percentage, depending on the reimbursement model, will essentially become the providers and employers of choice. This will affect market share and have a beneficial economic result for those achieving the established goals.

It is our belief that GI practices need to begin to incorporate ways to enhance clinical quality outcomes before the mandates occur. Systems are being created so GI practices can implement benchmarks and measurement tools to understand and use their data to improve outcomes. Patient satisfaction surveys are taking on new meaning. In our experience, with working with GI practices around the country, early implementation of clinical best practices and strong compliance programs will give providers the foundation they need to succeed in the new healthcare environment. It is time to move from discussing to implementing.

<sup>1</sup> PPACA cite

<sup>2</sup> PPACA §10303

<sup>3</sup> PPACA §3022

<sup>4</sup> PPACA §3021

<sup>5</sup> PPACA §3023

<sup>6</sup> GAO-11-126R Private Sector Initiatives for Bundled Payments, January 31, 2011

<sup>7</sup> PPACA § value-based payment modifier to physician fee schedule

<sup>8</sup> Peter B. Cotton, MD, FRCP, FRCS, interviewed March 24, 2011.

<sup>9</sup> PPACA §3022

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