New Regulations for Physician Incentive Plans Regulating Quality Through the Back Door

May 01 1996

Practice Area: Health Law & Provider Groups and Clinics & Health Intellectual Property

Introduction

During the last twenty years, Congress and the Health Care Financing Administration ("HCFA") have established laws and regulations designed to prohibit, limit or discourage the direct or indirect payment of compensation in order to induce referrals.

Health care has changed. Today, there are a number of risk-based plans that incentivize physicians to use fewer services. This, in turn, has created concerns within HCFA of a possible decrease in the quality of care and a reduction in the provision of medically necessary services.

Therefore, Congress and HCFA have decided to regulate the establishment of physician incentive plans that, from their perspective, inappropriately cause physicians to avoid referrals. While these regulations are intended to remain in place until comprehensive quality assurance and patient protection standards are established for such plans, they are likely to remain beyond that time.

These regulations were published on March 27, 1996 ("Rules") and directly govern managed care plans providing services to Medicare and Medicaid patients. However, their implications go far beyond the managed care plans themselves.

What is a Physician Incentive Plan?

A physician incentive plan (PIP) is any compensation arrangement between any organization and a physician or a physician group that directly or indirectly has the effect of reducing or limiting services furnished to Medicare beneficiaries or Medicaid recipients enrolled in the organization.

The rules initially appear to apply only to relationships between managed care organizations and physicians. However, the rules also apply to independent practice associations, physician hospital organizations, super-PHOs, integrated delivery systems and any individual physician who provides services to Medicare or Medicaid patients.

Further, because the physician self-referral statutes, commonly referred to as the Stark rules, have an exemption for compensation arrangements which satisfy the incentive plan rules, even more providers and arrangements will be affected.

The Basic Rules

In general, the Rules provide that a contract with physician incentives is appropriate only if:

1. No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; *and*
2. The appropriate stop loss protection, enrollee survey requirements and disclosure provisions of the regulations are satisfied.

Under no circumstance is a payment affecting the availability of services for a specific individual allowed. However, payments which incentivize physicians to reduce the number of referrals are appropriate if the standards of these regulations are satisfied.

Regulation of Plans

Minimum Requirements

Every managed care plan must at least make a statement that it has not placed its physicians at substantial financial risk under the terms of its plan. The statement must be made to the Health Care Financing Administration or to the appropriate state Medicaid agency and should provide that the plan only uses physician incentive payments that put physicians or physician groups at risk solely for the services they themselves provide or that the plan does not use any regulated PIPs. However, if as a result of any contract, physicians or physician groups are placed at substantial financial risk, the stop loss protection, enrollee survey and disclosure requirements discussed below apply.

Determining Substantial Risk

A key question is whether or not the incentive arrangement places the physician or physician group at substantial financial risk for amounts beyond the risk threshold if the risk is based on the use or cost of referral services. The risk threshold is 25%. Amounts at risk based solely on factors other than the physician or physician group referrals do not contribute to the determination of substantial financial risk.

The Rules assume that a patient panel size greater than 25,000 does not result in substantial financial risk. If the panel size is less than 25,000 (or is greater than 25,000 only as the result of inappropriate pooling), substantial financial risk occurs in any plan that provides for the following:

1. Withholds greater than 25% of potential payment;
2. Withholds less than 25% of potential payment if the physician or physician group is potentially liable for amounts exceeding 25% of potential payments;
3. Bonuses that are greater than 33% of potential payments minus the bonus;
4. Withholds plus bonus if they equal more than 25% of potential payments;
5. Capitation arrangements in which the maximum difference between possible payments and minimum payments is more than 25% of the maximum payments; or the maximum and minimum possible payments are not clearly explained in the group contract; *or*
6. Any other arrangements that have the potential to hold the physician or physician group liable for more than 25% of potential payments.

Substantial Risk-Special Requirements

If substantial financial risk is present, it is necessary to conduct enrollee surveys, assure the purchase of stop loss insurance and satisfy greater disclosure requirements.

Enrollee surveys must canvas all current Medicare/Medicaid enrollees and those who have disenrolled for reasons other than loss of eligibility or relocation outside of the service area in the past twelve months. The survey must be designed, implemented and analyzed in accord with commonly accepted principles of survey design and statistical analysis and address enrollee/and former disenrollee satisfaction with the quality of services provided and the degree of access. These surveys must be conducted no later than one (1) year after the effective date of the plan and at least every two years thereafter.

The managed care company must also ensure that the physician and physician groups have aggregate or per patient stop loss protection that satisfies specified requirements. If aggregate stop loss protection is provided, it must cover 90% of the cost of referral services that exceed 25% of potential allocated payments. If coverage is provided on a per patient basis, the level of protection varies based upon the number of patients in the pool for the physician or physician group. For example, if there are less than 1,000 patients in the pool, the stop loss protection must begin at $10,000. On the other hand, if there are between 10,000 and 25,000 patients, the stop loss protection may be $200,000 or less.

The managed care company must pay for the stop loss protection or at least that portion of the stop loss protection that relates to its enrollees.

Any managed care company that uses a physician incentive plan that influences utilization of referral services must disclose to HCFA and/or the appropriate state Medicaid agency the following:

1. All types of PIPs utilized: for example, withhold, bonus or capitation;
2. The percent of the withhold or bonus;
3. The amount and type of stop loss protection;
4. The panel size and if patients are pooled according to one of the allowed methods, the method used (the allowable methods are to include commercial, Medicare and/or Medicaid in the calculation of the panel size or to pool together, by the organization, several physician groups into one panel);
5. When capitated payments are made, the percentage of payments made in the most recent year for primary care services; services of specialist physicians; and institutional services; and survey results.

These disclosures must be made to HCFA upon application for a contract, upon application for a service area expansion or within 30 days of request. Further, an organization must notify HCFA 45 days before implementing changes in the plan incentives, the amount of risk or stop loss protection, or to expand the risk formula.

Finally, disclosures must be made to any Medicare beneficiary or Medicaid recipient who makes a request for any of the following information:

1. Whether the prepaid plan uses a physician incentive plan that affects referrals;
2. The type of incentive arrangement;
3. Whether stop loss protection is provided; and
4. A summary of any survey results.

This information is to be provided to a Medicare beneficiary or Medicaid recipient regardless of enrollment in that particular plan.

Subcontracts

It is noteworthy that these obligations also apply to subcontract arrangements. Accordingly, a managed care organization which contracts with a physician group that places individual physician members at substantial financial risk is responsible for disclosing the nature of the incentive arrangements as if they were provided by the managed care contracting organization, and provide appropriate stop loss protection and conduct surveys when required.

Organizations that contract with other intermediate entities (other than a physician group), such as but not limited to an independent physician association, or a PHO that contracts with an entity other than a physician group, must also disclose to HCFA any incentive plan that establishes compensation based on the use or cost of services furnished to Medicare beneficiaries or Medicaid recipients. The disclosure requirements are similar to those discussed above. Further, if the PIP puts the physician or physician group at substantial financial risk, it must provide appropriate stop loss protection and conduct any necessary surveys.

If a managed care organization fails to comply with these Rules it is subject to a range of sanctions including suspension of the enrollment of new Medicare beneficiaries or Medicaid recipients and a civil monetary penalty of up to $25,000 for each violation.

Summary

Managed care has moved referral regulation to a new era. Now it is also necessary to be careful about arrangements which provide improper incentives not to refer. The push of business and government to develop effective financial incentives to avoid referrals is clear. While providers need to be responsive, they must assure that plan design complies with these and similar requirements.
