Gainsharing Arrangements and Bundled Payments: Latest Developments

TUESDAY, MARCH 5, 2013
1pm Eastern  |  12pm Central  |  11am Mountain  |  10am Pacific

Today’s faculty features:

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Gainsharing Arrangements and Bundled Payments: Latest Developments

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Jett Stansbury, Integrated Healthcare Association
Agenda for Today’s Webinar

- Understanding what constitutes gainsharing and bundled payment arrangements
- Identifying legal considerations in gainsharing and bundled payment arrangements
- Gaining an awareness of existing gainsharing and bundled payment models and demonstrations
- Reviewing FMV considerations and structural guidance
Gainsharing

- Hospitals and physicians are generally paid separately for care provided in hospitals, creating misalignment between the incentives facing hospitals and those facing physicians.
- There are no direct financial gains to physicians - who often control the use of supplies and selection of devices which are paid for by the hospital - for providing more efficient care and decreasing hospital costs.
- Gainsharing is a contractual arrangement that sets up a formal reward system in which participants share in cost savings resulting directly from increased efficiency. Physicians participating in a gainsharing arrangement will have a financial stake in controlling hospital costs.
Bundled Payment

- A bundled payment is a fixed, single payment for a package of services delivered by a group of providers during a defined episode of care.
- In a knee replacement, the bundled payment may include the cost of the surgeon, anesthesiologist, hospitalist, inpatient stay, device and treatment complications, including readmission occurring during a defined period.
- Bundled payment often includes a gainsharing aspect.
- Bundled payment models differ from the ACO model in that the ACO model is focused on the care provided to an entire population of patients, not a particular episode of care.
Legal Considerations
Gainsharing has had a slow start in federally funded health care due in part to certain fraud and abuse laws, including the Civil Monetary Penalty Law (CMPL), the federal anti-kickback statute and, to a lesser extent, the federal physician self-referral law (“Stark law”).

Interest in gainsharing arrangements grew after the OIG issued more favorable Advisory Opinions beginning in 2005. Cost pressure and interest in integrated models has spurred more recent interest.
Civil Monetary Penalty Law (CMP)

- The CMP prohibits hospitals and physicians from knowingly making or receiving a payment, either directly or indirectly, to a physician as an incentive to reduce or limit services to Medicare or Medicaid fee-for-service beneficiaries.
- A gainsharing model that aimed to save money by having physicians negotiate lower prices for supplies with one manufacturer in exchange for reducing or eliminating the options from other manufacturers could violate CMP if a reduction in choices of supplies could lower the quality of care to beneficiaries.
- Each violation is subject to a $2,000 fine, up to $100,000.
OIG’s Implementation of the CMP Statute

- No regulations implementing statute. A proposed rule issued but never adopted.
- July 1999 Special Advisory Bulletin is the primary source of guidance.
- OIG refused to issue advisory opinions on proposed gainsharing arrangements until 2001 and has issued 15 favorable opinions to date, including 4 in 2008 and 1 in 2009.
- OIG first granted approval to gainsharing programs lasting more than one year in 2008. The limited duration of gainsharing programs was seen as a safeguard against potential patient harm.
- The OIG stated that gainsharing arrangements “may offer significant benefits where there is no adverse impact on the quality of care received by patients” and that the CMP is violated even if the hospital's payment to the physician “need not be tied to an actual diminution in care, so long as the hospital knows that the payment may influence the physician to reduce or limit services.”
The AKS prohibits hospitals from knowingly and willfully paying, soliciting, or receiving any remuneration to induce referrals of items or services provided under any federally funded program.

A gainsharing model in which hospitals pay physicians for cost savings from changes in physician behavior (such as ordering of tests or treatments) for Medicare beneficiaries could violate AKS.

AKS is a criminal statute, whereas CMP is a civil statute.

A violation of AKS could result in up to 5 years in prison, a $25,000 fine, and mandatory exclusion from participation in Medicare or Medicaid.
Why Is the OIG Concerned with Programs Focused on Reducing Costs?

The OIG’s concerns include, but are not limited to, the following:

1. stinting on patient care;
2. “cherry picking” healthy patients and steering sicker (and more costly) patients to hospitals that do not offer such arrangements;
3. payments in exchange for patient referrals; and
4. unfair competition (a “race to the bottom”) among hospitals offering cost-savings programs to foster physician loyalty and to attract more referrals.
Threshold Inquiry under CMP Statute

- “A threshold inquiry is whether the Arrangement induces physicians to reduce or limit items or services.”
- If so, does the arrangement have sufficient safeguards so that the OIG would not seek sanctions under sections 1128A(b)(1)-(2) of the Act?
  
  See OIG Advisory Opinion No. 09-06.
OIG typically concludes that some or all aspects of the arrangement would constitute an improper payment under the CMP statute but that it would not seek sanctions.

OIG has provided favorable opinions to incentive plans for verifiable cost-savings from standardizing supplies or reducing administrative expenses as long as quality is not adversely affected and volume/case mix changes are not rewarded.

Product substitutions are found to implicate the CMP Statute.
# OIG Opinions

<table>
<thead>
<tr>
<th>OIG Opinion</th>
<th>Physicians eligible to participate</th>
<th>Source of savings</th>
<th>Distribution of savings</th>
</tr>
</thead>
</table>
| 05-01       | Cardiac surgeons                   | ▪ opening surgical supplies (trays and similar as needed)  
▪ blood cross-matching only as needed  
▪ substitution, in whole or in part, of less costly items  
▪ product standardization for certain cardiac devices | 50% of savings to the surgical group, who will then distribute to individual physicians |
| 05-02       | Multiple cardiology groups         | ▪ standardization of cardiac catheterization devices  
▪ use of certain vascular devices as needed | 50% of savings attributable to each specific group |
| 05-03       | Cardiac surgeons                   | ▪ opening surgical supplies (trays and similar) as needed  
▪ blood cross-matching only as needed | 50% of savings attributable to the group |
| 05-04       | Five cardiology groups             | ▪ standardization of cardiac catheterization devices  
▪ use of certain vascular devices as needed | 50% of savings attributable to each specific group |
## OIG Opinions (Continued)

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</thead>
</table>
| 05-05       | Cardiology Group                  | ▪ standardization of cardiac catheterization devices  
▪ use of certain vascular devices as needed | 50% of savings from curbing use or waste in current cardiac catheter lab practice |
| 05-06       | Cardiac Surgery Group             | ▪ opening surgical supplies (trays and similar as needed)  
▪ use of certain vascular devices as needed  
▪ substitution, in whole or in part, of less costly items  
▪ product standardization for certain cardiac devices | 50% of savings |
| 06-22       | Cardiac Surgery Group             | ▪ opening surgical supplies (trays and similar) as needed  
▪ substitution, in whole or in part, of less costly items  
▪ product standardization for certain cardiac devices | 50% of cost savings |
### OIG Opinions (Continued)

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<th>OIG Opinion</th>
<th>Physicians eligible to participate</th>
<th>Source of savings</th>
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</table>
| 07-21       | Cardiac Surgery Group            | opening disposable cell saver components only when excessive bleeding  
                                                         opening surgical supplies (trays and similar) as needed  
                                                         substitution, in whole or in part, of less costly items  
                                                         product standardization for certain cardiac devices | 50% of cost savings |
| 07-22       | Anesthesiology                   | limit the use of a specific drug and a device used to monitor patients' brain function to only as needed  
                                                         substitution, in whole or in part, of less costly items  
                                                         product standardization for certain fluid warming hot lines used in cardiac surgical procedures | 50% of cost savings |
| 08-09       | Orthopedic surgery groups        | limiting use of bone morphogenetic protein to as needed  
                                                         standardize the use of certain spine fusion devices and supplies where medically appropriate | No more than 50% of savings |
OIG Opinions (Continued)

<table>
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<th>OIG Opinion</th>
<th>Physicians eligible to participate</th>
<th>Source of savings</th>
<th>Distribution of savings</th>
</tr>
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</table>
| 08-15       | Two cardiology groups              | ▪ standardization of cardiac catheterization devices  
▪ use of certain vascular devices as needed  
▪ substitution for less costly antithrombotic medications | Share of savings for three years |
| 08-21.2     | Four cardiology groups, one radiology group | ▪ standardization of cardiac catheterization devices  
▪ Use of certain vascular devices as needed  
▪ Substitution for less costly contrast agents and antithrombotic medications | Share of savings for two years |
| 09-06       | Cardiology group, vascular surgical group, interventional radiology group | ▪ Standardize the types of cardiac catheterization devices and supplies (stent, balloons, interventional guidewires and catheters, vascular closure devices, diagnostic devices, pacemakers, and defibrillators) | 50% of savings, separately for each group |
| 12-22       | One cardiology group (only group within 50 miles) | ▪ standardization of cardiac catheterization devices  
▪ Substitution for less costly contrast agents and antithrombotic medications | Co-management fee composed of fixed portion and performance fee; performance fee composed of (1) results of satisfaction surveys, (2) quality measures and (3) cost reduction |
Factors Important to the OIG

- Commercially reasonable/FMV compensation based on independent appraisal
- Cost savings tied to specific protocol/cost shavings activity. Must be measured on basis of existing volume (no incentive to change volume)
- Ensure quality is measured and maintained
- Transparency and disclosure to patients
- Monitor change in case mix (protect against steering away more costly patients)
Gainsharing Distribution to Physicians

- Each patient is assigned to one practitioner who takes financial responsibility for the care of the patient.
- Gainsharing payments are capped according to CMS policy at 25% of the physician’s affiliated Part B reimbursements.
Selection of Performance Measures

- Shared savings measures vs. quality measures
  - Shared savings measures may provide more flexibility in program design (quality measures may need to be listed in CMS Specifications Manual for National Hospital Quality Measures)
  - Shared savings may create more uncertainty under CMP Statute
  - May also have limits with shared savings measures (e.g., CMS proposal to limit payment to 50% of savings over base year, and/or restrictions on amount of savings paid per year in multi-year contracts)
  - Physicians may gravitate to shared savings over using quality measures
Selection of Performance Measures

- Performance measures must be supported by "credible medical evidence"
- Payment may not be based on reduction in hospital stays
- Role of third-party payor important (e.g., payor may establish quality incentive under hospital payor agreement that cannot be achieved without assistance of medical staff)
- Measures must not be a sham or reflect payments for referrals
Physician Choice of Treatment

- Program may not limit physicians’ ability to make medically appropriate patient decisions.
- Program may condition payment on a certain physician choice, but hospital must allow access to same supplies and devices as available before.
- Physicians must be able to use new technology that meets same FDA and Medicare coverage decisions as items/supplies included in program.
- Physicians should not receive payments involving a product with respect to which the physician has an investment interest or consulting contract.
- Disclose any conflicts-of-interest.
Selection of Physicians

- May not select physicians based on the volume/value of referrals
- Potential physician concerns over selection process:
  - May limit participation to a specialty or department (but if all will participate, some physicians may benefit from efforts of others)
- Hospitals should not use program to induce physicians from other hospitals to join staff - must be a member of medical staff at onset of program
Physician Self-Referral Law (Stark):

- The Stark Law prohibits physicians from referring Medicare and Medicaid patients to entities with which the physician has a financial relationship unless the activity falls within a regulatory exception.
- Most gainsharing programs include a financial relationship between the hospital and physicians to which physicians are referring patients for inpatient or outpatient hospital services.
- As a result, the gainsharing program must meet a Stark exception.
- Stark is a strict liability statute and does not require intent for a violation.
- A violation can result in up to a $15,000 fine, damages up to three times the fine, and exclusion from participating in Medicare and Medicaid.
Proposed Stark Exception for Incentive Payments and Shared Savings Plans

- CMS proposed new exception for incentive payments and shared savings plans.
- The proposed exception would permit remuneration by a hospital to physicians on its medical staff.
- See 73 Fed. Reg. 38548 (July 7, 2008); see also 73 Fed. Reg. 69793 (Nov. 19, 2008)
Proposed Stark Exception

- 16 standards
- Similarities to factors found in favorable OIG advisory opinions.
- Quality measures must be listed on CMS’ Specification Manual for National Hospital Quality Measures
- Applies to “cost savings resulting from reduction in waste or changes in physician or clinical practices”
- Performance measures to be judged against baseline historic and clinical data
Proposed Stark Exception

- At least 5 physicians must participate in each performance measure – service line may have less than 5 physicians.
- Independent medical review prior to commencement and annually thereafter
- Physicians must have access to same selection of items as before commencement of program – implications of standardization initiatives – ties between doctors and pharma or device companies could impact clinical decisions
- Targets developed by comparing to national/regional performance norms – may not be available benchmarks
Proposed Stark Exception

- Term of no less than 1 nor more than 3 years
- Re-basing – cannot periodically rebase standards or pay for “maintenance” of quality/efficiency gains
- Remuneration set in advance and cannot change during term – no opportunity to set new performance standards and reappraise during multi-year agreement
Proposed Stark Exception

- Proposed exception not finalized
- The public was critical of the proposed exception as not guarding against program or patient abuse. The industry criticized the proposal as unhelpful.
- The 2009 MPFS Final Rule reopened the comment period and solicited comments on specific areas.
Existing Stark Exceptions

- Can existing exceptions protect a gainsharing arrangement?
- The PSA and FMV exceptions contain requirement that compensation be FMV and “set in advance” and not vary with volume/value of referrals
- “Set in advance” permits a specific formula that is set in advance, can be objectively verified and does not vary with volume/value of business generated (e.g., fixed payment for objective quality metrics)
- Percentage compensation arrangements can “be set in advance”
Special Considerations for Risk-Based Contracts

- Physician incentive arrangements related to Medicare risk-based managed care contracts, similar Medicaid contracts, and Medicare Advantage plans are subject to CMS regulation under sections 1876(i)(8), 1903(m)(2)(A)(x), and 1852(j)(4) of the Act (respectively).

- For further guidance on risk-based contracts see the OIG letter regarding hospital-physician incentive plans for Medicare and Medicaid beneficiaries enrolled in managed care plans (dated August 19, 1999), available on the OIG’s website.

- See also 42 C.F.R. § 417.479 (Medicare HMOs or competitive medical plans); 42 C.F.R. § 422.208 (Medicare Advantage plans); 42 C.F.R. § 438.6 (Medicaid risk plans).
Tax-Exempt Considerations

- No inurement, private benefit or excess benefits
  - Reasonable compensation (base fee, each component of bonus fee, and in aggregate)
    - Not based on service-line net earnings
    - Members of medical staff are disqualified persons.
    - If co-manager overpaid, then excess benefit is awarded.
    - Tax first imposed on recipient (physicians) of 120% but up to 200% if not paid promptly.

- See Rev. Rul. 69-383 (the arrangement entered into between hospital and radiologist does not constitute inurement of net earnings to a private individual within the meaning of section 1.501(c)(3)-1(c)(2) of the regulations).
Tax-Exempt Considerations

- May achieve a rebuttable presumption of reasonable compensation under intermediate sanctions regulations
  - Board/committee obtains appropriate comparability data.
  - Members of Board/committee have no personal interest in the arrangement.
  - Board/committee approves the arrangement in advance w/o participation by any person with a conflict of interest.
  - Document basis for decision, approval date, members present, comparability data, and members recused.
  - Board reviews/approves documentation as being reasonable, accurate and complete
  - Shifts burden to IRS to disprove reasonableness.

- See IRC § 4958; 26 C.F.R. 53.4958 – IT et. seq.
Models and Demonstrations
Medicare Demonstration Project

- Began October 1, 2008
- Two sites: Beth Israel Medical Center in New York City and Charleston Area Medical Center in Charleston, West Virginia
  - BIMC continued participation through September 30, 2011 and CAMC elected to end participation as of December 31, 2009
- CAMC demonstration was limited to cardiac DRGs
March 28, 2011 Report to Congress

- Demonstration project is Secretary’s response to requirements under Section 5007(e)(3) of the Deficit Reduction Act of 2005 as amended by Section 3027 of the Affordable Care Act
  - Began October 1, 2008
  - Test and evaluate methods and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial performance with sharing of remuneration
Staff estimates savings as a result of reduction in length of stay resulting from:

- Use of electronic health records
- More efficient use of consults
- Improved communication and management of imaging choices
- Streamlining evidence based care through implementation of protocols
- Implementation of interdisciplinary rounds
- More efficient operating room management
- More appropriate use of intensive care unit beds
BIMC proposed a range of physician quality standards, which, if not met by individual physicians, would make them ineligible for the gainsharing bonus. These overall standards are as follows:

- Overall readmission rate within 7 days must not increase
- Adverse events and malpractice experience must not increase.
- Physicians must comply with available quality measures.

Complete evaluation results will be available through a report to Congress that is due in March 2013 and a final report to CMS that is due in December 2014.
Focused on cardiac DRGs.

CAMC anticipated that internal savings would be generated by the following initiatives:

- examination of practice differences,
- utilization of laboratory resources as needed,
- evaluation of product usage,
- increase in patient flow, and
- negotiation of lower prices for medical devices and supplies

The CAMC proposal did not propose Medicare savings and expects costs savings to be internal to the hospital.

CAMC proposed to measure physician care provided on several factors to ensure that quality of patient care remained the same. Worse performance on any of the following standards for an individual physician would make him or her ineligible to receive the gainsharing bonus:

- Readmission rates
- Repeat procedures
- Patient outcomes
- Major events during procedures
- Antithrombotic usage
Estimated savings are:

- Surgical costs reductions made via negotiated rates on devices and implants
- Reduced physician variation in practice patterns
- Reduction in infections, complications, and readmissions for cardiac and orthopedic procedures
Integrated Healthcare Association - Organization

- Statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in California; incorporated in 1997
- Actively convenes all healthcare parties for cross-sector collaboration on health care topics; administers regional and statewide programs; and serves as an “incubator” for pilot programs and projects
- Organized as a 501(c) (6) non-profit association; does not operate as a trade association
- Mission: to create breakthrough improvements in health care services for Californians through collaboration among key stakeholders
**Medicare Acute Care Episode (ACE) Demonstration**
- 2009- multi-year pilot with acute ortho/cardiac procedures
- Four southwestern states
- Savings/margin results

**Geisinger ProvenCare**
- Not-for-profit rural health system – like Kaiser
- Cardiac and maternity bundles
- Comprehensive process redesign
- Introduced concept of 90-day “warranty”
- Improved quality and efficiency, saved money

**Prometheus Payment**
- Acute conditions, chronic care and episodic procedures
- Focus on potentially avoidable complications especially chronic care
- Incorporates complex risk-adjustment methodologies
- Virtual bundle (global budget): no down-side risk 1st year
U.S. Bundled Payment Landscape

Center for Medicare and Medicaid Innovation (CMMI)
Bundled Payments for Care Improvement Initiative (BPCI)
- BPCI developed by CMMI through its statutory authority also established through the ACA
- Targets fee-for-service Medicare beneficiaries
- Tests several models of care

Medical Travel Programs
- Self-insured employers, bundled pricing for procedure episodes
- Employee and caregiver travel and lodging, copay/deductible’s often waived
- Cleveland Clinic, Mayo Clinic, Johns Hopkins, Geisinger, etc.
The Value of Bundled Payment

- **AHRQ Evidence Report/Tech Assessment #208:**
  - Bundled payment yields ≤ 10% decline in spending
  - Decreased utilization of services in the bundle by 5-15% through decreases in length of stay/utilization
  - Small changes in quality measures in both directions

- **Cutler and Ghosh, NE Journal of Medicine 3-22-12:**
  - Medicare’s 17 most expensive episodes, capped at 25th and 50th percentile regions = $4.7-10 billion annual in estimated savings.
  - Same cap to 245 episode types = $15-29 billion in annual estimated savings.
The Value of Bundled Payment

- **Why do it?**
  - Foster coordination across care settings, align incentives
  - Benefit from new opportunities to develop quality and service enhancements such as implementation of evidence-based care pathways
  - Bend the cost curve and reduce cost variability
  - Achieve administrative and gain sharing experience ahead of payer mandates
  - Increase revenue or offset losses through shared savings arrangements
IHA’s Bundled Payment Projects

- **Agency for Healthcare Research and Quality (AHRQ)*** Bundled Payment Demonstration
  - Grant awarded to IHA in September 2010
  - Period of performance: 2010-2013

- **Center for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement Initiative (BPCI)**
  - IHA as a facilitator convener with 5 hospitals
    Phase 1 – non-risk learning until June; Implementation July, 2013
  - Period of performance: 2013-2016

*This project was supported by grant number R18HS020098 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.*
IHA’s Bundled Payment Projects

AHRQ* Bundled Payment Demonstration Goals:

• Test feasibility/scalability of procedural episodes in the California delivery system and regulatory environment

  • Facilitate health plan and hospital/outpatient surgery contracting
  • HMO, Medicare Advantage, PPO, Medi-Cal
  • Develop 10 episode definitions (8 completed to date)
  • Contract Templates

• Evaluate results (RAND and UC Berkeley)
• Disseminate key takeaways and best practices

*This project was supported by grant number R18HS020098 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.
# Total Knee Replacement Definition

## Patient Qualification

For inclusion in the pilot, patient must be:
- Covered (as primary plan) by a participating employer and health plan on date of surgery
- Undergoing surgery provided by an orthopedic surgeon contracting to provide services under the pilot for the specific health plan
- Being admitted to a hospital contracting to provide services under the pilot for the specific health plan
- Over age 18 and under age 65
- Presenting for index procedure with an ASA rating of <3 (APR-DRG SOI level of 1 or 2)

Patients are excluded from the pilot when:
- Transferred at any time during initial hospital stay
- Primary coverage with participating employer and health plan ends at any time during the episode
- Clinical history demonstrates clinical condition of:
  - Active Cancer
  - HIV/AIDS
  - ESRD
- BMI is 40 or greater

## Index Procedure

<table>
<thead>
<tr>
<th>Index Procedure Code:</th>
<th>DRG:</th>
<th>Diagnosis Exclusions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This procedure must exist to trigger the episode.</td>
<td>Episode must map to one of these DRGs.</td>
<td>Diagnosis (any position) must NOT equal one of the following:</td>
</tr>
<tr>
<td>CPT:</td>
<td></td>
<td>714.0x—Rheumatoid Arthritis</td>
</tr>
<tr>
<td>- 27447—Arthroplasty, knee condyle and plateau, medical and lateral compartments</td>
<td>MS DRG 470</td>
<td>736.89—Other acquired deformities, lower limb</td>
</tr>
<tr>
<td></td>
<td>Major Joint Replacement or Reattachment of Lower Extremity without MCC</td>
<td>170.7—Malignant neoplasm of long bones of lower limb</td>
</tr>
<tr>
<td>ICD-9 Px:</td>
<td>AND</td>
<td>171.3—Malignant neoplasm of soft tissue, lower limb, hip</td>
</tr>
<tr>
<td>- 81.54—Total Knee replacement</td>
<td>APR DRG SOI of 1 or 2</td>
<td>198.5—Secondary malignant neoplasm of bone, marrow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>822, 823, 827, 828. 836, 891—Fractures, dislocations and open wounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>928—Crushing injury</td>
</tr>
</tbody>
</table>
Bundled Payment: Issues and Challenges in California

- Undoing capitation unrealistic
- Lack of physician leadership/solo practices
- Hospital drives the model – physicians are wary
- Care redesign is new and different
- Manual claims adjudication
- Regulatory oversight – Department of Managed Health Care (DMHC)
California Regulatory Oversight

PPO lines of business

DMHC

Blue Shield of CA

DOI

Aetna, Cigna
DMHC: Initial Concerns

- **Provider Risk**
  - Health plan pays the bundle to hospital; hospital pays all providers – no DMHC oversight/TNE requirements
  - Health plan oversight of hospitals with delegated risk, claims payment, grievances

- **Enrollee Communication**
  - Managing enrollee notification of program participation

- **Benefit Administration**
  - Will enrollee’s benefits, deductibles/copays remain unchanged?
  - Changes impact on the annual Evidence of Coverage
CMMI - Bundled Payments for Care Improvement Initiative

- Medicare fee-for-service beneficiaries
- National call for Letters of Intent – August 2011
- Initial four models, three year demonstration – July 2013
- Extend bundled price discounts to CMS, including risk adjustment and outlier payments
- *Barriers to gainsharing must be lifted*
| **Gainsharing** | • CMS will provide safe harbor against laws prohibiting gain sharing  
• Gainsharing bonuses up to 50% of physician’s Part B fee schedule  
• Gainsharing is an incentive to improve care, reduce cost per case and improve Medicare reimbursement |
| **Positive Results from Medicare’s ACE Demonstration** | • Immediate improvement in adherence to quality measures  
• Device standardization  
• Shift toward evidence based, standardized practice  
• Baptist Health saved $6.15M before distribution during the first 18 months |
| **Future CMS mandate?** | • Opportunity for leg-up over competition with physician alignment and operational adjustments  
• Gain experience implementing/tracking quality improvement efforts  
• Participation leads to greater physician/hospital collaboration ahead of a payment mandate |
## CMMI Bundled Payment Model

**Model 4**

| Payment Model                  | • Pre-determined price, prospectively paid to hospital by CMS  
  | • All providers paid by the hospital for bundled episode DRGs  
  | • Physicians that sign the letter of agreement will be eligible for gainsharing |
|-------------------------------|-------------------------------------------------------------------|
| Covered Services              | • Hospital Part A and Physician Part B charges  
  | • 30-day post discharge warranty period for related complications and hospital readmissions |
| Rate Setting                  | • Minimum 3.25% discount to CMS for ortho/cardiac DRGs  
  | • Risk adjustment and outlier payments included in CMS bundled price |
| Risk                          | • All Medicare fee-for-service beneficiaries  
  | • All care, including non-participating providers and hospitals  
  | • ESRD patients excluded |
| Gainsharing                   | • Allowed up to 50% of Part B fee schedule  
  | • Physician eligibility for bonus determined by performance against CMS quality benchmarks and additional physician benchmarks |
CMMI Quality Measures

CMS Standardized Set of Quality Measures

- Process Measures
- Patient Safety Measures
- Patient Satisfaction Measures
- Outcomes Measures
CMMI Bundled Payment Initiative
Gain Share Model  Flow of Funds

CMS

Participating Hospital

Trigger 1: Is there a fund surplus?

Trigger 2: Baseline performance met for CMS quality metrics?

Trigger 3: Benchmark performance met by physicians

Physicians
Gainsharing: Example Metrics to Physician Bonus

- Reduce 30 day readmission rates for hip, lower extremity joint replacement within 30 days of discharge – at or below benchmark target

- Improve HCAHPS score for Physician’s Communication aggregate

- Patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery – at or above benchmark target

- Patients who received prophylactic antibiotics recommended for their specific surgical procedure – at or above benchmark target

- Reduced orthopedic cost per case for DRGs 469 and 470
CMMI Physician Payment Process

**Patient Identification**
- Physician identifies FFS Medicare patient and performs the procedure

**Medicare Part B Payment**
- Physician submits Part B claims to hospital and CMS
- Hospital pays physician Medicare fee schedule

**Gainsharing**
- Is there a fund surplus?
- Quality and physician performance marks achieved?
- Hospital distributes gainshare payment to physician
Gainsharing: Payment Timeline

- Day 30 - Cost Data Complete
- Day 60 - Quality Data Reviewed
- Days 60 to 70 - Gainshare Amounts calculated
- Day 71 - List of Checks sent to TPA
- Day 70 - Physician Steering Committee Approve
- Day 90 - Checks Delivered to President
- Day 90 - Checks Delivered to Physicians

Project Kickoff

Courtesy of THE CAMDEN GROUP
Secure Federal Waivers

- OIG - Physician self referral law; anti-kickback statute
- Title 18 SSA - 20% coinsurance
- 3 day rule
- 1128 (a)(5) and (b)(7) SSA – beneficiary inducements
Review of FMV Considerations
Gainsharing Models

Model

What is it?

Pros

Cons

Demand Matching

Shared cost savings for supplies

Easily quantifiable

Limited effect on improvement in quality of care

Quality Gainsharing

Share reduction of expenses resulting from improved quality

Easily developed metrics, improved outcomes

Difficult to quantify
Business Considerations

- How is healthcare provided at a lower cost while maintaining a high standard of care?
  - Reduction in direct costs
    - Supplies and staffing costs
  - Better quality care resulting in lower utilization of current system (e.g., LOS) and reduced readmissions
    - More on-time starts and faster room turnover
    - Lower infection rates
    - Better documentation (EMR, coding)
    - Meeting national quality benchmark standards (e.g., AMI core measures)
  - Reduce drug adverse events
  - Reduce duplicate/marginal tests
Developing a Gainsharing Arrangement – Business Considerations

- **Service area covered**
  - Cardiology, orthopedic surgery, anesthesiology
  - Full surgical care

- **Physician participation**
  - Full participation may not occur at outset
  - Services provided on a group or individual basis

- **Setting metrics**
  - Developed independently or in conjunction with participating physicians
  - Goals are definable and measurable
    - Identifying comparable systems and accessing data

- **Measuring success**
  - Tools in-place to successfully track on a perpetual basis

- **Compensation once measures are achieved**
  - Compensation based on predefined goals (e.g., current cost per encounter) and allocation method (e.g., 50% of cost savings)
  - Incentive is weighted toward improvement at beginning and then moves toward performance relative to peer group
    - Weighting can be maintained to emphasize improvement
1. *Fair market value* means the value in arm’s-length transactions, consistent with the general market value.

2. “General market value” means the price that an asset would bring as the result of *bona fide* bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of *bona fide* bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.
Usually, the fair market price is the price at which *bona fide* sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in *bona fide* service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.

With respect to rentals and leases described in § 411.357(a), (b), and (l) (as to equipment leases only), “fair market value” means the value of rental property for general commercial purposes (not taking into account its intended use). In the case of a lease of space, this value may not be adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor when the lessor is a potential source of patient referrals to the lessee. For purposes of this definition, a rental payment does not take into account intended use if it takes into account costs incurred by the lessor in developing or upgrading the property or maintaining the property or its improvements.
FMV Considerations

- Comparison to appropriate base of comparable hospitals
- Appropriately calculating cost savings per encounter
- Assigning to a single physicians to avoid double payment
Time spent by physicians on various tasks necessary to improve quality of care and reduce cost of care, including but not limited to:

• Researching medical device and pharmaceutical use, cost, and alternatives
• Educating patients and staff on medical devices and pharmaceuticals
• Reviewing with patients procedure and post procedure care (including patient follow up)
• Developing evidence based protocols / pathways
• Creating / Reviewing / Approving dashboard quality and strategic benchmarks
• Reviewing complications and developing strategies to improve
FMV Considerations

- Relationship to all other agreements with a physician:
  - Clinical staffing agreement
  - Call coverage agreements
  - Medical directorship agreements
  - Department/division chair agreements
  - Physician lease/lease-back agreements

- Allocation of value among participating physicians within a medical group

- Engagement of valuator by counsel to obtain benefit of attorney-client privilege to facilitate discussion of preliminary issues without waiving privilege
Shared Savings Criteria

Incentive Compensation

Quality
- Quality Goals Achieved
- Quality Goals Missed

Cost
- Cost Target Achieved
- Cost Target Missed

Base Compensation: Hospital and Physicians
- Geometric Mean

Patient Encounter: DRG 440

GI Medical

Patient Encounter: DRG 440

Base Compensation: Hospital and Physicians
- Geometric Mean

Cost
- Cost Target Achieved
- Cost Target Missed

Quality
- Quality Goals Achieved
- Quality Goals Missed

No Shared Savings

Shared Savings

No Shared Savings

• Review basis for miss
**Report for Dr. John Doe – Attending Physician**

**GI Medical Bundle**

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**TOTALS**

|               | $80,852 | $95,136 | $14,284 |

**ELIGIBLE SAVINGS**

|               | $11,644 |

Gray indicates savings eligibility

Indicates a mortality. Even though savings were generated, and this case they will be excluded from distribution.

Cost and quality measures must be met for savings to be distributed. These cases are excluded from eligible savings, and any savings generated will go back to Hospital.

**Attending Physician (30%)** $3,493.20

**Hospital (50%)** $5,822.00

**Consultant (20%)** $2,328.80

**TOTAL PAYOUT:** $11,644
Questions & Comments

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