Structuring Gainsharing Arrangements and Bundled Payments: Latest Developments
Complying With Legal and Regulatory Requirements, Overcoming Implementation and Operational Challenges

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1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today’s faculty features:

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William T. Mathias, Principal, Ober | Kaler, Baltimore

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Gainsharing Arrangements and Bundled Payments: Latest Developments
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
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.
Underlying Goals & Motivation

- **Underlying Goals**
  - Improve quality of care
  - Control costs

- **Underlying Motivation**
  - Money drives performance
  - Aligning Financial Incentives
    - Hospitals & Physicians
    - Acute & Post-acute Providers
Legal Considerations

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Applicable Laws

- Anti-kickback statute
- Civil money penalty (CMP) against hospital payments to reduce or limit services
- Stark physician self-referral law
Fundamental Criteria for Evaluating Gainsharing & Bundled Payments

- Additional Cost
- Over, Under, and Mis-Utilization
- Quality of Care
- Access to Care
- Patients’ Freedom of Choice
- Competition
- Exercise of Professional Judgment
Federal anti-kickback law generally prohibits the provision of any economic benefit in exchange for the referral of patients or business that will be reimbursed under any Federal health care program.

42 U.S.C. § 1320a-7b(b).
Penalties

- Criminal fines & imprisonment
- Civil money penalty of $50,000 plus 3X the amount of the remuneration
- Exclusion
- False Claims Act liability
Anti-Kickback Statute

- Prohibited Conduct
  - Knowing & willful
  - Solicitation or receipt -or-
  - Offer or payment of
  - Remuneration – directly or indirectly, overtly or covertly, in cash or in kind
  - For referring patient -or-
  - For inducing the purchase or lease of items or services -or-
  - For arranging for or recommending the purchase or lease of items or services
  - Paid for by a Federal health care program
Prohibited Conduct

- Hospital (or critical access hospital)
- knowingly
- making payments, *directly or indirectly*
- to physician
- as an inducement to reduce or limit services
- to Medicare (Parts A or B) or Medicaid patients
- under the physician’s direct care

42 USC 1320a-7a(b)
CMP – Reduce or Limit Services

- **Penalties**
  - CMP of $2,000 per patient covered by the improper payment
  - Both Hospital and Physician liable

- **Enforcement**
  - OIG discretion
  - No private right of action
OIG’s Implementation

• No regulations implementing CMP
• A proposed rule issued but never adopted
• July 1999 Special Advisory Bulletin
• OIG ignores whether current medical practices at hospital are consistent with what is medically necessary
  • Any effort to induce physicians to reduce or limit current medical practices at the hospital (including medically unnecessary care) may violate the CMP.
Avenues for Avoiding CMP

- Payment not made by hospital
- Payment not made to physician
- Payment unrelated to reducing or limiting services
- Payment does not apply to patients covered under Medicare (Parts A or B) or Medicaid
- Payment does not cover patients under the physician’s direct care
The federal Stark physician self-referral law generally prohibits a physician from making referrals to an entity for any of eleven (11) designated health services if the physician (or an immediate family member) has a “financial relationship” with the entity.

- 42 U.S.C. § 1395nn
Stark Law

- Penalties
  - Denial of Payment (from anyone)
  - $15,000 per service
  - 2X damages
  - Exclusion
  - False Claims Act liability
Stark Law

- Physician may not refer:
  - Medicare [or Medicaid] patients
  - For “designated health services”
  - to an entity with which the physician or
  - an immediate family member has
  - a “financial relationship”
    - Ownership interest – through equity or debt
    - Compensation arrangement
  - Unless the relationship fits in an exception
Stark Law

- Relevant exception:
  - Employment
  - Personal services arrangement
  - Fair market value
  - Indirect compensation arrangement
  - Risk sharing arrangement
Stark Law

- Avenues for Avoiding Stark Law
  - Payment not made by hospital or other DHS entity
  - Payment not made to physician (or immediate family member)
Special Advisory Bulletin on Gainsharing

- 64 Fed. Reg. 37,985 (July 14, 1999)
- OIG said: “appropriately structured gainsharing arrangements may offer significant benefits.”
- OIG initially understood to say that all gainsharing arrangements between hospitals and physicians were impermissible
  - Violated CMP against hospital payments to reduce or limit services
- OIG said it could not provide “any regulatory relief ... absent further authorizing legislation.”
Gainsharing Advisory Opinions

- OIG has issued a series of advisory opinions on gainsharing
- OIG acknowledged: “Properly structured, arrangements that share cost savings can serve legitimate business and medical purposes.”
Gainsharing Advisory Opinions

- OIG Concerns:
  - Stinting on patient care
  - “Cherry picking” healthy patients and steering sicker (and more costly) patients to hospitals that do not offer payment
  - Payments to induce patient referrals
  - Unfair competition among hospitals offering payments to foster physician loyalty and to attract more referrals (a “race to the bottom”)
<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>
<tbody>
<tr>
<td>05-01</td>
<td>Cardiac surgeons</td>
<td>▪ opening surgical supplies (trays and similar as needed)</td>
<td>50% of savings to the surgical group, who will then distribute to individual physicians</td>
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<td></td>
<td></td>
<td>▪ blood cross-matching only as needed</td>
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<td></td>
<td></td>
<td>▪ substitution, in whole or in part, of less costly items</td>
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<td></td>
<td></td>
<td>▪ product standardization for certain cardiac devices</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>50% of savings attributable to each specific group</strong></td>
<td></td>
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<tr>
<td>05-02</td>
<td>Multiple cardiology groups</td>
<td>▪ standardization of cardiac catheterization devices</td>
<td>50% of savings attributable to each specific group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ use of certain vascular devices as needed</td>
<td></td>
</tr>
<tr>
<td>05-03</td>
<td>Cardiac surgeons</td>
<td>▪ opening surgical supplies (trays and similar as needed)</td>
<td>50% of savings attributable to the group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ blood cross-matching only as needed</td>
<td></td>
</tr>
<tr>
<td>05-04</td>
<td>Five cardiology groups</td>
<td>▪ standardization of cardiac catheterization devices</td>
<td>50% of savings attributable to each specific group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ use of certain vascular devices as needed</td>
<td></td>
</tr>
<tr>
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</tbody>
</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 |
<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>
<tbody>
<tr>
<td>07-21</td>
<td>Cardiac Surgery Group</td>
<td>▪ opening disposable cell saver components only when excessive bleeding&lt;br▪ opening surgical supplies (trays and similar) as needed&lt;br▪ substitution, in whole or in part, of less costly items&lt;br▪ product standardization for certain cardiac devices</td>
<td>50% of cost savings</td>
</tr>
<tr>
<td>07-22</td>
<td>Anesthesiology</td>
<td>▪ limit the use of a specific drug and a device used to monitor patients’ brain function to only as needed&lt;br▪ substitution, in whole or in part, of less costly items&lt;br▪ product standardization for certain fluid warming hot lines used in cardiac surgical procedures</td>
<td>50% of cost savings</td>
</tr>
<tr>
<td>08-09</td>
<td>Orthopedic surgery groups&lt;brNeurosurgery group</td>
<td>▪ limiting use of bone morphogenetic protein to as needed&lt;br▪ standardize the use of certain spine fusion devices and supplies where medically appropriate</td>
<td>No more than 50% of savings</td>
</tr>
<tr>
<td>OIG Opinion</td>
<td>Physicians eligible to participate</td>
<td>Source of savings</td>
<td>Distribution of savings</td>
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<td>-------------</td>
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</tr>
<tr>
<td>08-15</td>
<td>Two cardiology groups</td>
<td>▪ standardization of cardiac catheterization devices&lt;br&gt;▪ use of certain vascular devices as needed&lt;br&gt;▪ substitution for less costly antithrombotic medications</td>
<td>Share of savings for three years</td>
</tr>
<tr>
<td>08-21.2</td>
<td>Four cardiology groups&lt;br&gt;One radiology group</td>
<td>▪ standardization of cardiac catheterization devices&lt;br&gt;▪ Use of certain vascular devices as needed&lt;br&gt;▪ Substitution for less costly contrast agents and antithrombotic medications</td>
<td>Share of savings for two years</td>
</tr>
<tr>
<td>09-06</td>
<td>Cardiology group&lt;br&gt;Vascular surgical group&lt;br&gt;Interventional radiology group</td>
<td>▪ Standardize the types of cardiac catheterization devices and supplies (stent, balloons, interventional guidewires and catheters, vascular closure devices, diagnostic devices, pacemakers, and defibrillators)</td>
<td>50% of savings, separately for each group</td>
</tr>
<tr>
<td>12-22</td>
<td>One cardiology group (only group within 50 miles)</td>
<td>▪ standardization of cardiac catheterization devices&lt;br&gt;▪ Substitution for less costly contrast agents and antithrombotic medications</td>
<td>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</td>
</tr>
</tbody>
</table>
Gainsharing AO Safeguards

- **Identified Cost Savings.** Specific cost-saving actions and resulting savings were clearly and separately identified to allow public scrutiny and individual physician accountability.

- **Credible Medical Support.** Credible medical support that cost savings recommendations would not adversely affect patient care. Plus, periodic reviews of impact on clinical care.
Gainsharing AO Safeguards

- **Limited Impact on Federal Health Care Programs.** Payments based on surgeries regardless of payor. Federal health care program procedures subject to cap. Cost savings based on actual acquisition costs.

- **Protections Against Inappropriate Reductions in Service.** Baseline thresholds established through the use of objective historical and clinical measures to protect against inappropriate reductions in service.
Gainsharing AO Safeguards

- **Savings from Inherent Clinical and Fiscal Value.** Savings from product standardization based on “inherent clinical and fiscal value.” Physicians would have access to the same selection of devices.

- **Patient Disclosure.** Hospital and the physician groups provide patients with written disclosures about the arrangements.
Gainsharing AO Safeguards

- **Limits on Incentives.** Financial incentives reasonably limited in duration, amount, and scope.

- **Protections Against Disproportionate Cost Savings.** Physician groups distribute profits on a per capita basis, thus limiting any incentive for individual physicians to generate disproportionate cost savings.
Factors Important to OIG

- Commercially reasonable/FMV compensation based on independent appraisal
- Cost savings tied to specific protocol/cost savings activity. Measured based on 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)
Not limit physician’s ability to make medically appropriate patient decisions

May condition payment on certain physician choice, but must allow access to same supplies and devices as available previously

Not induce physicians from other hospitals to join medical staff – must be a member of medical staff at outset of program
ACO Waivers

- Waivers – CMS and OIG Interim Final Rule
  - 5 separate fraud and abuse waivers that may be used by entities participating in Medicare Shared Savings Program (MSSP)
  - Satisfying a waiver provides protection from
    - Stark self-referral law
    - Anti-kickback law
    - Gainsharing CMP
    - Certain applications of CMP for inducements to beneficiaries
Final Words of Advice

“Be careful out there”
Models and Demonstrations

Joane Goodroe, RN, BSN, MBA, Goodroe Healthcare Services, LLC, (770) 441-3195, jgoodroee@jgoodroe.com
Examples of Two Types of Gainsharing

**Gainsharing OIG Approvals**
- 14 approvals – same model for different specialties
  - Cardiac Surgery, Interventional Cardiology, EP, Ortho/Spine, Anesthesia: supplies & drugs
  - Gainsharing: Up to 50% of Savings Identified

**CMS Bundled Payment Gainsharing**
- 4 models: Acute & Post Acute Savings
  - General Medical and Surgical Services: All costs
  - Gainsharing: Up to 50% of Professional Fee
Use Disposable Products Only As Needed for Each Procedure

Change Processes to Utilize Less Quantity of a Product or Substitute a Less Costly Product to Achieve the Identical Result

Change Processes to Limit Use of Products to Medically Indicated Clinical Circumstances

Three Categories with Monitoring of Quality, Cost and Utilization
Steps in Gainsharing

1. Measure current cost, quality and utilization.
2. Identify and Quantify Waste Reduction Opportunities
3. Prepare Hospital’s & MD Contracts by Group
4. Develop Specific Work Plan with Physicians to Reduce Costs
5. Provide Quarterly Performance Reviews and Benchmarks – know how much has been saved
6. Payment to Physicians at the end of One Year
Flow of Funds

Savings Opportunities Identified

$1,000,000

Opportunities Realized (90%)

$900,000

50%

50%

Hospital

$450,000

(MDs)

$450,000
$1,000,000 of Identified Opportunity

GROUP A
Total Opportunity For Savings
60%
$600,000
Actual Savings $400,000

GROUP B
Total Opportunity For Savings
30%
$300,000
Actual Savings $300,000

GROUP C
Total Opportunity For Savings
10%
$100,000
Actual savings $50,000
Money Saved at the End of the Year

GROUP A
- Actual Savings: $400,000
- Payment to Group: $200,000

GROUP B
- Actual Savings: $300,000
- Payment to Group: $150,000

GROUP C
- Actual Savings: $50,000
- Payment to Group: $25,000
OIG Gainsharing Program

CAN NOT:

- Pay for Future Volume/Value of Referrals
- Pay a Physician for Individual Performance
- Pay for Historical Performance
- Pay a Physician if Quality or Severity Decreases
- Exclude “Qualified” Physicians
- Pay Physicians an Unlimited Amount of Money
Opportunity by Physician Group

- Each group’s opportunity is dependent on the cost they control.

- Case types have different levels of cost.

- Opportunities for cost reduction are based on the types of cases the group performs and how many cases
Knee Implant Cost per Case When Standardization Had Already Occurred
Example of OIG Submitted List: Knee Replacement

<table>
<thead>
<tr>
<th>ITEM</th>
<th>SAVINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee Implants</td>
<td>$989</td>
</tr>
<tr>
<td>Suture Routine</td>
<td>$11.68</td>
</tr>
<tr>
<td>1000 Drape</td>
<td>$2.59</td>
</tr>
<tr>
<td>Disposable Tourniquet</td>
<td>$17.59</td>
</tr>
<tr>
<td>Instrument Pouch</td>
<td>$4.03</td>
</tr>
<tr>
<td>Gown and Hood</td>
<td>$73.28</td>
</tr>
<tr>
<td>Bone Cement</td>
<td>$70.44</td>
</tr>
<tr>
<td>Reinfusion Unit</td>
<td>$135.53</td>
</tr>
<tr>
<td>Foley Catheter</td>
<td>$9.16</td>
</tr>
<tr>
<td>Proximate</td>
<td>$5.77</td>
</tr>
<tr>
<td>Plastic Boots</td>
<td>$3.47</td>
</tr>
<tr>
<td>Freight</td>
<td>$19.27</td>
</tr>
<tr>
<td>Osteonics Burr</td>
<td>$3.73</td>
</tr>
<tr>
<td>Saw Blades</td>
<td>$20.92</td>
</tr>
<tr>
<td>Dressings</td>
<td>$22.67</td>
</tr>
<tr>
<td>Whitney Curette</td>
<td>$20.03</td>
</tr>
</tbody>
</table>
### CMS Bundled Payment / Innovation

<table>
<thead>
<tr>
<th>Payment of Bundle</th>
<th>Acute Care Stay Only</th>
<th>Acute plus Post Acute</th>
<th>Post Acute Only</th>
<th>Chronic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retrospective Traditional:</strong> payment with retrospective adjustment based on target</td>
<td>Model 1</td>
<td>Model 2</td>
<td>Model 3</td>
<td>Model 7</td>
</tr>
<tr>
<td><strong>Prospective:</strong> Single payment for episode in lieu of FFS</td>
<td>Model 4</td>
<td>Model 5</td>
<td>Model 6</td>
<td>Model 8</td>
</tr>
<tr>
<td>CMS BUNDLED PAYMENT EPISODES</td>
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<td></td>
<td></td>
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<tr>
<td>Acute myocardial infarction</td>
<td>Diabetes</td>
<td>Other respiratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AICD generator or lead</td>
<td>Double joint replacement of the lower extremity</td>
<td>Other vascular surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amputation</td>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
<td>Pacemaker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atherosclerosis</td>
<td>Fractures of the femur and hip or pelvis</td>
<td>Pacemaker device replacement or revision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back &amp; neck except spinal fusion</td>
<td>Gastrointestinal hemorrhage</td>
<td>Percutaneous coronary intervention</td>
<td></td>
<td></td>
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<tr>
<td>Coronary artery bypass graft</td>
<td>Gastrointestinal obstruction</td>
<td>Red blood cell disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>Hip &amp; femur procedures except major joint</td>
<td>Removal of orthopedic devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac defibrillator</td>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
<td>Renal failure</td>
<td></td>
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<tr>
<td>Cardiac valve</td>
<td>Major bowel procedure</td>
<td>Revision of the hip or knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Major cardiovascular procedure</td>
<td>Sepsis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical spinal fusion</td>
<td>Major joint replacement of the lower extremity</td>
<td>Simple pneumonia and respiratory infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>Major joint replacement of the upper extremity</td>
<td>Spinal fusion (non-cervical)</td>
<td></td>
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</tr>
<tr>
<td>Combined anterior posterior spinal fusion</td>
<td>Medical non-infectious orthopedic</td>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex non-cervical spinal fusion</td>
<td>Medical peripheral vascular disorders</td>
<td>Syncope &amp; collapse</td>
<td></td>
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</tr>
<tr>
<td>Congestive heart failure</td>
<td>Nutritional and metabolic disorders</td>
<td>Transient ischemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>Other knee procedures</td>
<td>Urinary tract infection</td>
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</tr>
</tbody>
</table>
Bundled Payments: Two different opportunities for gainsharing with physicians

**Inpatient**
- Based on measured internal cost savings – can calculate ongoing
- Can measure each MD’s work
- Reward individual effort

**Post Acute**
- Quarterly Reconciliation Report from CMS
- Enormous Variation in Patient Needs
- Reward specialty effort
Two Separate Tracks

Inpatient

- Orthopedic Procedure Admission
  - Gainsharing can be MD Specific
    - Orthopedic MDS
      - Decrease supply costs
      - Other identified costs savings
    - Other MDs
      - Anesthesia
      - General Medicine

Post Acute

- Category Specific (i.e. Ortho, General Med, etc)
  - Multiple MDS
    - Ortho
    - General Medicine and Others
      - Change in Post Acute Dollars
      - Change in Post Acute Dollars
Example of Post Acute Gainsharing

Gainsharing Activities

Outcomes of Chronic Medical Patients

- Readmission Rate Improvement
- Decrease in SNF utilization
Example of Post Acute Gainsharing Calculation

**Readmission & SNF Net Savings**
- $1,000/patient

**Chronic Patient Volume in Bundled Payment**
- 500

**Total Savings**
- $500,000

Total Savings = 500 x $1000 = $500,000
Review of FMV Considerations

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

GI Medical

Patient Encounter: DRG 440

Base Compensation: Hospital and Physicians

- Geometric Mean

Incentive Compensation

Quality

Quality Goals Achieved

Quality Goals Missed

Cost

Cost Target Achieved

Cost Target Missed

- Review basis for miss

No Shared Savings

Shared Savings

No Shared Savings
### Savings Calculation

**Report for Dr. John Doe – Attending Physician**

**GI Medical Bundle**

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<th>DRG</th>
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<th>Target Cost</th>
<th>Savings</th>
<th>LOS &lt; GMLOS</th>
<th>Order Set Used</th>
<th>30 Day Readmission (same MDC)</th>
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**TOTALS**

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**ELIGIBLE SAVINGS**

- 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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