Structuring Gainsharing Arrangements and Bundled Payments: Latest Developments

Complying With Legal and Regulatory Requirements, Overcoming Implementation and Operational Challenges

THURSDAY, DECEMBER 10, 2015

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

- Discussion of problems that gainsharing and bundled payment are trying to address
- 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

- Misalignment of incentives between hospitals and physicians
- Hospitals and physicians are generally paid separately for care provided in hospitals
- Physicians often control the use of supplies and selection of devices, but these items are paid for by hospitals
  - No financial incentive for physicians to provide more efficient care and decreasing hospital costs.
- Gainsharing is contractual arrangement that allows hospitals and physicians to share cost savings from increased efficiency.
Bundled payment is a single, fixed payment for a package of services delivered by multiple providers during an episode of care.

- For example, in 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 arrangements often include gainsharing.

ACO model differs because it is focused on care provided to 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, directed or indirectly
- to physician
- as an inducement to reduce or limit MEDICALLY NECESSARY 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

- Big change
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
    - Signed April 16, 2015
    - OIG previously interpreted CMP to apply to any effort to induce physicians to reduce or limit current medical practices at the hospital (including medically unnecessary care)
    - MACRA Limits the CMP to MEDICALLY NECESSARY services
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
Avenues for Avoiding CMP

- Payment limits medically unnecessary care
  - What is medically unnecessary?
- Payment not made by hospital
- Payment not made to physician
- 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)
    - Create entity
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”)
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.
  - Key under CMP changes
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)
Factors Important to OIG

- 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
Various Models

- Traditional Gainsharing
- Clinical Co-management Arrangements
- Bundled Payments
  - Bundled Payments for Care Improvement (BPCI) program
  - Comprehensive Care for Joint Replacement (CJR) program
- ACOs
- Clinically Integrated Networks
- Population Health
Models and Demonstrations

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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**
- BPCI & CJR: Acute & Post Acute Savings
- General Medical and Surgical Services: All costs
- Gainsharing: Up to 50% of Professional Fee
OIG Gainsharing Opportunities

Three Categories with Monitoring of Quality, Cost and Utilization

1. Use Disposable Products Only As Needed for Each Procedure
2. Change Processes to Utilize Less Quantity of a Product or Substitute a Less Costly Product to Achieve the Identical Result
3. Change Processes to Limit Use of Products to Medically Indicated Clinical Circumstances
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
Savings Opportunities Identified

$1,000,000

Opportunities Realized (90%)

$900,000

50%

Hospital

$450,000

50%

(MDs)

$450,000

50%

$900,000

Flow of Funds
$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>
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<th>ITEM</th>
<th>SAVINGS</th>
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<tr>
<td>Knee Implants</td>
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<td>Suture Routine</td>
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<td>1000 Drape</td>
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<td>Disposable Tourniquet</td>
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<td>Instrument Pouch</td>
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<td>Gown and Hood</td>
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<td>Reinfusion Unit</td>
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<td>Foley Catheter</td>
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<td>Proximate</td>
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<td>Plastic Boots</td>
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<td>Saw Blades</td>
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<td>Dressings</td>
<td>$22.67</td>
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<td>Whitney Curette</td>
<td>$20.03</td>
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### CMS Bundled Payment / Innovation

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<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>
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<td><strong>Retrospective</strong></td>
<td><strong>Model 1</strong></td>
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<tr>
<td>retrospective</td>
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<tr>
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<td>based on target</td>
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<td><strong>Prospective:</strong></td>
<td><strong>Model 4</strong></td>
<td><strong>Model 5</strong></td>
<td><strong>Model 6</strong></td>
<td><strong>Model 8</strong></td>
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<td><strong>Single payment</strong></td>
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<tr>
<td>lieu of FFS</td>
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<tr>
<td>CMS BUNDLED PAYMENT EPISODES</td>
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<tr>
<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>
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<td>AICD generator or lead</td>
<td>Double joint replacement of the lower extremity</td>
<td>Other vascular surgery</td>
<td></td>
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<tr>
<td>Amputation</td>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
<td>Pacemaker</td>
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<tr>
<td>Atherosclerosis</td>
<td>Fractures of the femur and hip or pelvis</td>
<td>Pacemaker device replacement or revision</td>
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<td>Back &amp; neck except spinal fusion</td>
<td>Gastrointestinal hemorrhage</td>
<td>Percutaneous coronary intervention</td>
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<tr>
<td>Coronary artery bypass graft</td>
<td>Gastrointestinal obstruction</td>
<td>Red blood cell disorders</td>
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<tr>
<td>Cardiac arrhythmia</td>
<td>Hip &amp; femur procedures except major joint</td>
<td>Removal of orthopedic devices</td>
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<tr>
<td>Cardiac defibrillator</td>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
<td>Renal failure</td>
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<td>Cardiac valve</td>
<td>Major bowel procedure</td>
<td>Revision of the hip or knee</td>
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<td></td>
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<tr>
<td>Cellulitis</td>
<td>Major cardiovascular procedure</td>
<td>Sepsis</td>
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<tr>
<td>Cervical spinal fusion</td>
<td>Major joint replacement of the lower extremity</td>
<td>Simple pneumonia and respiratory infections</td>
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<tr>
<td>Chest pain</td>
<td>Major joint replacement of the upper extremity</td>
<td>Spinal fusion (non-cervical)</td>
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<td>Combined anterior posterior spinal fusion</td>
<td>Medical non-infectious orthopedic</td>
<td>Stroke</td>
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<tr>
<td>Complex non-cervical spinal fusion</td>
<td>Medical peripheral vascular disorders</td>
<td>Syncope &amp; collapse</td>
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<tr>
<td>Congestive heart failure</td>
<td>Nutritional and metabolic disorders</td>
<td>Transient ischemia</td>
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<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>Other knee procedures</td>
<td>Urinary tract infection</td>
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</tbody>
</table>
Mandatory for 800 hospitals

- MS-DRG 469 & 470
- 90 days
- Implement: January 1, 2016
- 5 yrs
  Target 2% savings from Baseline
CMS Gainsharing Parameters

Must be able to track cost and quality

Reward individual physician for work

Pay physicians up to 50% of their professional fee for quality and cost savings

Professional fee + 50% (gainsharing)
Ex: $1,800 professional + $900 gainsharing
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
- Determine how to divide total savings
Two Separate Tracks

Inpatient

Orthopedic Procedure Admission

Gainsharing can be MD Specific

Orthopedic MDS

Other MDs

Decrease supply costs

Other identified costs savings

Anesthesia

General Medicine

Post Acute

Category Specific (i.e Ortho, General Med, etc)

Multiple MDS

Ortho

Change in Post Acute Dollars

General Medicine and Others

Change in Post Acute Dollars
Example of Post Acute Gainsharing

Gainsharing Activities

Medicare Savings Generated

Readmission Rate Improvement

Decrease in SNF utilization
Example of Post Acute Gainsharing Calculation

- **Readmission & SNF Net Savings**: $250/patient
- **Chronic Patient Volume in Bundled Payment**: 500
- **Total Savings**: $125,000

Total Savings: 500 x $250 = $125,000
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.
Comparison to appropriate base of comparable hospitals
 Appropriately calculating cost savings per encounter
 Assigning to a single physician to avoid double payment
Cost Approach

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

Base Compensation: Hospital and Physicians

- Geometric Mean

Incentive Compensation

Quality

- Quality Goals Achieved
- Quality Goals Missed

Cost

- Cost Target Achieved
- Cost Target Missed

- No Shared Savings

- Review basis for miss

- Shared Savings

- No Shared Savings
# Savings Calculation

## Report for Dr. John Doe – Attending Physician

### GI Medical Bundle

<table>
<thead>
<tr>
<th>DRG</th>
<th>Encounter</th>
<th>Actual Cost</th>
<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**: $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.

### Payout Distribution

- **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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