

Gain-sharing: P4P or Not

Pay for Performance Summit

Beverly Hills, CA

February 15, 2007

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Gain Sharing

A. P4P & Gain-sharing

B. Gain-sharing

- OIG Changes
- OIG Requirements
- Timing & Decisions

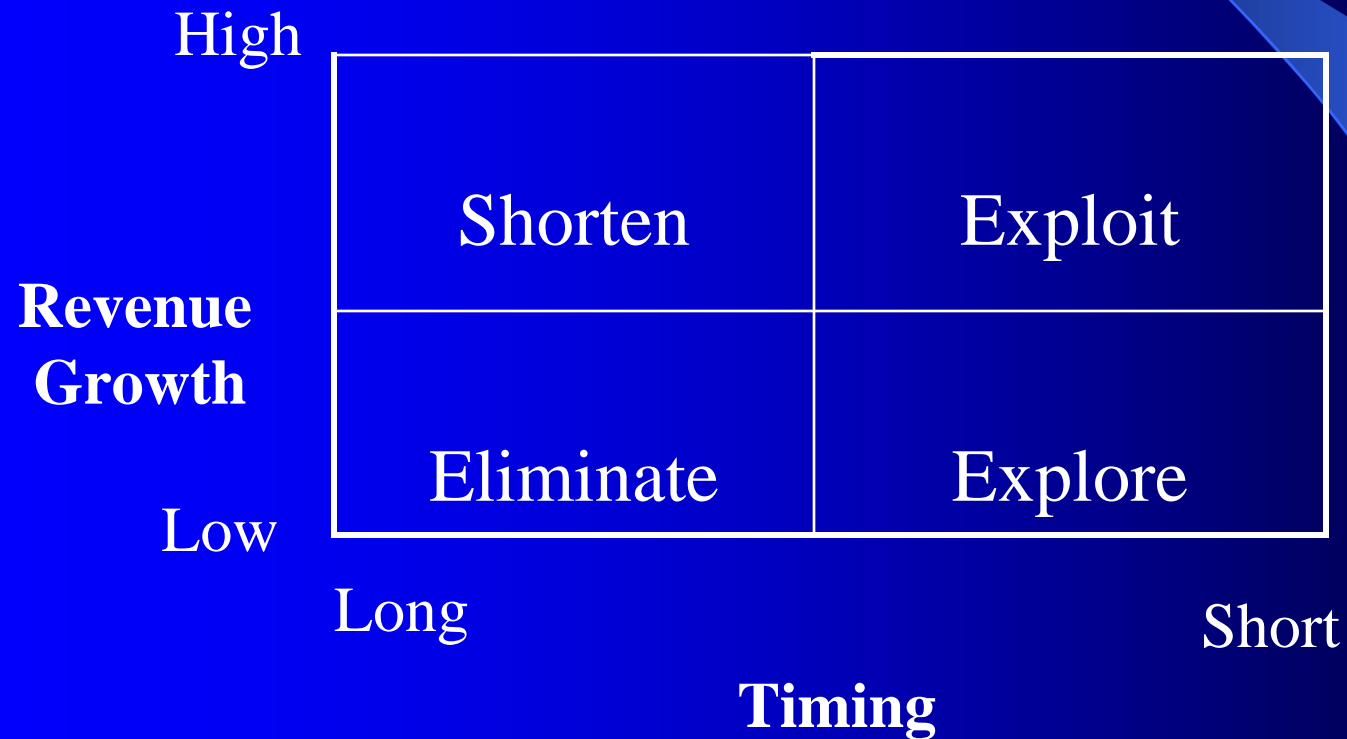
C. Ten Rules

D. Savings

E. Non Gain-sharing

F. Summary & Quiz

When looking for revenue...



Looking for revenue...

Revenue Growth	High	Gain-sharing	Denials, Out-of-network Non-contract
	Low		Underpaid, Strategic Pricing
		Long	Short

Timing

A. Pay for Performance

- Multiple sources
 - Payers
 - CMS (July 1, 2007 for physicians)
- Multiple forms
 - Performance standards
- Incentives
 - Payments to hospitals / physicians.

Annual Medicare Increase

<u>FFY</u>	<u>%</u>
2001	10.7
2002	1.9
2003	6.2
2004	10.5
2005	9.6
2006	N/A

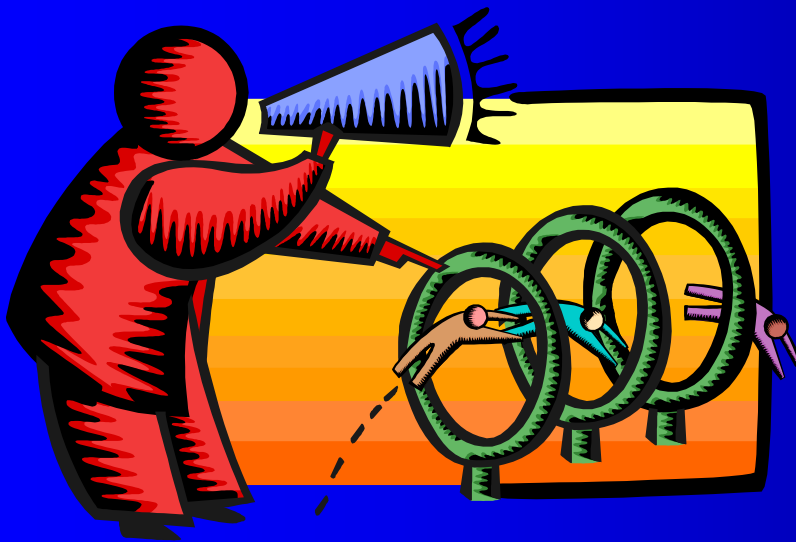
Source: "Medicare Physician Payments", GAO, July 2006

Annual Medicare Payment

2001	4.2%
2002	-4.8 (cut)
2003	1.7
2004	1.5
2005	1.5
2006	N/C
2007 *	N/C

** Doctors eligible for 1.5 percent data reporting bonus as of July 1, 2007.*

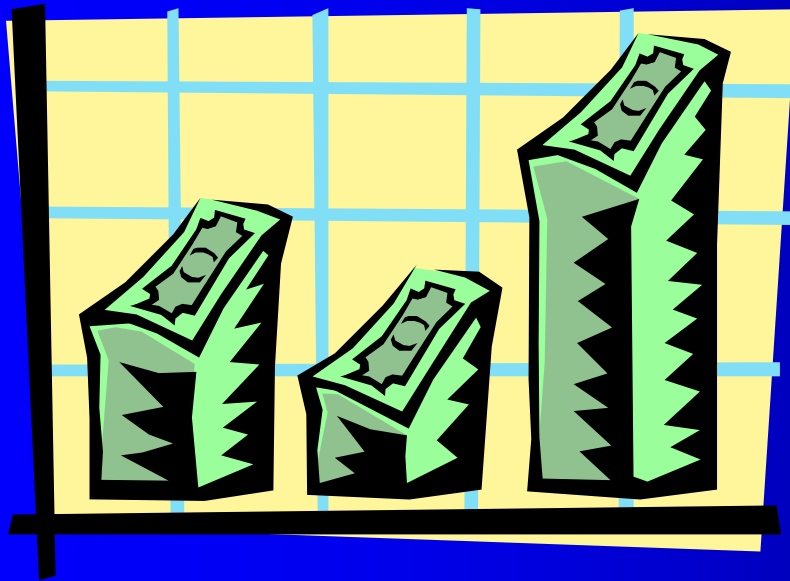
Implications



- o Most physician charts are paper
- o Reporting means EMR
- o EMR means cost
- o Costly for single / small groups.
- o Mergers likely

Implications

2007



- o Voluntary
- o 1.5 % increase
- o Not big deal

2012 ?

- o No longer voluntary
- o 4.5 % increase
- o Ouch!

B. Gain-sharing – Old & New

- Gain-sharing – “sharing of hospital savings with participating physicians”
- In 1999, prohibited under regulations
 - Subject to civil money penalties (CMP)
- In 2005, gain-sharing ‘approved’
 - Still ‘improper payment’, but no CMP imposed
 - Specific agreements to share savings,
 - Approved for cardiology and cardiac surgery.

Landscape Changes

1. Level playing field for 'physician preference'.
2. Savings shared with participating physicians.
 - No CMP for 'approved' arrangements.
3. Savings can be huge!
 - Cardiology = \$1.5 M
 - Cardiac surgery = \$2.0 M.
4. New strategy for physician-hospital relations.

Clinical Changes

- Opening packaged items only as needed,
- Performing blood cross matching only as needed,
- Substituting less costly items,
- Standardization of certain devices.

OIG approval if...

- 1. Financial incentives limited duration & amount.*
- 2. Specific cost saving identified.*
- 3. No adverse effect on patient care.*
- 4. Applies to all Payers*
- 5. Base thresholds set*
- 6. No limit on product choice*
- 7. Written patient disclosures*
- 8. No inappropriate 'steering'*
- 9. No shifting of cost savings.*

Common Provisions

1. Financial incentives limited in duration and amount.

- Each proposal is limited to one year.
- Payments to the physician groups would be 50 percent of the difference between the adjusted current year costs and its base year costs.
- Aggregate physician payments limited to a maximum of 50 percent of cost savings identified in the study.

Common Provisions

2. *Specific Cost Saving Identified.*

- Each proposal clearly & separately identified specific cost saving actions and resulting savings.

3. *No Adverse Effect on Patient Care.*

- Credible medical support that the cost saving measures would not adversely affect patient care.

Common Provisions

4. *All Payer Application* –

- Gain-sharing payments would not be limited to procedures reimbursed by Medicare, but instead would be based on all applicable categories of procedures, regardless of payer.

Common Provisions

5. *Baseline Thresholds Established* –

- Protection against inappropriate reductions in services by using objective historical and clinical measures establish baseline thresholds beyond which no savings would accrue to the physicians.
- For example, if the volume of Medicare procedures in the current year exceeds the volume of Medicare reimbursed procedures in the base year, there would be no sharing for the additional procedures.

Common Provisions

6. No Diminution in Product Choice.

- While product standardization would be encouraged, physicians would make a patient-by-patient determination and choose the most appropriate cardiac device from among the same selection of devices as before.

7. Written Disclosures.

- Hospital and the physician groups would provide written patient disclosures describing the arrangement.

Common Provisions

8. *No Inappropriate "Steering"* –

- Hospital committee would monitor the case severity, ages and payors of the affected patients to ensure that participating doctors are not steering costly patients to other hospitals. If a physician's case mix shows a significant change from historical measures, the physician would be terminated from the program.

Common Provisions

9. *No Shifting of Cost Savings* - Savings would be calculated for each recommendation
 - Preclude shifting of cost savings
 - Assure that the savings generated by utilization beyond a set target would not be credited to physician group.

Checklist

- **Agreements with participating physicians,**
- **Clinical guidelines,**
- **Hospital – physician sharing agreement,**
- **Written patient consent form,**
- **Independent consultant computation of base year savings,**
- **Independent consultant to track savings.**

Time Line

- **Timing**

- **Quantify savings** - 60 - 90 days
- **Complete agreements** - 60 – 120 days
- **OIG Advisory Opinion** - 120 – 180 days
- **Total** - 240 – 390 days

Decisions



Service line?

Participation?

– Champion

Standardization?

Savings?

Sharing?

Medical Staff Reaction?

Strong business case?

C. Ten Rules

Adopted from
“Ten Rules for Strategic Innovations”
HBSP, 2006

2. The idea is only Chapter 1

- Incentivize employees in ways that are consistent with competitive strategy and long-term organizational goals.
- Without agreeing to the “reasons why” behind the program, gainsharing arrangements may become entitlement programs.
- Strong leadership is necessary to foster a culture of change where physician interests are identified with those of the organization.

2. Organizational memory is powerful.

- Financial stability – physician preference items impact on institution's income & ability to tolerate a level of financial risk
- Existing cost savings initiatives – gainsharing should dovetail with other initiatives under-way
- Use of performance incentives – existing programs will likely want to include physicians in the overall program.

3. Established organizations can beat start-ups.

- High resource utilization and/or the use of high-cost pharmaceutical, supplies, devices
 - Cardiology & Cardiac Surgery (OIG advisories)
 - Orthopedics c/o high cost of implants
 - GI and Vascular Surgeries
- High volume procedures (significant cost savings to organization and significant income potential for physician)
- High physician diversity in practice

4. Strategic innovations face critical unknowns.

- Are physicians historically difficult?
- Are joint endeavors routine and easily completed?
- Are physician interests income-focused or mission-focused?
- Are physician ties tight with manufacturers? Have alliances been formed with them?
- Are there significant product loyalties?
 - Successful change is dependent on having prominent and well-respected staff member as “champion”.

5. Must be built from scratch.

- What is the motivation for adopting gainsharing initiatives?
- Will physicians have final determination whether proposed change will impact patient safety?
- Is GS spark competition among groups?
 - Not all physicians will elect to participate for philosophical, ethical, practice, professional, or competitive reasons.

6. Managing tension is job 1.

- Is the organization located in a congested market that routinely competes for physicians?
- Will gainsharing enhance the organization's ability to compete for quality physicians?
- Will gainsharing enable organization to maintain or capture market-leading position?

7. GS needs its own planning process.

- Accurate and long-term data
- Baseline performance levels
 - Internal & External
- Identification of logical targets
- Measure performance change
 - Physician's actual contribution
- Reproducible - based on a sound formula
 - Formula may change during process.

8. Influence and politics disrupt learning.

- Less prepared an organization is (e.g., weak data, competitively focused vs. mission-driven, lack of physician cooperation), the greater the risk.
- Is opportunity large enough to assume risk?
 - In an ideal world, the opportunity far exceeds the risk. In the real world, not all scenarios will be ideal.

9. Accountable for learning, not for results.

- Agreements are typically approved for 12 months
- Physicians are not paid on recurring savings, but only new savings
 - How do you continue to incent once savings have been achieved?
- How do you avoid physicians viewing gainsharing as entitlements?
- How do you align personal and organizational objectives?

10. A savings innovation.

- Gainsharing has the potential to bring physician interests in line with hospital interests.
 - Not the solution to a hospital's ongoing cost containment pressures, but as one part of an overall solution of total cost management.
 - Risk of losing sustainability and becoming an entitlement program.
- For success, an organization needs:
 - strong data systems, cooperation between hospital and physicians,
 - leadership-driven organizational framework,
 - Significant number of savings opportunities.

D. Savings

- Reduce cost by reducing waste, like:
 - Use disposable products only as needed.
 - Utilize less quantity.
 - Substitute a less costly product.
 - Change processes to limit use of products to “medically indicated” clinical outcomes.

Savings – Ex # 1

- Medusa Tubing
 - Opened on 100% of CABG cases, but utilized on 64% of cases.
 - Of 64% of cases, Y tubing could have been used for 50% of cases.
 - Estimated annual savings: \$8,710.00

Savings – Ex # 2

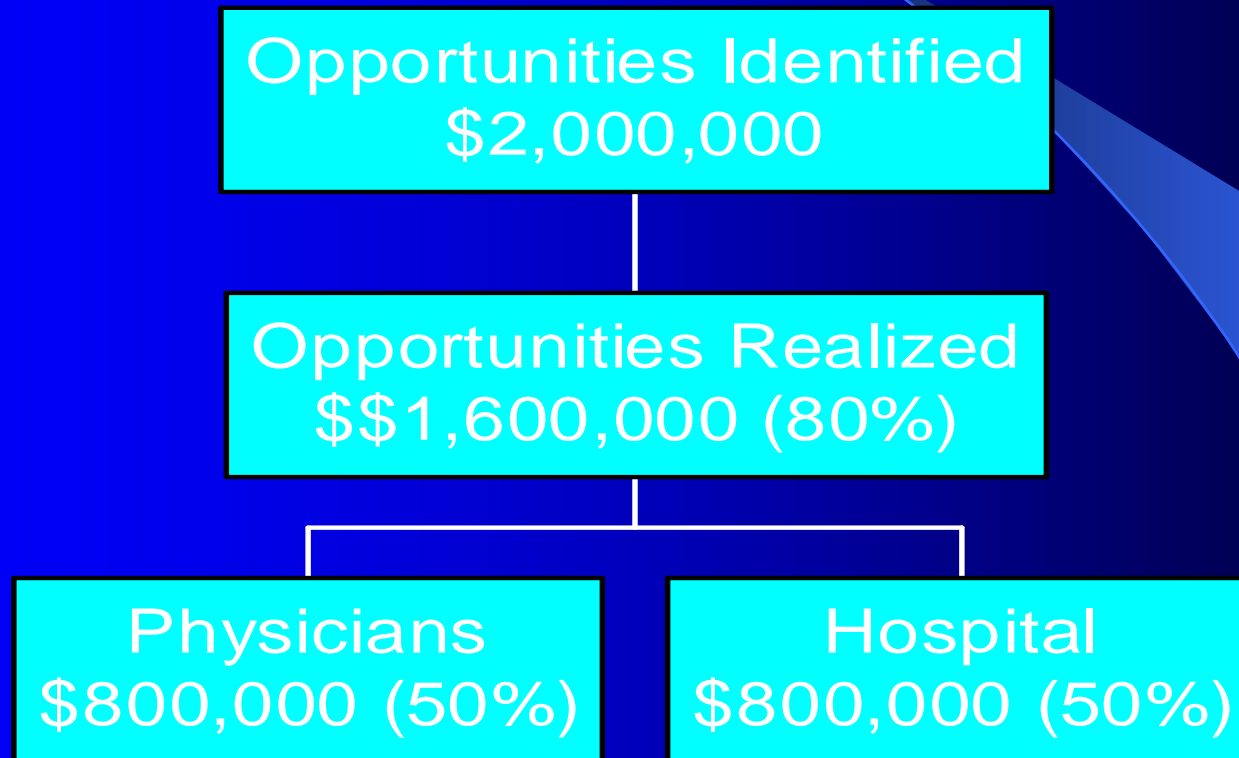
- Cell Saver

- Set up on 81% of open heart cases, but processed blood was returned on only 8% of cases.
- Unless excessive bleeding is recognized, usage could be reduced to 10% of cases.
- Estimated annual savings: \$147,600.00

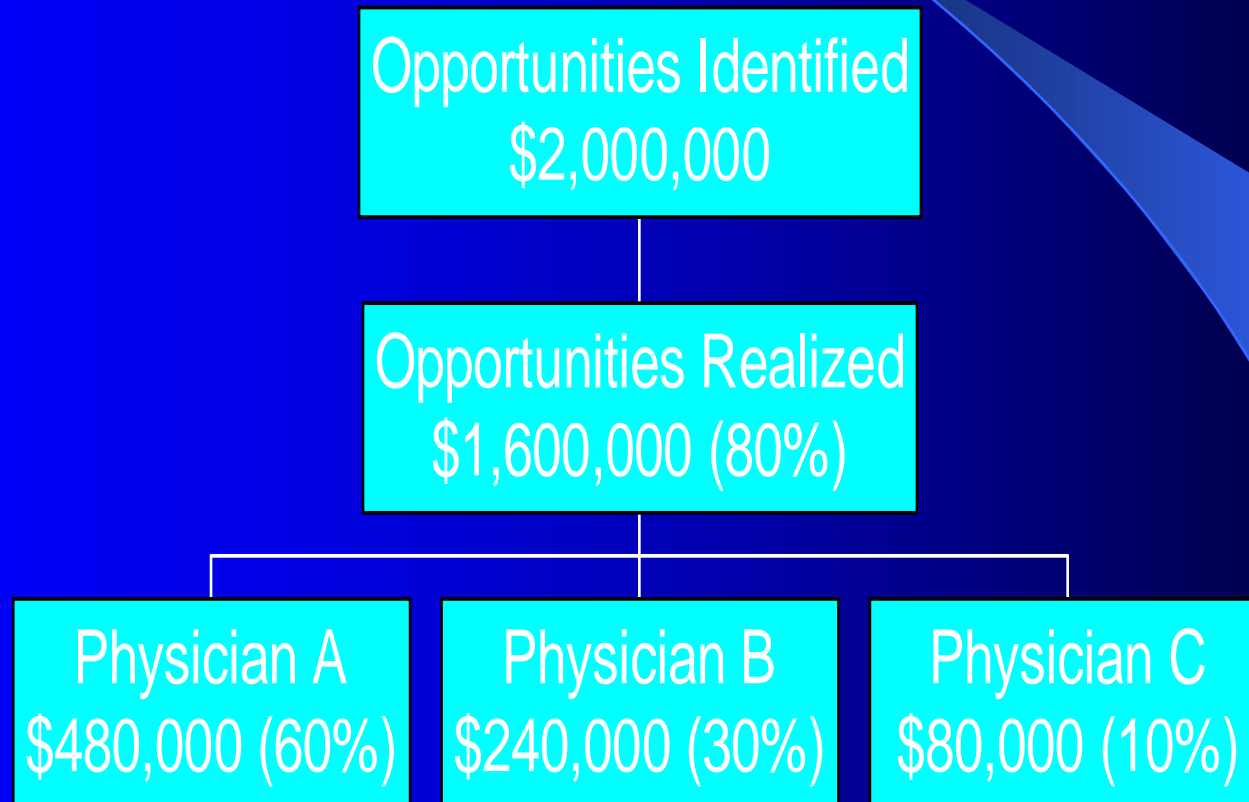
Savings – Ex # 3

- Implantable Cardiac Defibrillators
 - ACD annual use was 123 with four vendors
 - Price range was from \$17,500 - \$27,500.
 - If market share to one vendor increased, average price per unit decrease to \$18,700.
 - Prior year cost: \$2,900,000
 - Next year cost: \$2,350,000
 - Estimated annual savings: \$ 550,000

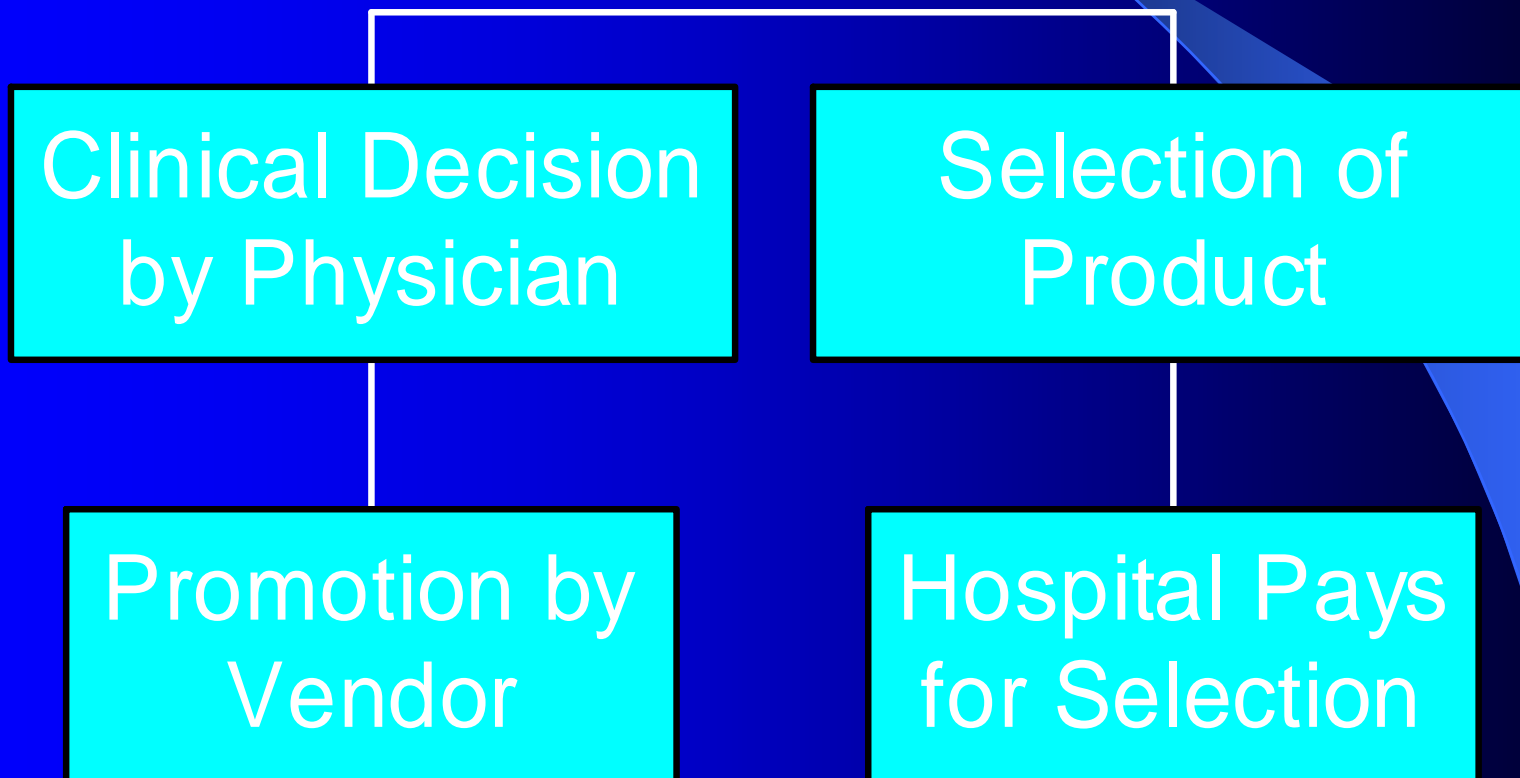
Savings Flow – Ex # 1



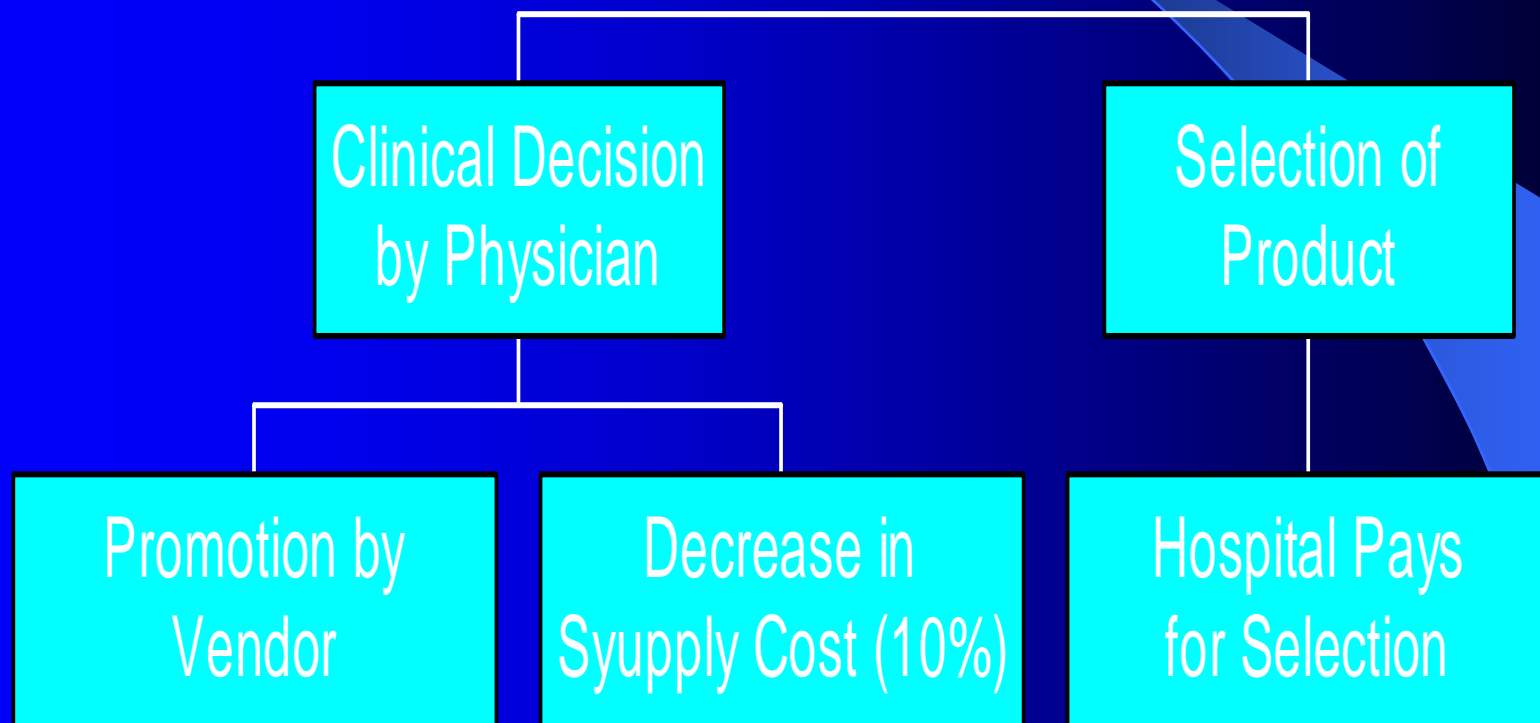
Savings Flow – Ex # 2



Hospital MD Vendor - Before



Hospital / MD / Vendor - After



E. Non - Gainsharing

- Involving physicians in developing product formularies and determining treatment protocols that can reduce treatment costs and ensure quality by:
 - Strong communication
 - Creation of an innovative and inclusive culture
 - Physician champions
 - Practice of evidence based medicine
 - Incentives

Achieving consensus amongst physicians is like “herding cats.” And those cats can be intimidating!!

A respected champion can be your biggest asset.



Surgeon

Champion

Case Study 1

Non - Gainsharing

- Majority of CRM devices implanted in the Cath Lab
- Annual budget over \$6 M.
- Current prime vendor for CRM devices was a long time partner with facility and 90% market share.
- Vendor kept the facility at market advantage by providing aggressive pricing.
- Cardiologists were comfortable with vendor and products and felt no need to change.
- Benchmarking revealed savings opportunity.

Case Study 2

Non - Gainsharing

- Case developed for change through benchmarking
- Facility goals aligned with cardiologists.
 - Cardiologists wanted to expand services.
 - Use savings to add another Cath Lab.
- Department chief as champion and active participant in savings initiative activities
 - Gained support of his peers,
 - Obtained signed pre-commitment to RFP to provide winning vendor 90% market share.

Case Study 1

Non Gainsharing

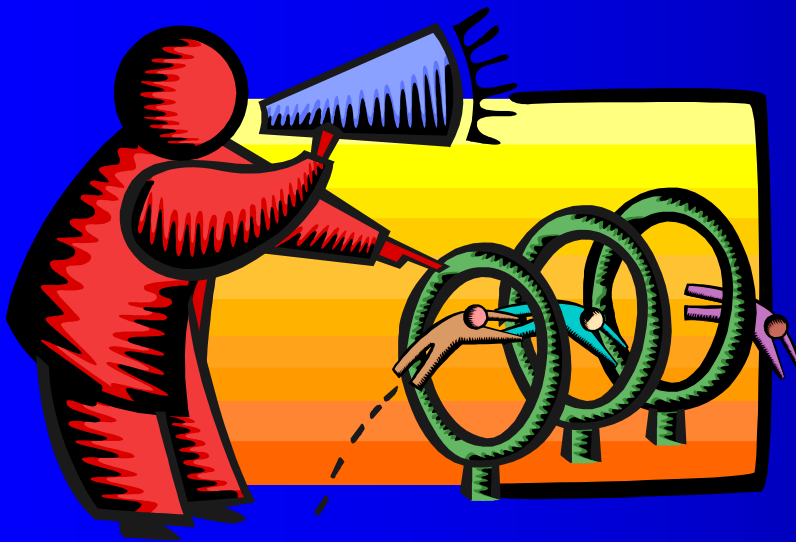
- CRM initiative was a tremendous success
 - Surpassed savings projections by 70%
 - First year savings exceeded \$1.4M
- Facility is currently constructing the new Cath Lab
 - Scheduled to open next month
- CRM success led to physician participation in other initiatives including:
 - coronary stents, inflation devices, haemostatic closure devices, and others.

Cardiology Savings

<u>Beds</u>	<u>T S & D</u>	<u>Total CRM</u>	<u>%</u>	<u>Saving</u>
< 250	\$30.4 M	\$ 3.0 M	21%	\$0.6 M
251–375	\$44.6 M	\$ 4.4 M	27%	\$1.2 M
376-500	\$61.0 M	\$ 6.0 M	34 %	\$2.0 M
Av. 375	\$45.3 M	\$ 4.5 M	27 %	\$1.2 M

Source: Michael Constantine, 2005

Good Idea - Bad Rap



Gain sharing II

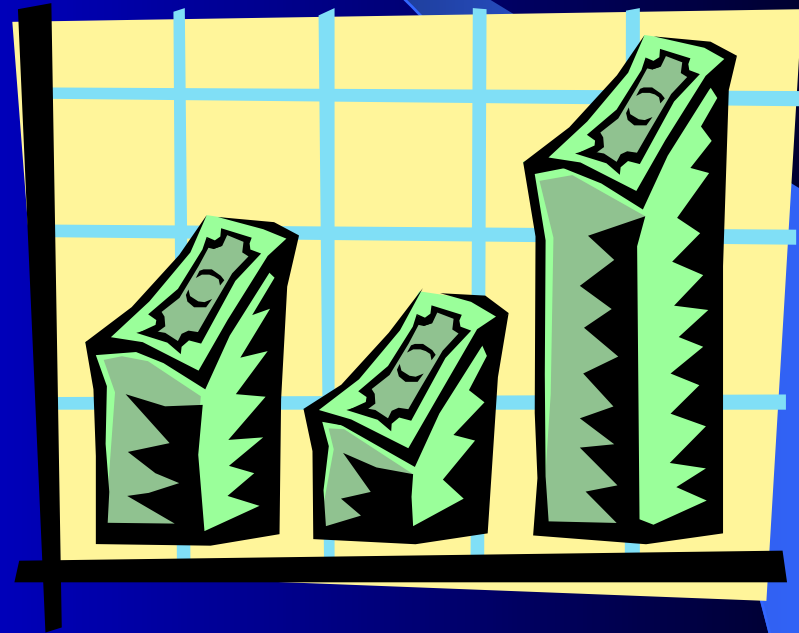
- Expand to group practices and IDS
- Offer new structures for improved quality and reduced cost.

Health Affairs, Dec 2006

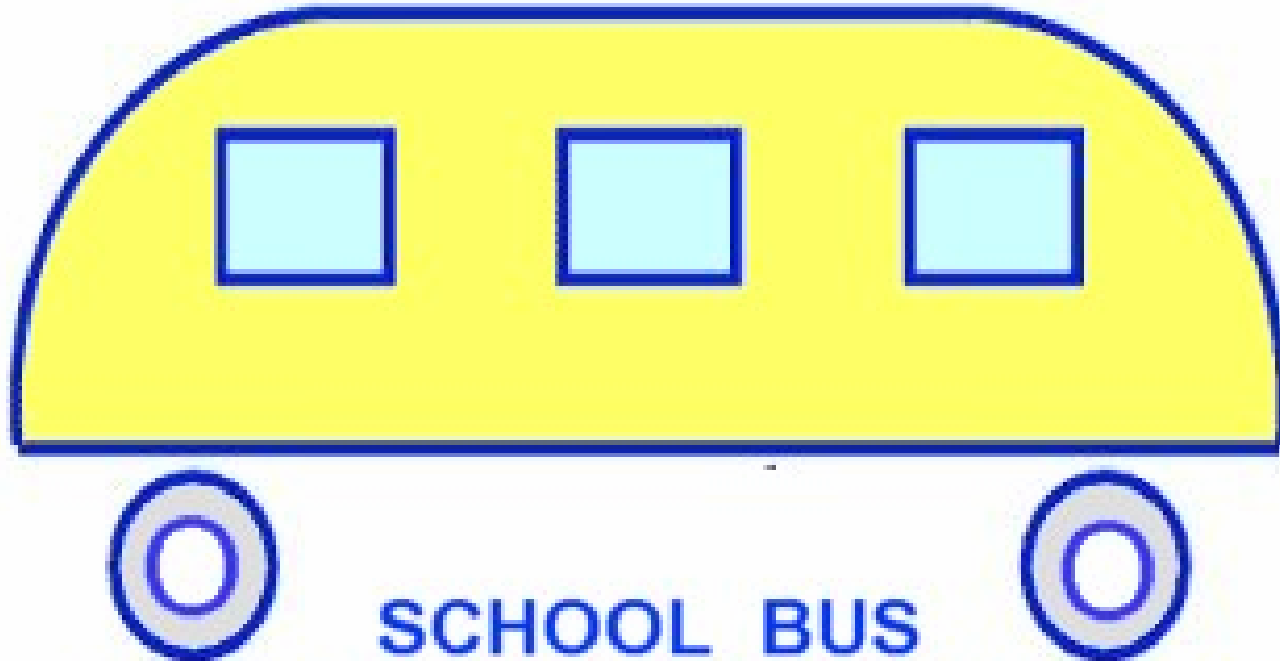
In summary...

OIG Gain-sharing

- Substantial savings
- Today –
 - Cardiology
 - Cardiac surgery
- Tomorrow -
 - Orthopedics
 - Spinal



1st Grade Quiz



L.H. < Which way is it going ? > R.H.

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More on Gain-sharing...

“Gain-sharing”, HFMA Executive Briefing, April 26, 2006, Washington, DC.

“Gain-sharing”, HFMA AWC, Jan 2007.

“Gain-sharing Arrangements”, Goodroe, J, HFMA Executive Briefing, Sept 28, 2005.

“Gain-sharing”, Burke, Robert, 2006 ACHE Congress, March 2006.

“Medicare Physician Payments”, GAO, July 2006

“More Patients – Less Money”, Health Affairs, Dec 2006