How Everyone Can Win by Combining P4P with Gainsharing to Lower Healthcare Costs & Improve Profitability

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Agenda

1. Does ***high quality, efficient care*** cost less to deliver?
2. ***Gainsharing*** can provide incentives for clinical improvement
3. ***Pay 4 Performance*** and hospitals
4. ***Combining*** Gainsharing and Pay 4 Performance
5. ***Trust*** is the most important Success Factor

Does High Quality, Efficient Care Cost Less To Deliver?

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- ***The Premier/CMS Demonstration*** showed that as much as $1.4 billion in hospital costs could have been saved in 2004 for selected patient problems
- ***The published study results of John Wennberg, MD,*** demonstrate that higher quality clinical outcomes are positively correlated with lower case costs
- ***CareScience comparisons of performance*** across high frequency DRGs indicate the potential for a 20%+ reduction in case costs along with comparable reductions in severity-adjusted mortality rates

Improving Clinical Outcomes Requires The Design of Standardized Protocols/Pathways and Physician Adherence to Them.

1. Pick a ***patient condition*** that is a high priority for performance improvement -- clinical ***and*** financial
2. Select a national or hospital-based ***clinical protocol*** that reflects evidence-based best practices for that patient condition
3. Identify related opportunities to streamline ***hospital departmental performance***
4. Define ***relevant outcome measures*** of clinical and financial performance
5. ***Compare adherence and outcomes*** for your hospital with peer group benchmarks, adjusted for severity
6. Set ***performance targets*** for your hospital and customize the clinical protocol
7. Measure and ***monitor performance*** against process and outcome targets
8. ***Compare outcomes*** for cases that adhere to the protocol with those that do not
9. Compare ***outcomes among physicians*** who treat the condition and regularly share comparative information with those physicians
10. Follow up with selected physicians to ***reduce variability*** in practices and outcomes

Premier, Care Science, Cerner and Other Vendors Are Offering Hospitals Computerized Information Systems That Support Proactive Management Of The Care Process

- ***Severity-adjusted clinical outcome data*** permits you to examine and equitably compare clinical outcomes across physicians, clinical specialties and peer hospitals.

- The use of ***causal hypotheses helps you identify root causes*** in the clinical process so that you can model alternative solutions.

- These tools support the active involvement, understanding and commitment of the physicians involved in the care process to ***redesign the clinical process*** to produce:
  - Better ***clinical outcomes***
  - Lower ***costs per discharge***.

Possible Inpatient Cost Savings At CGH For Nine Different Kinds Of Patient Conditions Total $6 Million Per Year

PATIENT CONDITION	DISCHGS	Possible Performance Improvements Based On Top Quartile Of Premier Hospitals As Target: Severity-adjusted Mortality Rates ACTUAL	TARGET*	IMPROVEMENT	Severity-adjusted Cost Per Discharge ACTUAL	TARGET*	IMPROVEMENT	TOTAL COST SAVINGS
MEDICAL (NON-SURGICAL) CONDITIONS	3,278	7.5%	5.8%	23%	$5,395	$4,675	13%	$2,359,971
1. Acute Myocardial Infarction (including	940	8.9%	7.2%	19%	$6,890	$6,081	12%	$760,537
2. Congestive Heart Failure	956	4.4%	3.0%	32%	$4,822	$4,198	13%	$596,953
3. Community Acquired Pneumonia	1,003	8.7%	7.1%	18%	$4,837	$4,134	15%	$704,918
4. Stroke	379	8.3%	5.8%	30%	$4,605	$3,820	17%	$297,563
SURGICAL CONDITIONS	1,288	1.8%	0.7%	61%	$16,361	$13,974	15%	$3,075,134
5. Coronary Artery Bypass Graft (CABG)	647	3.3%	1.4%	58%	$22,493	$19,472	13%	$1,954,632
6. Hip and Knee Replacement	334	0.5%	0.0%	100%	$9,783	$8,787	10%	$332,703
7. Spine Surgery: Back & Neck Procedures, Except Dorsal and Lumbar Fusion	241	0.0%	0.0%	N/A	$8,220	$6,708	18%	$364,376
8. Spine Surgery: Dorsal & Lumbar Fusion Procedure, Except For Curvature of Back	66	0.0%	0.0%	N/A	$19,272	$12,856	33%	$423,423
OBSTETRICS CONDITIONS	2,112	0.4%	0.2%	50%	$3,996	$3,709	7%	$606,436
9. Pregnancy and Related Conditions (Including Newborns)	2,112	0.7%	0.2%	71%	$3,996	$3,709	7%	$606,436
TOTAL 9 BENCHMARK CONDITIONS	6,678	4.1%	3.0%	27%	$7,067	$6,163	13%	$6,041,541

•Targets set at top quartile of Premier Perspective online hospitals
Note: Data have been severity adjusted by Premier
Source: Premier/Clinical Performance Reports, CGH Administration, and Reynolds and Company

Gainsharing Can Provide Incentives for Clinical Improvement

Generally, Physicians are Disinclined to Participate In Hospitals' Clinical Process Improvement Efforts

- Most physicians in private practice see their ***practice incomes*** threatened by purchasers' tightening payment policies

- Much of their attention is focused on ***maximizing revenue*** in their own practices by treating larger volumes of patients and adding new revenue sources

- ***Hospitals,*** on the other hand, have opportunities to improve their clinical outcomes (mortality, complication and readmission rates) while reducing resource consumption patterns if their physicians will take an active role

- Physicians are ***understandably reluctant,*** however, to take time away from their practices to help re-design hospital-based care processes and dilute their professional autonomy when they do not receive any compensation

Clinical Gainsharing Provides The Means to Motivate Physicians to Participate

Physicians and hospitals face five related issues:

- **Affordability:** Increasing operating costs and malpractice practice insurance premiums
- **Clinical quality** of outcomes: Mortality and Complication rates
- **Payment methods** that often don't cover cost increases
- **Declining profitability** of hospital and physician services
- **CMS** is moving to value-based purchasing policies

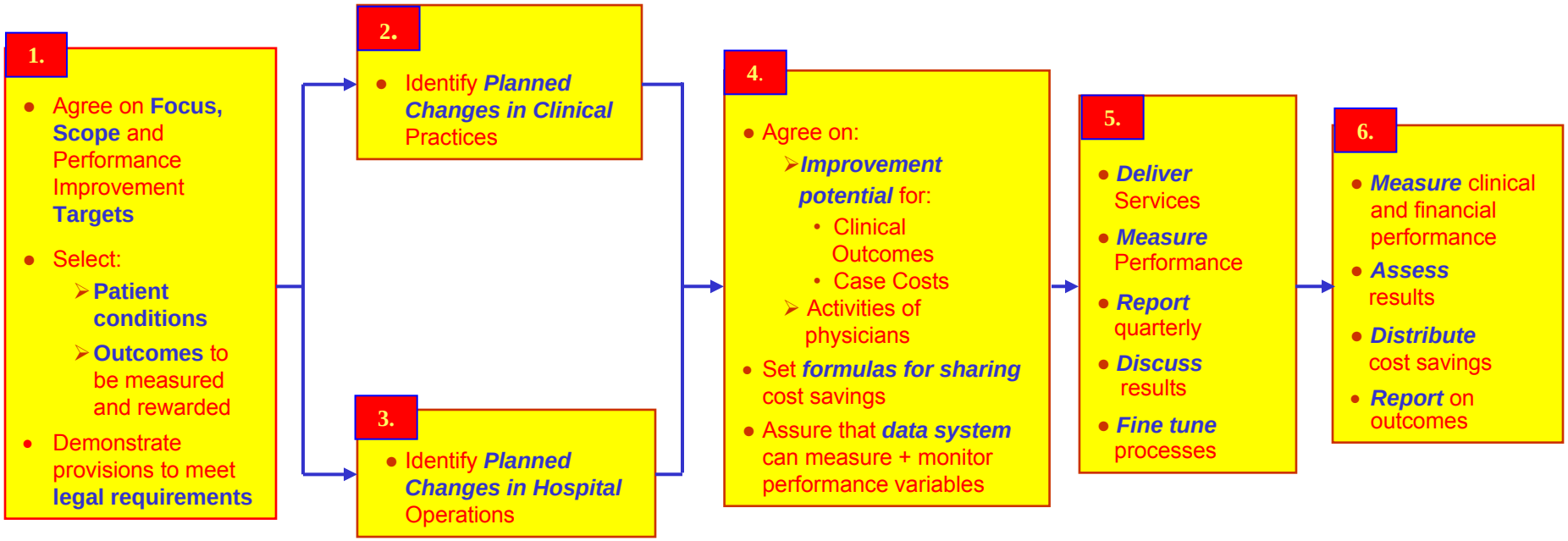
Clinical Gainsharing can produce synergistic results:

- **Hospital benefits:**
  - Improved outcomes, such as mortality and readmission rates, that differentiate services
  - Greater coding accuracy
  - Lower cost per case
  - Increase in market share from differentiated services
- **Physician benefits:**
  - A share of realized hospital cost savings
  - Increasing reputation for high quality results
  - Better market positioning and increased volume

A Legally Permissible Gainsharing Arrangement Should Satisfy Four Requirements

- ***The Stark law*** prohibits a physician from making referrals for designated health services, for which payment may be made under the Medicare or Medicaid program, to entities with which the physician has a financial relationship. Exceptions are enforced by CMS
- ***The Anti-Kickback statute*** makes it a felony for persons knowingly and willfully to solicit, receive, offer or pay any remuneration to induce a person to refer patients for Medicare or Medicaid reimbursed services. A facts and circumstances test is enforced by the OIG
- ***The Civil Monetary Penalty*** statute prohibits a hospital from knowingly making a payment to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. Enforced by the OIG
- ***Private Benefit/Inurement***: to maintain tax-exempt status, a tax-exempt hospital must avoid permitting private inurement to a physician. Enforced by IRS
- ***Health Plan Sponsorship of a Gainsharing Program,*** however, avoids issues of compliance with the Civil Monetary Penalty statute

The Launch of A Clinical Gain Sharing Program Focuses on Six Tasks



This Approach Calls for Distributing Cost Savings to Participating Physicians Only if They Simultaneously Improve Clinical Outcomes

- Using baseline year values for relevant measures of clinical and direct cost performance for the selected patient condition, ***targets for improvement*** in these outcome measures are set in conjunction with evidence-based changes in the clinical and operational care process

- During the implementation year, dollars of ***cost savings*** associated with the targeted patient condition flow into a pool which will be shared proportionately between the hospital and participating physicians

- Prior to implementation, the ***definition of fair market value*** for payments to the physicians will be agreed upon; this definition may involve use of a cap

- Interim clinical and financial results are ***reviewed quarterly*** with participating physicians, and process design elements are fine-tuned to improve outcomes

- At the ***end of the implementation year*** changes in clinical and case cost outcomes are measured, and cost savings that are correlated with improvements in clinical outcome measures are distributed

- The design and implementation activities go on for ***three years*** for each targeted patient condition to give the team sufficient time to get up the learning curve with respect to clinical effectiveness and economic efficiency

This Approach to Improving Clinical and Cost Performance Focuses on Targeting Severity-Adjusted Outcomes for Process Redesign.

- ***Patient-centered problems and opportunities to be addressed:***
  - Clinical outcomes, such as mortality, complications and readmissions
  - Operational inefficiencies, such as discharge planning
  - LOS and Case Costs
- Likely ***team members:***
  - High volume physicians and Chief of Service
  - Relevant diagnostics/therapeutics Chiefs
  - Nurse/Case Manager
  - Chief Medical Officer
  - Chief Information Officer
  - Senior Managers, as necessary
- ***Care process characteristics*** to review for underlying problems and opportunities:
  - LOS by procedure and admission source/discharge destination
  - Cases by kinds and frequency of complications
  - Cases by patient care unit
  - Cases by timing and opportunities of diagnostics/therapeutics
  - Physician ordering patterns for diagnostics and therapeutics
  - Physician LOS patterns by procedure.
- ***Design changes*** to improve clinical effectiveness and efficiency
- Methods for ***monitoring adherence*** to process design and related outcomes

Pay 4 Performance and Hospitals

Pay for Performance Demonstrations Have Called for Public and Private Purchasers to Pay More to Those Providers Who Deliver Better Practices and Outcomes

- Healthcare opinion leaders view Pay for Performance as a way to ***reward quality*** and as a strategy to ***increase efficiency*** in healthcare delivery
- Many purchasers accept the theory that better clinical outcomes are correlated with ***lower case costs***
- Pay for Performance programs for ***physicians*** tend to focus on office-based care for ***patients with chronic conditions***
- Pay for performance programs for ***hospitals*** have tended to focus on adherence to ***best practices*** for selected inpatient conditions, but this focus is broadening

Pay for Performance Programs for Hospitals Are Just Getting Underway

- There are over ***110 P4P Programs*** in the USA
- They involve ***Physicians, Hospitals and Payers***
  - Most of the Programs involve ***Physicians and Payers***
  - Some of the Programs involve ***Hospitals and Payers***
  - ***None*** involve Physicians, Hospitals and Payers in sharing risks and rewards
- The ***major players in P4P for hospitals*** to-date include:
  - CMS and Premier
  - The Leapfrog Group

The Leapfrog Group: National Incentive & Reward Program

Hospital Rewards Program: Efficiency and Effectiveness
Comparison of Leapfrog Hospital Rewards Program & CMS-Premier

	E2Reward Program	*CMS/Premier Demonstration*
Conditions	Coronary Artery Bypass Graft (CABG), Acute Myocardial Infarction (AMI), Percutaneous Coronary Intervention (PCI), Community Acquired Pneumonia (CAP), Pre/Newborn	CABG, AMI, HF, CAP, Hip/Knee
Effectiveness Measures	NQF Hospital Care Measures + Leapfrog	Premier
Efficiency Measures	Risk-adjusted and regional price adjusted total cost of condition	None
Measure Reporting	JCAHO ORYX Vendors, Leapfrog Hospital Quality and Safety Survey	Premier Informatics Database
Hospitals invited	All contracted hospitals	Premier Hospitals
Basis of Rewards	Hospitals ranked in four cohorts based on performance along two dimensions: Effectiveness & Efficiency	Hospitals ranked in deciles based on effectiveness and re-admission rates
Size of Rewards	Hospitals in top E+2 quartile can receive at least 2% direct financial rewards (DFR) & incremental market share. Hospitals in other cohorts also get a DFR for improving	Hospitals in top two deciles of effectiveness receive 2% and 1% respectively

The Leapfrog Group's Reward Program Principles

- ***Top hospital performers*** will get bonuses and the expectation of increased market share through patient shift (co-pay/co-insurance differentials)
- ***Other hospitals*** will get bonuses when they improve performance
- ***Rewards for top hospital performers*** will kick in after second reporting period if they are still in the top cohort
- ***Rewards for all others*** will kick in after second consecutive reporting of sustained improvement

Combining Gainsharing and Pay 4 Performance

The Gainsharing and Pay for Performance Concepts Grew Out of Two Different Initiatives

- The ***Gainsharing concept*** came out of a Medicare Demonstration Project which paid a global rate for physician and hospital services to CABG patients
- The ***Pay for Performance concept*** is a response to the Institute of Medicine's recommendation that payment policies should be realigned to promote quality care

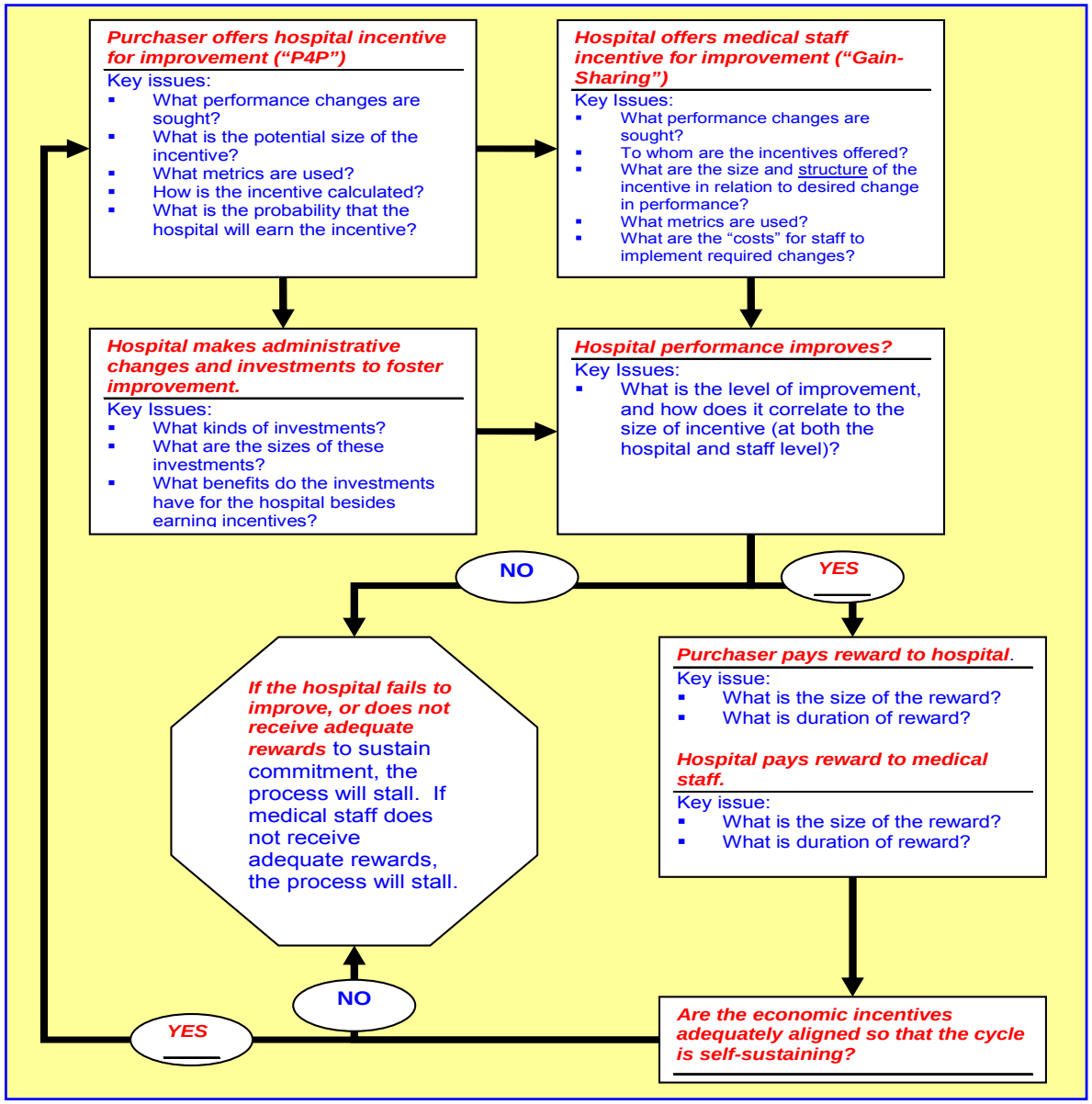
Gainsharing and Pay for Performance Both Focus on Improving Clinical Outcomes

- The ***Gainsharing*** concept calls for physicians and hospitals to share the financial benefits of:
  - Redesigning the ***care process*** to be more effective
  - Improving ***clinical outcomes*** and patient satisfaction
  - Producing ***cost savings*** by being more efficient
- The ***Pay for Performance*** concept as applied to hospitals calls for purchasers to reward hospitals that are effective in delivering high quality care. To-date:
  - The focus has been on ***measuring adherence*** to best practices in the care process
  - Offering ***non-recurring financial rewards*** for making investments in clinically related capabilities and reporting on compliance

Flow Chart for Launching a Gainsharing Demonstration

Flow Chart for Adding a P4P Component to the Demonstration

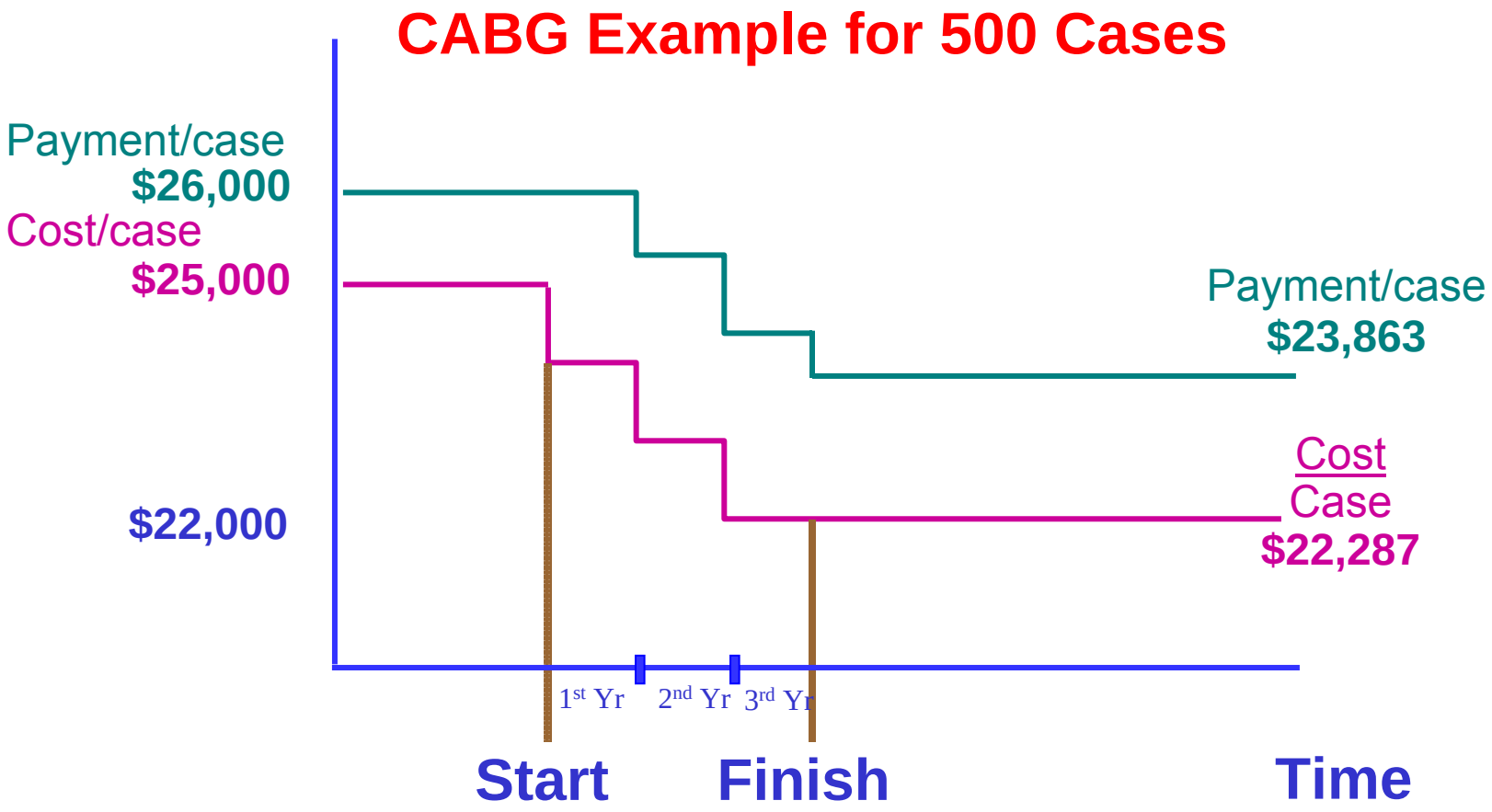
This Incentive Cycle for A Hospital, Its Physicians & A Purchaser Was Used to Simulate the Effects of a Combined Program



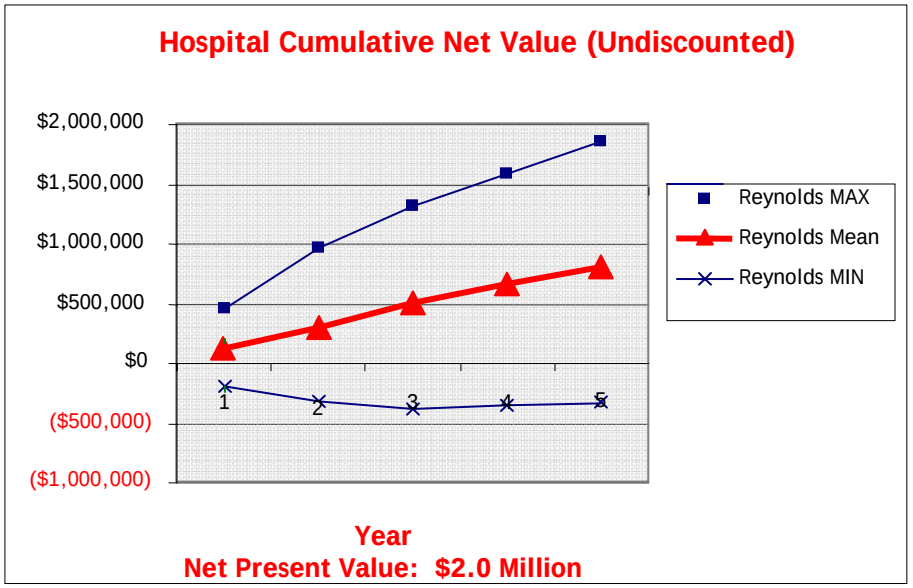
List of Variables in Our Combined Model

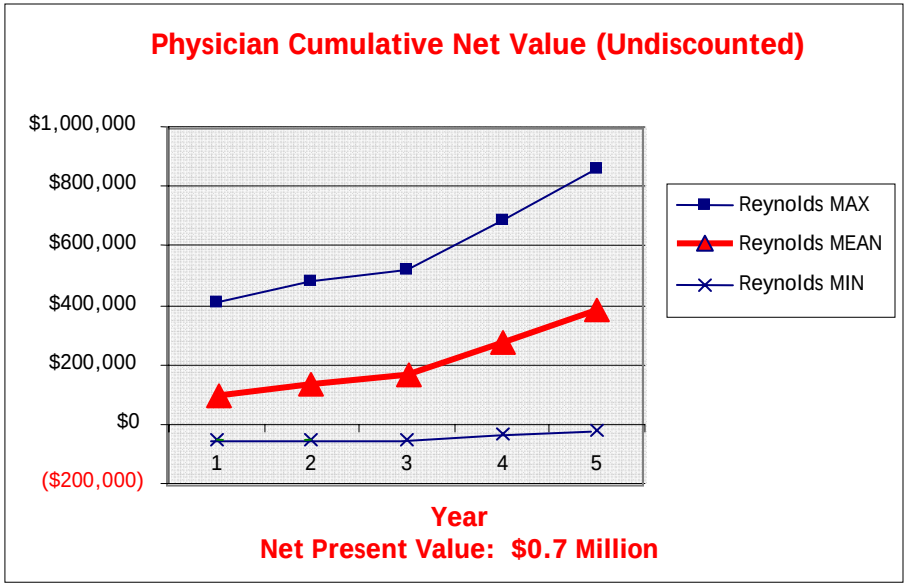
3-year rewards and gain-sharing initiative						
1. Hospital with [a] *annual admissions* for DRG 109 (CABG), with a *growth rate* of [ad]%	**a=**	**500**	**ad=**	**0%**		
2. At the outset of the project (Year 0), the hospital's *average payment* is $[b] for a DRG 109 admission, and incurs [b] in costs.	**b=**	**$26,000**	**c=**	**$25,000**		
3. *Hospital must invest* [d] in each of the three years of the initiative. The hospital deducts this amount before any gain-sharing awards are calculated.	**d=**	**($200,000)**				
4. Annual *collateral benefits* to the hospital from the quality investment are $[z].	**z=**	**$0**				
5. *Physicians must "invest"* [e] in each of the three years of the initiative, representing the opportunity cost of implementation.	**e=**	**($50,000)**				
6. Physicians have an [f] probability of *meeting quality criteria* in the first year, reducing by [g] each year thereafter.	**f=**	**80%**	**g=**	**0%**		
7. *The discount rate* is [h].	**h=**	**10%**				
8. *If the physicians meet the quality criteria,* the improvement in the hospital's (Leapfrog) quality score is from [q] to [r]%, with [s]% being the most likely value [triangular distribution*]. If the physicians* fail to meet the quality criteria, the improvement in the hospital's quality score is from [t] to [u]%, with [v]% being the most likely value	**q=** **t=**	**1.0%** **0.0%**	**r=** **u=**	**5.0%** **1.0%**	**s=** **v=**	**3.0%** **0.5%**
9. For each 1% *improvement in the quality* score, the hospital's per admission costs are reduced between [i]% and [j]% (uniform distribution).	**i=**	**1.0%**	**j=**	**2.0%**		
10. For purposes of *physician ROI calculation*, hospital contributions to the departments count as [ac]% of direct rewards to physicians.	**ac=**	**75%**				
11. In the year after any per case cost reductions are achieved, the *payer's per case payment* to the hospital is reduced by [p]% of the amount of the per case cost reduction.	**p=**	**75%**				
12. If the physicians achieve their targets, the *hospital shares* [o]% of the cost savings from baseline (after annual implementation costs) with the physicians. Otherwise, the hospital contributes [o]% of the savings to the department.	**o=**	**50%**				

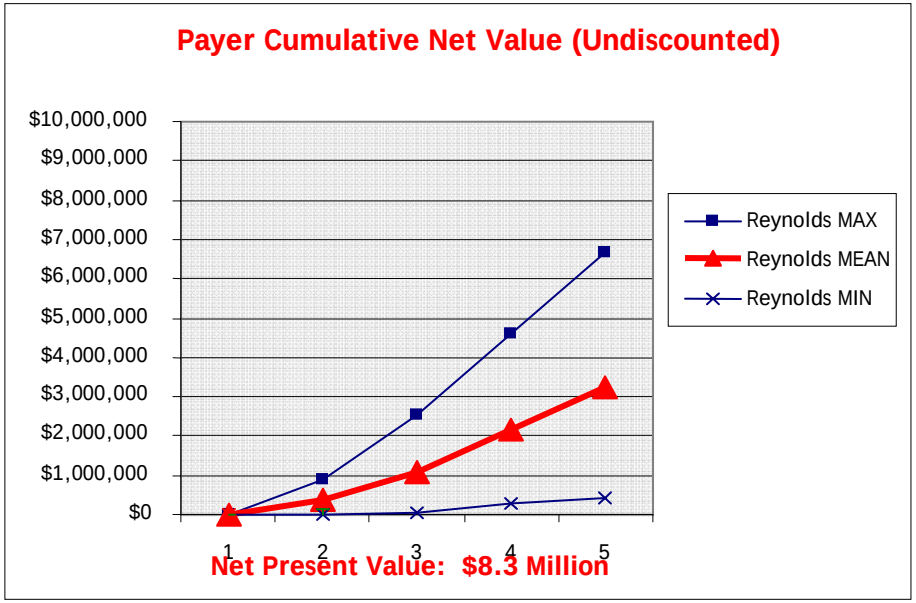
Combined P4P and Clinical Gain Sharing Program that Enables Hospital to Share Savings with Participating Physicians While Generating Financial Benefit to the Purchaser



Financial Benefits to Key Players





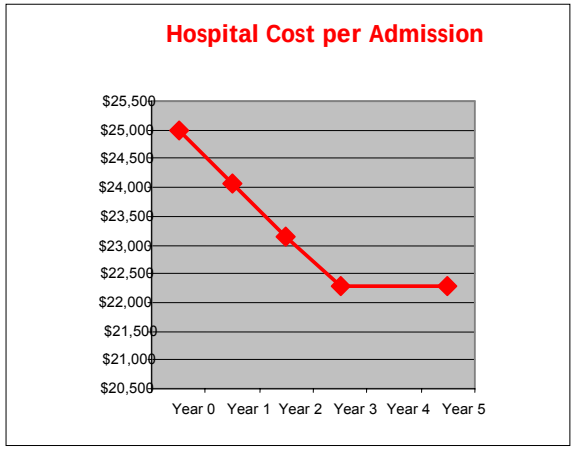


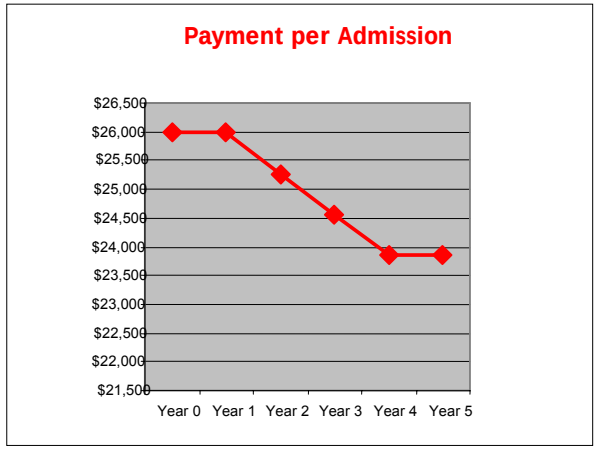
Changes in Quality, Cost per Case & Payment Rate

		Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
% Improvement in Quality by Year		0.00%	2.50%	2.51%	2.49%	0.00%	0.00%

		Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Hospital Cost per Admission		$25,000	$24,061	$23,154	$22,287	$22,287	$22,287

		Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Payment per Admission		$26,000	$26,000	$25,268	$24,553	$23,863	$23,863





Trust is The Most Important Success Factor

Current Issues Pertain to Misaligned Incentives

- ***Physicians,*** concerned with maintaining their procedure-based practice incomes, have no incentives to work with hospital managers to improve hospital performance
- ***Hospital managers*** have no incentives to reduce cost per case for those insurer contracts that pay per diem rates or a percentage of charges
- ***Insurers*** who anticipate that CPOE and EMR applications will eventually produce better clinical outcomes at lower case costs have few incentives now to share cost savings with hospitals

A Combination of P4P and Clinical Gain Sharing Programs Could Realign the Incentives for All of the Players By:

- ***Motivating physicians to participate*** in clinical process redesign and compliance activities that increase quality and reduce cost per case in hospitals
- ***Utilizing existing retrospective clinical information systems,*** with nominal investments of time and funds, to measure and compare clinical and financial outcomes in hospitals
- ***Providing a means to reassure hospital managers*** through P4P demonstrations that are based on hospital case rates
- ***Affording innovative insurers*** lower payment rates and a market positioning opportunity that offers the successful hospitals and physicians to consumers as a narrow panel provider network
- Motivating insurers, hospitals and physicians to pursue innovative P4P arrangements for hospital and physician services that ***make healthcare more affordable and profitable***

Who Gets the Savings

- The ***elephant in the room*** is the potential 20% +/- of cost savings per case for hospital inpatient services
- Is there a way in each situation for the potential cost savings to be ***distributed among the purchasers and providers*** that will motivate all of them to participate?

Two Factors Are Critical to Success in Making This Combination Work

- ***Physicians must be engaged*** in efforts to improve hospital performance
- All of the ***key players must be able to trust*** that their contributions to cost reduction will be equitably rewarded