

CASE STUDY APPROACH: SUCCESSFUL IMPLEMENTATION OF COMPLEX GAINSHARE MODELS

National Bundled Payment Summit

Jill Gordon, MHA, JD
Partner, Nixon Peabody
jgordon@nixonpeabody.com

Jennifer Cormano, JD
Associate, Nixon Peabody
jcormano@nixonpeabody.com



Catherine A. Kay, JD
Senior Counsel, Dignity Health
cathy.kay@dignityhealth.org



Jen Johnson, CFA
Partner, VMG Health
jenj@vmghealth.com



OVERVIEW

- Pay for performance vs. gainsharing
- Designing an overall gainsharing strategy
- Regulatory guidelines for structuring gainsharing arrangements
- Regulatory guidelines for valuing various arrangements
- Case study with common issues and hot spots

P4P PHYSICIAN ALIGNMENT ARRANGEMENTS GROWING

- Physicians and hospitals need to collaborate more than ever – P4P drivers
 - Affordable Care Act – 6 sections on P4P
 - Security – healthcare reform, changing reimbursement
 - Investment requirements for information technology
 - Participate in risk-based contracting, ACOs, quality initiatives
- January 26, 2015 – HHS Secretary Burwell Announces P4P plan
 - 85% of all traditional Medicare payments to quality or value by 2016
 - 50% percent of payments to alternative payment models by the end of 2018 (ACO, bundled payments)



INCENTIVE PAYMENTS

—Payment for performance – Payment for meeting metrics measuring excellence of care given

- Quality, patient satisfaction, good citizenship, participation

—Payment for Savings or “Gainsharing” – Payment for achieving cost savings

- Product substitution, standardization, efficiency



P4P BACKGROUND - QUALITY

- Sharing savings was a slippery slope -> quality focus for years
- Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals: 2003-2009
- Physician Group Practice Demonstration for ten physician groups: 2005-2010



P4P BACKGROUND – QUALITY (CONT'D)

— In 2008, the Robert Wood Johnson Foundation and California HealthCare Foundation reported results of a national program that tested the use of financial incentives to improve the quality of health care. Tested seven projects across the nation that adjusted compensation based on performance scores – hospitals and physicians. Notable findings:

- Financial incentives motivate change
- Alignment with physicians is a critical activity for quality outcomes
- Public reporting is a strong catalyst for providers to improve care

P4P BACKGROUND – QUALITY (CONT'D)

- February 2012 – Committee on Ways and Means – 1 example
 - UnitedHealth Group discusses results of its Premium Designation Program (PD)
 - Results show over 50% decrease in some complication rates



SAVINGS & QUALITY COMBINED

— Savings alone (capitation) no longer in the mix

- 13 Gainsharing Opinions (2001-2008) guidance
- Quality thresholds key

— ACO Business News Reports on programs— always mixed reviews — late 2014-early 2015

- ACO Pioneer Program – 24% earned shared savings in 1st 2 years, 19 of 32 remain
- Wellmark/BCBS 5 ACOs – improved quality 35% and saved \$12 million over 2 years
- Sharp dropped out because it was at risk for “a significant shared loss”



SAVINGS & QUALITY COMBINED (CONT'D)

- Medicare ACO New proposal – 3 models – taking comments now
 - Keeping 1 sided model, but want to reduce savings rate from 50% to 40% - consensus this track is key
 - Adding 3rd track, 75% savings, but downside 40% to 75%
 - Payments for telehealth included
- Multiple Models and arrangements exist today beyond commercial and Medicare ACOs
 - 2013 Greater New York Hospital Association - 100 hospitals desired to work with participating physicians to account for the use of hospital resources. Physicians that met hospital quality targets while lowering costs could be compensated a portion of the savings.
 - Medicare Shared Savings Program
 - Bundled Payments for Care Improvement
 - Commercial payor programs growing exponentially

THE BIG PICTURE – GETTING ORIENTED AND ORGANIZED

DESIGNING AN OVERALL CONTRACTING
STRATEGY



CAN THE PARTIES ACTUALLY DO WHAT THEY ARE AGREEING TO DO?

—Identify the Program

- Co-Management
- BPCI
- MSSP

—Identify the Episode of Care

- Clinical Inputs
- Duration
- Location
- Exclusions (EOC and Qualifying Beneficiaries)

—Identify Participating Parties

- Hospital
- Subacute Facility
- Physician (PCP/Specialist)
- Ancillaries (PT, imaging, etc.)

CAN THE PARTIES ACTUALLY DO WHAT THEY ARE AGREEING TO DO?

- How Does Funds Flow Work?
- Who Bears Risk and for What?
- Governance?
- Responsibility?
- Dispute Resolution?

ORGANIZATION IS KEY

- Identify all contractual relationships in the bundle
- Identify all existing contracts to be amended
- Map out flow of funds and who does what
- Start with the contract “at the top” and identify all terms to flow down into other agreements

INITIAL LEGAL CONSIDERATIONS: NO SPECIFIC REQUIRED LEGAL STRUCTURE

- Multi-Layered Analysis
- Plan for Overall Structure
- Payor to Provider Relationship
- Provider to Provider Relationship
- Identify Which Contracts are Mandatory and Which are Desired

INITIAL FMV & VALUATION CONSIDERATION

— **Co-Management** – identify savings metric, monitor quality, per capita (OIG guidance)

— **Bundled Payments** – understand market reimbursement for physician services and consider caps

— ACO type model- balanced approach for overall model should be assessed

- Third party funded or from hospital
- Infrastructure cost recovery
- Buy-in or participation Fee
- Time spent/effort – hourly rate paid
- Split of savings – existence of minimum savings threshold
- Split of quality - benchmarks utilized
- Upside and downside risk
- Care coordinator payments – ie: Nurse care manager

ANTICIPATING LEGAL ISSUES

UNDERSTANDING WHAT LAWS APPLY



FEDERAL LAW

- **Civil Money Penalties Law (CMP)**

prohibits compensation to physicians from a hospital to induce them to reduce or *limit medically necessary services* to Medicare or Medicaid beneficiaries (42 U.S.C. §1320a-7a)

- **Physician Self-Referral Prohibitions (Stark Law)**

apply to any financial arrangement between a physician and a hospital (or other entity for certain services) for which no exception applies (42 U.S.C. §1395)

- **Anti-Kickback Statutes**

payments to physicians and others that are intended to induce, or that relate to the volume or value of, patient referrals or generation of business (42 U.S.C. §1320a-7b(b))

- **Reimbursement Compliance**



STATE LAW

— State Fraud and Abuse Statutes

— Corporate Practice of Medicine

- Who's receiving payment?
- How is the service advertised?

— Potential Department of Insurance Oversight

- What parties are taking financial risk and in what form?
- Who bears the risk for nonpayment?
- Has a new entity been formed for the bundle?
- Which entities hold the payor contracts?
- What beneficiaries are involved? (PPO, HMO, MA)
- How does this payment model integrate with existing contracts?
- Potential State Agency approval of payor contracts

FRAUD AND ABUSE WAIVERS

—BPCI Waivers

- Savings Pool (Internal Cost Savings)
- Incentive Payments
- Group Practice Gainsharing
- Patient Engagement Incentives



PAYMENT POLICY WAIVERS

- 3-Day Hospital Stay Requirement for SNF Payment (BPCI Model 2)
- Telehealth (BPCI Models 2 and 3)
- Post-Discharge Home Visit (BPCI Models 2 and 3)

WAIVERS?! “WORKAROUNDS” FOR COMMERCIAL CONTRACTING

— Anti-Kickback Statute

- No Medicare/Medicaid fee for service
- Theoretically some risk of a “pull through” claim
- Can minimize exposure by adopting some of the OIG advisory opinion safeguards

— Gainsharing CMP

- Inapplicable – no Medicare/Medicaid FFS or no payment by a hospital?
- Spillover effect?

— Stark

- Exception? (bona fide employment relationships, personal service arrangements (physician incentive plan), prepaid plans, risk sharing)

FAIR MARKET VALUE & P4P

- Based on the anti-kickback statute, and other healthcare regulations and guidelines, any transaction between hospitals and physicians must be at Fair Market Value.
- The amount at which property would change hands between a willing seller and a willing buyer when the former is not under any compulsion to buy and the latter is not under any compulsion to sell and when both have reasonable knowledge of the relevant facts, absent the consideration of referrals.

FAIR MARKET VALUE & P4P (CONT'D)

- Provides a conclusion which should not reflect consideration for value or volume of referrals.
 - Offer equal P4P opportunities to all providers
 - Do not tie P4P compensation to expected referrals
- P4P comparables
 - Stick to regulatory guidance when it comes to paying for quality or shared savings
 - Governmental programs and third party payors are good market comparables



OIG OPINIONS – GENERAL P4P GUIDANCE – VALUATION LENS

— Advisory Opinion 00-02 (non-physician hospital employee cost savings reward programs) could not approve pre-payments without understanding:

- The amount of the payment
- The person the payment will be made to
- The action or activity that will be proposed

****Therefore, these factors must be essential in order to determine if payments are proper***

OIG OPINIONS – GENERAL P4P GUIDANCE – VALUATION LENS (CONT'D)

- Advisory Opinion 01-01 (Cardiac Surgery Gainsharing) favorable partially due to:
 - Transparency setting out verifiable cost savings tied to specific actions
 - Limited duration and specific scope



REGULATORY GUIDANCE - QUALITY

- Quality measures should be clearly and separately identified
- Quality measures should utilize an objective methodology verifiable by credible medical evidence
- Quality measures should be reasonably related to the hospital's practice and consider patient population
- Do not consider the value or volume of referrals
- Consider an incentive program offered to all applicable providers

REGULATORY GUIDANCE – QUALITY (CONT'D)

- Incentive payments should consider the hospital's historical baseline data and target levels developed by national benchmarks
- Thresholds should exist where no payment will accrue and should be updated annually based on new baseline data
- Hospitals should monitor the incentive program to protect against the increase in patient fees and the reduction in patient care
- Incentive payments should be set at FMV



OIG ADVISORY OPINION GUIDANCE ON GAINSHARING

1. Payment based on recognized quality standards
2. Payment linked to base year utilization
3. Programs apply to all patients
4. Developed and administered by expert independent parties
5. Devices or therapies used prior to program implementation must continue to be available at discretion of individual physician
6. Ongoing quality monitoring to assure no inappropriate reductions or limitations in services
7. 1 year term (flexible?), with potential for renewal/modification



OIG ADVISORY OPINION GUIDANCE ON GAINSHARING

8. Physicians participate on a group basis and distribute funds on a per capita rather than per service basis
9. Participation limited to physicians already on staff
10. Gainsharing percentage limited to 50% of hospital savings (expect some sort of “rebased” for future years)
11. Patients are notified of Program
12. Monitor referral patterns of participating physicians
13. Records maintained and available for review by Secretary of HHS
14. Representation in submission that payments represent FMV for services provided



VALUATION CHECKLIST

- Start small
- Have a written agreement
- Modest set of metrics – perhaps consistent with those found in both commercial ACOs and Medicare ACOs
- Update and rebase metrics annually
- Understand who is driving cost savings and quality
- Have safeguards which prevent cherry picking and lemon dropping
- Identify flow of funds allocation early on in process
- Understand your FMV opinion and underlying assumptions
- Compliant P4P payment formula = Good Data + Logic + FMV guidance



LEGAL ISSUES IN BUNDLED PAYMENT CONTRACTING

- No Specific Required Legal Structure for Gainsharing – Requires a Multi-Layered Analysis
 - Overall structure
 - Payor to Provider Relationship
 - Provider to Provider Relationship
 - If BPCI, then CMS will have to approve of arrangement
- Fraud and Abuse Waivers for BPCI Programs
 - Applies: Stark law, federal anti-kickback statute & CMP law
 - Must request a waiver in the BPCI application
- The Devil's in the Contracts: Gainsharing Limitations, Individual Physician Execution & Other Tricky Provisions
- Look Out for State Law Prohibitions: CPOM, Insurance Laws and State Fraud & Abuse Prohibitions

PRACTICAL TIPS

—Identify Internal Constituencies and Goals

- System and Hospital Expectations

—Define Terminology and Use Consistently

- When is a bundled payment not a bundled payment

—Financial Analysis of Data is Complex

- Episode Selection, Target Price calculation, gainsharing caps, etc

PRACTICAL TIPS (CONT'D)

—Messaging to Physicians

- Explaining complex programs; regulatory requirements

—Adequate Staffing and Training

- More than you thought you'd need

—Tech, Tech, Tech

—Avoid “Waiver Creep”

- Waivers under BPCI do not apply to other programs

—Watch For Unexpected Program Requirements

- BPCI 10 year record-keeping requirement
- EFT payment requirement



CASE STUDY

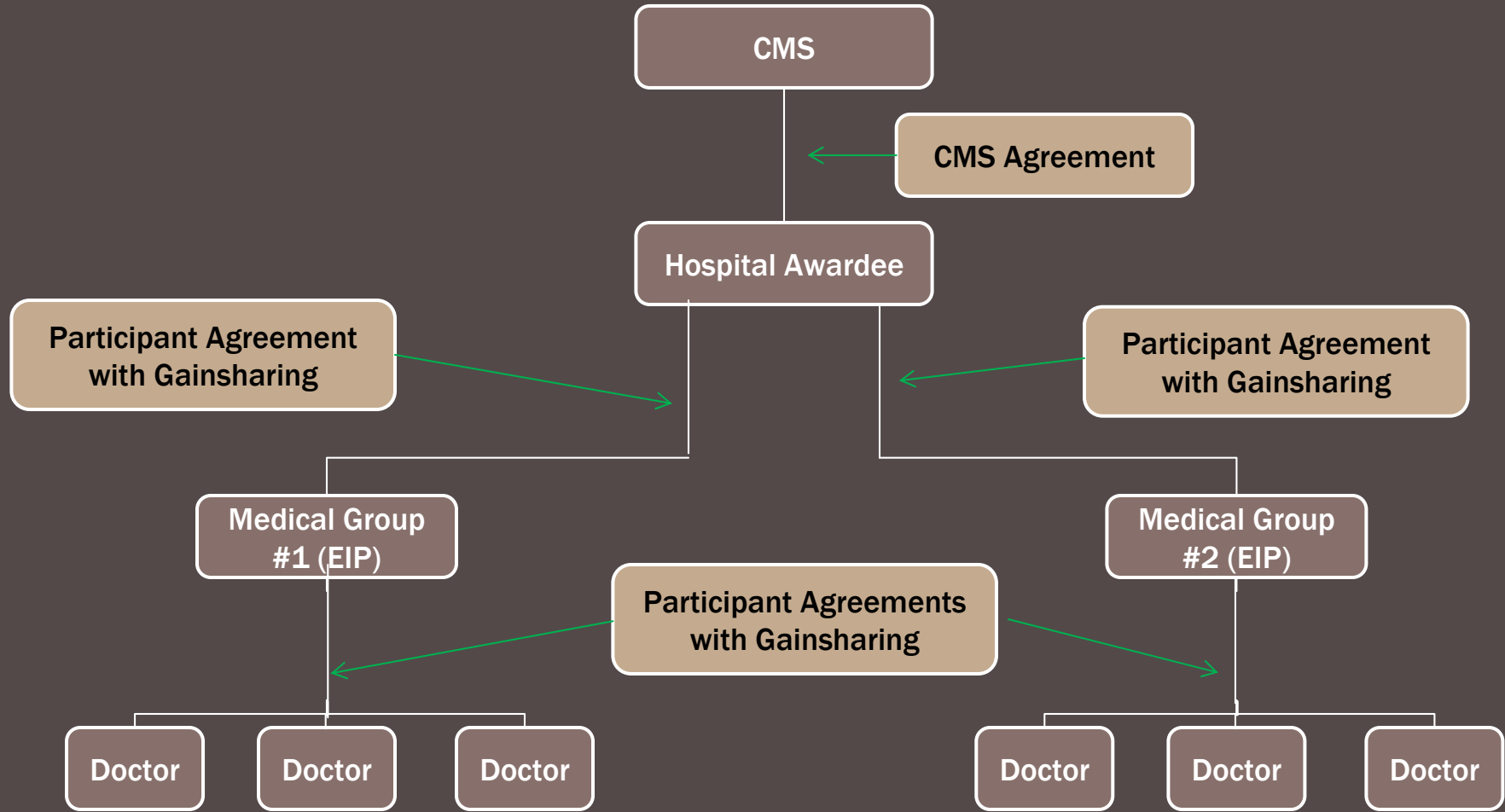


THE CASE STUDY

- Where does the money come from?
 - Pool Creation & Rules
- What can I get paid for?
 - Incentive Payments types & Rules
- When can I get paid & how much?
 - Gainsharing Qualifications Limits
- Can I get paid more?
 - Gainsharing for non-BPCI Beneficiaries



BPCI BUNDLED PAYMENTS: A QUICK REVIEW OF TERMINOLOGY



WHERE DOES THE MONEY COME FROM?

— BPCI Savings Pool

A collection of funds that consist solely of contributions from EIPs of Internal Cost Savings and contributions from the Awardee of positive Net Payment Reconciliation Amounts (collectively, “BPCI Savings”) that are made available to distribute as Incentive Payments.



WHERE DOES THE MONEY COME FROM?

– Internal Cost Savings Definition

For each EIP, the measurable, actual, and verifiable cost savings realized by the EIP resulting from Care Redesign undertaken by the EIP in connection with providing items and services to the BPCI Beneficiaries within specific Episodes of Care. Internal Cost Savings does not include savings realized by any individual or entity that is not an EIP.

– Ways to Calculate Internal Cost Savings

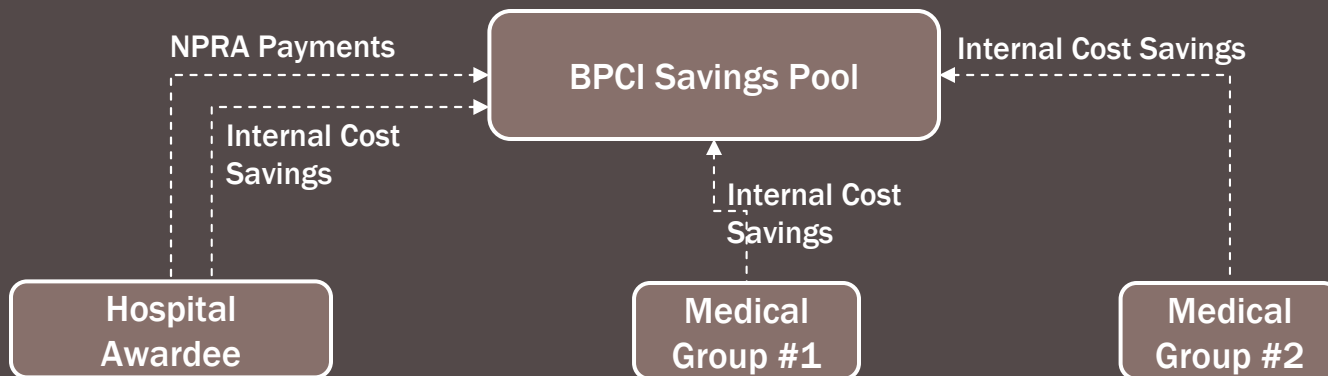


WHERE DOES THE MONEY COME FROM?

— Net Payment Reconciliation Amount (“NPRA”)

The Target Price minus the total dollar amount of Medicare fee-for-service expenditures for items and services (collectively referred to as “Aggregate FFS Payment” or “AFP”) furnished by the Awardee, the Episode Initiator, EIPs, Gainsharers, or Third Party Providers during an Episode of Care.

COMBINED/UNIFIED POOL



A Gainsharing Arrangement must be described in the Implementation Protocol including:

- A specific methodology & accounting formula for calculating and verifying the Internal Cost Savings generated by each EIP based on Care Redesign specific to that EIP.
- A description of the methodology, accounting formula and frequency of contributions made by the Awardee, and each EIP to the BPCI Savings Pool from Internal Cost Savings and/or made by the Awardee from quarterly positive NPRA's.

BPCI SAVINGS POOL RULES

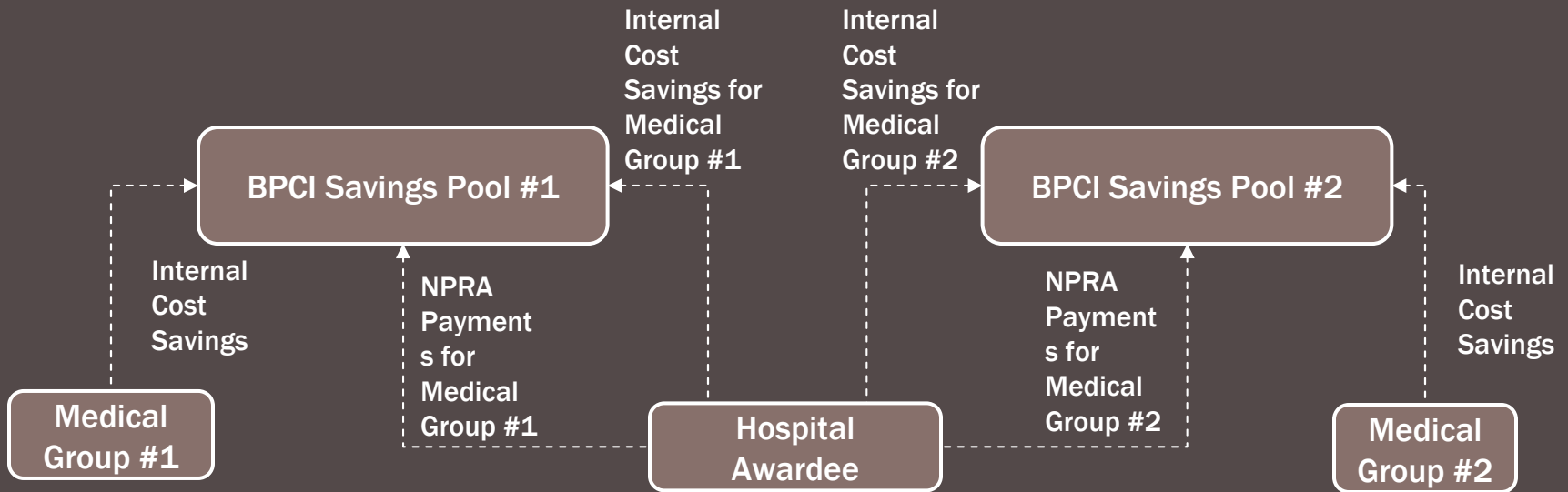
- The BPCI Savings Pool must meet the requirements set forth in the CMS Agreement and be administered by the Awardee in accordance with GAAP.
- Each contribution within the BCPI Savings Pool must be clearly and separately identifiable as to the EIP from which it originated.
- All Internal Cost Savings and positive NPRAs must be clearly and separately identifiable and independently verifiable.



BPCI SAVINGS POOL RULES (CONT'D)

- In no event may the BPCI Savings Pool include, nor be used to distribute, any amounts that are not Internal Cost Savings or positive NPRA.
- The BPCI Savings Pool must be administered by the Awardee and must not be comingled with the Awardee's operating funds or any other accounts or funds.
- All Internal Cost Savings to the BPCI Savings Pool must reflect actual, Internal Cost Savings achieved by the EIP making the contribution through implementation of Care Redesign elements identified in the Implementation Protocol and cannot reflect “paper” savings from accounting conventions or past investment in fixed costs.

A DIVIDED POOL



ADDITIONAL DIVIDED POOL RULES

- At the level of each Episode Initiator, Internal Cost Savings from all EIPs that are associated with the BPCI Beneficiaries in Episodes of Care initiated at the Episode Initiator are placed in a BPCI Savings Pool.
- For each Episode Initiator the portion of the Awardee's NPRA associated with the BPCI Beneficiaries in Episodes of Care initiated at the Episode Initiator is placed in a separate BPCI Savings Pool.
- The methodology for calculating and distributing Incentive Payments from each BPCI Savings Pool must consider the BPCI Beneficiaries of the Episodes of Care that pertain to the particular BPCI Savings Pool.

WHAT CAN I GET PAID FOR?

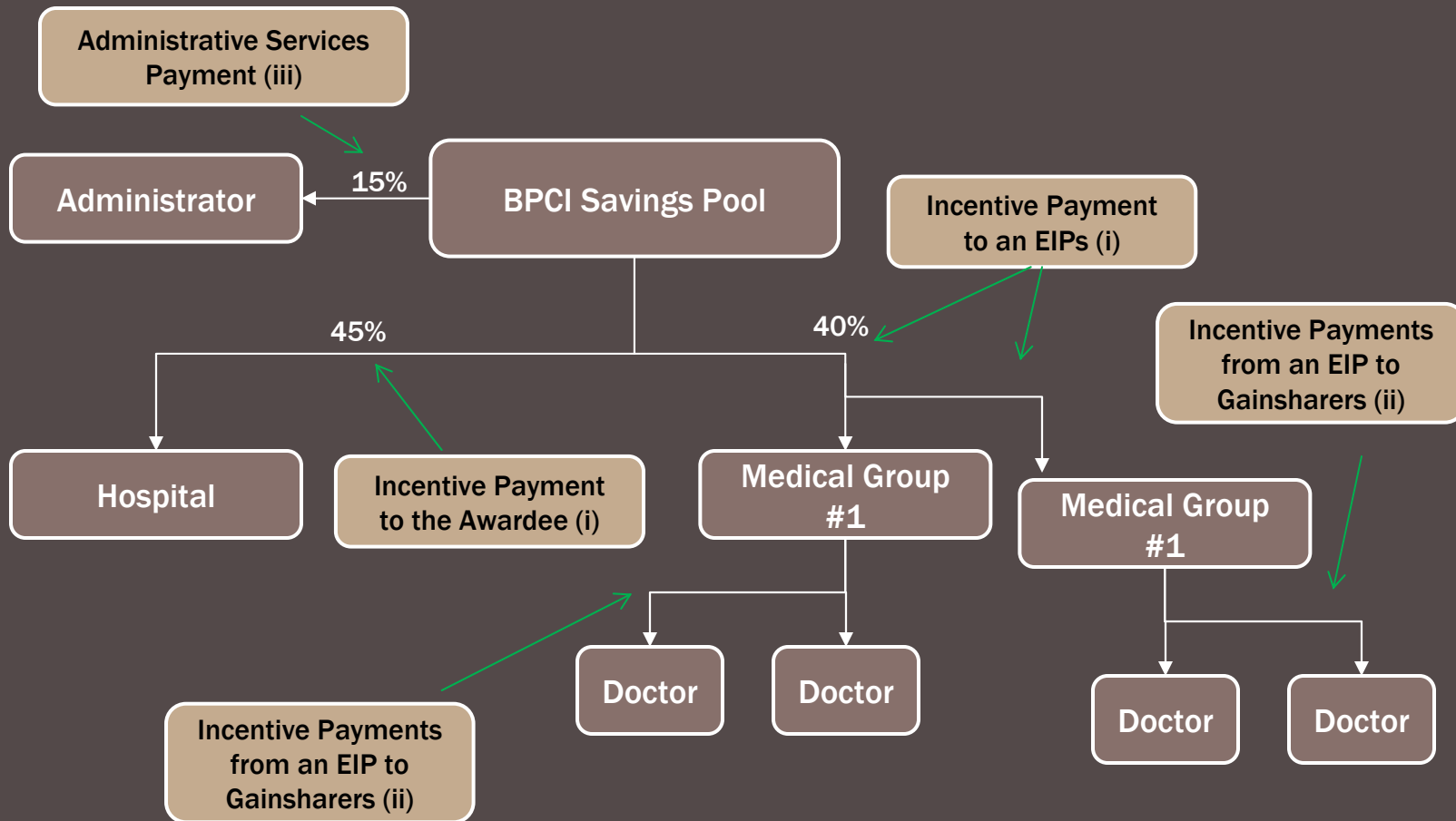
— Incentive Payments Definition

- (i) a payment made directly or indirectly from the BPCI Savings Pool to an Awardee or EIP pursuant to a Gainsharing Arrangement set forth in a Participant Agreement,
- (ii) a payment of a portion of BPCI Savings from an EIP to a Gainsharer, pursuant to a written gainsharing agreement between the EIP and the Gainsharer, or
- (iii) a payment made directly or indirectly from the BPCI Savings Pool to a BPCI Entity for Administrative Services actually furnished by the BPCI Entity pursuant to a Gainsharing Arrangement

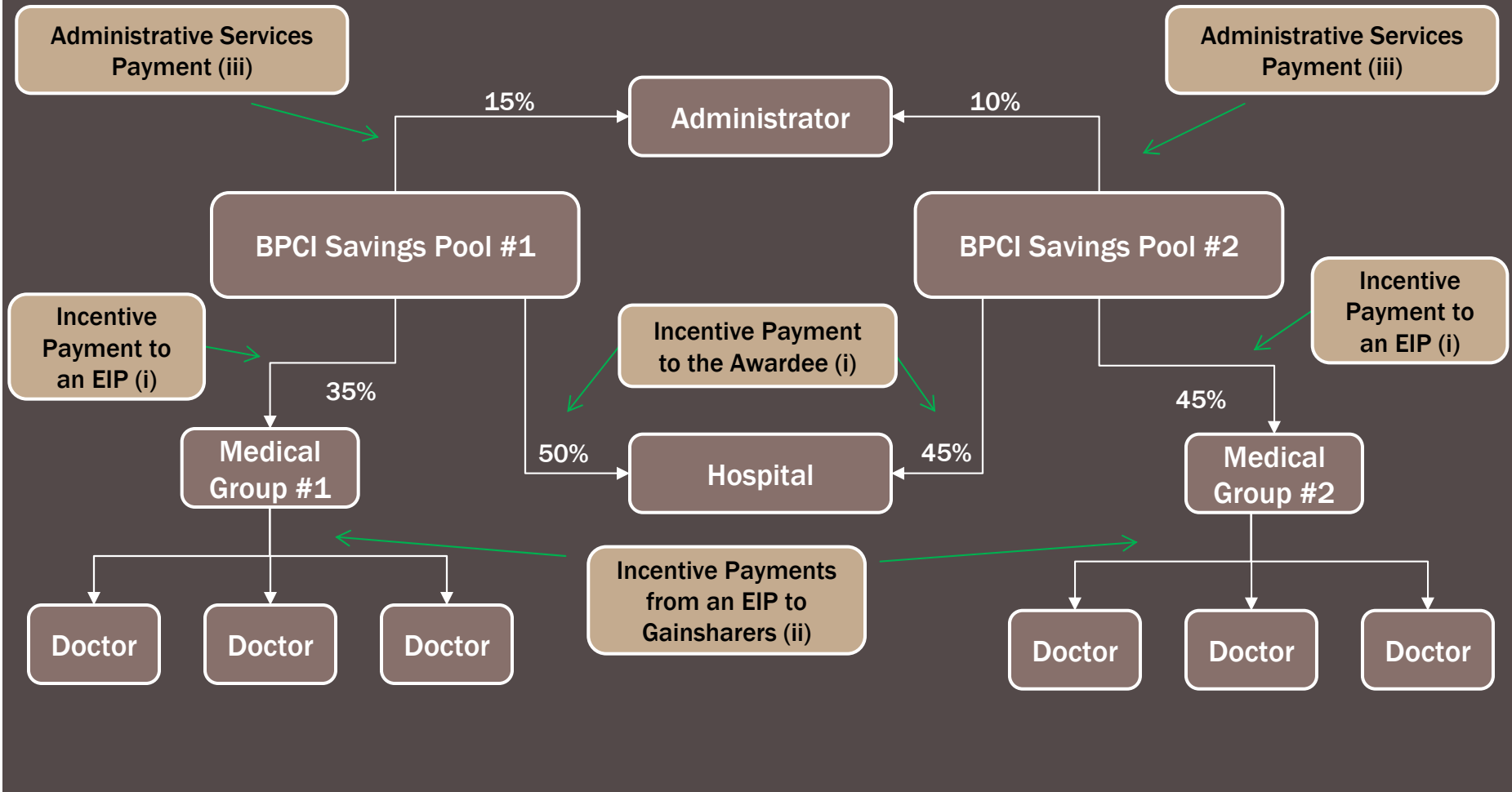
***Administrative services are services directly related to the administration of the Gainsharing arrangements.



COMBINED/UNITED POOL



A POOL DIVIDED



INCENTIVE PAYMENT RULES

- An EIP may only receive Incentive Payments from BPCI Savings Pools for which they have the potential to contribute Internal Cost Savings based on their care for BPCI Beneficiaries
- A Gainsharer may only receive Incentive Payments from BPCI Savings Pools that contain Internal Cost Savings if those BPCI Savings Pools have the potential to include Internal Cost Savings associated with the Gainsharer's BPCI Beneficiaries.
- With respect to BPCI Savings Pools that include NPRA, an EIP or Gainsharer may only receive Incentive Payments from a BPCI Savings Pool that contains NPRA based on an EIP or Gainsharer's BPCI Beneficiaries.

WHEN CAN I GET PAID AND HOW MUCH?

Qualifications:

- Hitting Quality Metrics
 - Examples
- Hitting Cost Savings Metrics
 - Examples

Limitations:

- Incentive Caps
- FMV Considerations

WHEN CAN I GET PAID AND HOW MUCH?

— Incentive Cap Definition

- The total amount of Incentive Payments or Gainsharing Payments for a calendar year paid to a physician or non-physician practitioner must not exceed a cap.
- the cap is 50% of the total Medicare approved amounts under the Physician Fee Schedule for services furnished by that physician or non-physician practitioner to that Awardee's BPCI Beneficiaries during the portion of a calendar year when that physician or non-physician is on the Gainsharing List for that BPCI program with confirmed eligibility by CMS.

CAN I GET PAID MORE?

—Gainsharing for non-BPCI Beneficiaries

- Examples

—Payments in a Commercial Context

- Examples

OTHER STICKY WICKETS TO CONSIDER

- Participating in more than one bundle
- Terms for non-payment
- Building flexibility for evolving terms
- Physician stacking
- Overlapping quality metrics
- CMS trumping rules
- Travel expenses
- Change Happens



QUESTIONS AND DISCUSSION



THANK YOU!

Jill Gordon, MHA, JD
Partner, Nixon Peabody
jgordon@nixonpeabody.com

Jennifer Cormano, JD
Associate, Nixon Peabody
jcormano@nixonpeabody.com



Catherine A. Kay, JD
Senior Counsel, Dignity Health
cathy.kay@dignityhealth.org



Jen Johnson, CFA
Partner, VMG Health
jenj@vmghealth.com

