Center for Medicare & Medicaid Innovation
Bundled Payment for Care Improvement Initiative

Accelerated Development Learning Session # 5:
Contractual and Governance Issues Among Providers in Bundled Payments

Thursday, March 22, 2012 3:30 pm–4:30 pm EDT

OPERATOR: Good day, ladies and gentlemen, and welcome to the Bundled Payments for Care Improvement, ADLS #5 conference call. My name is Erin and I'll be your operator for today. At this time all participants are in a listen-only mode and will remain muted for the duration of the presentation. If at any time during the call you require assistance, please press star followed by zero and an operator will be happy to assist you. I would now like to turn the conference over to the host for today's call, Weslie Kary from AIR. Please proceed.

WESLIE KARY: Thank you, Erin. Welcome, everybody, and good afternoon. We are about to embark on our fifth ADLS session and today we will be talking about Contractual and Governance Issues Among Providers in Bundled Payments. Before we begin, there's a couple things that you should know. And today for the first time we have available for you a PDF of the slides that you can download right now and take notes on if you'd like, during Ms. Gosfield's presentation. And you will do that by clicking the "supporting material" tab at the bottom of your screen and that should give you a PDF which you can then open or download to your own pc and print.

You will also be able to find these slides very soon at our website, http://cmmi.airprojects.org/bpci.aspx. I don't have them up right now, but we should have them up probably tomorrow and then early next week we will also have an audio file and a transcript of today's webinar. So and then also the other thing that you need to know is that the views expressed in these presentations that we do are the views of each speaker and do not necessarily reflect the views or policies of the Centers for Medicare and Medicaid Services. And the materials that we are providing are intended for educational use only and have no bearing on participation in any CMS program.

Our objectives today are as always to support you as practitioners in your efforts to successfully implement bundled payments in support of the three-part aim; to share expert knowledge and lessons learned by early adopters; and today with Ms. Gosfield we're also going to be sharing lessons learned along the way in the history of provider contracting, especially some of the lessons that came out of the '90s; and we will also be setting the stage for continued collaboration and collaborative learning during implementation.

We have only one speaker today, Alice Gosfield, and her presentation is Contractual and Governance Issues Among Providers in Bundled Payments. She's going to give her presentation and then we will do a Q&A session afterwards. You ask a question by clicking the "ask a question" button at the bottom of your screen. You can do that at any time and we will be queuing up questions so that when we get to the Q &A section, we'll have it ready to ask. So as you think of it, go ahead and put it in through "ask a question." We will not be taking live questions at the end of the call.

Okay. So my last chore here—chore—it's a delight to actually introduce our speaker today, Alice Gosfield. And she has a national law practice which is limited to health law and health regulation with a special emphasis on physician representation, managed care, quality, fraud and abuse, and medical staff

issues. She is a graduate of Barnard College and NYU Law School. She has been named one of the top 25 health lawyers in the country in 2007 and 2009. She has served as Chairman of the Board of Directors for NCQA for five terms. She was President of the National Health Lawyers Association. She was the Founding Chairman of the Board for Prometheus Payment, which many of you will know is a non-profit organization developing a bundled payment model. And she's been a member of the original and continuing design team for Prometheus Payment.

She's been a prolific author and any of you who have followed Prometheus Payment I'm sure have read papers that she's written in the past. I wanted to point out one paper in particular. She wrote on this very topic of organizational and governance structures for organizations looking to apply to the CMMI Bundled Payment Initiative and it was that paper which caused me to reach out to her and ask her to present today. And you can find that paper at http://www.hci3.org.

Okay. I'm going to turn this over to Ms. Gosfield to present. I want to just say a word to anybody who has tuned in a little bit late to tell you, you can download the PDF of all of these slides by clicking the "supporting materials" button at the bottom of your screen and that will lead you to a PDF which you can then open or print. And let me just change the slide presentation here. Okay. Can you see your slides, Alice?

ALICE GOSFIELD: I can. It's very exciting.

WESLIE KARY: Okay.

ALICE GOSFIELD: And so with that let me thank you for the introduction and say how delighted I am to be able to participate in this opportunity to share some experiences that I've had and I hope provoke some thoughts about very on-the-ground practical issues that go along with bundled payment in an environment where CMMI is offering what I think is a spectacular learning lab opportunity for experiences in the field.

Since some of what I say may raise questions, I think that I'm giving you my contact information so that you can after the presentation or even tomorrow or the next day if there's something that I said that raised problems for you, you can get back to me and I'll be happy to answer those kind of questions by email.

So let's look at what it is that I'm going to be addressing in this presentation. And the first is what kinds of entities, and there are a variety of models that CMMI is offering, but within those models a range of entities can play in this particular sandbox. I'm going to talk about governance issues, which are very important and in fact as far as I'm concerned, were part of the downfall of what happened with PHOs to the extent that they got contracts in the mid-90s.

Then I'm going to talk about issues that arise in contracts and things that should be dealt with in contracts among the providers who are participating in a bundled payment opportunity. And then I'll talk about dispute resolution because there will undoubtedly be disputes 'cause when there is money that is available for people to share, people fight over it and there will be problems that will emerge out of data and a variety of other issues that may come up.

So let's move to the fundamental issue of calculating the bundle and capturing the bundle. Obviously in a model like what CMMI is offering, the most critical factor that drives what should be dealt with

contractually is what the bundle includes. Defining the episode is most critical to the bundling. You'll see a link to a product so to speak—it's free—that the Prometheus Payment Program has made available that's a way to define episodes that is a really essential aspect to what you take into account in looking at contracting.

And some of the issues are what triggers a bundle? How do you know that a bundle has begun? What breaks a bundle? You thought the patient was being treated for diabetes and then they have a heart attack and so do you continue to treat them on the diabetes bundle or have you now broken the bundle? Or they break their leg and they're being treated for something entirely different. And then how do you know when a bundle has ended? It's the same thing in general episode payment issues.

How the bundle binds the providers together, which is the whole point of bundled payment, is another critical issue and the contracts are part of what is going to define that. Some of the potential contracts and how many you need and how complex the relationships are depend on how many and what conditions your bundles are addressing. So you may have contracts that are physicians to physicians where the PCPs and the specialists have a common understanding about who's playing for what part of the bundle.

You may have the issues where there need to be contractual relationships among specialists. As an example what happens when endocrinologists are treating a patient for diabetes and cardiologists are treating for CHF and they end up crossing borders with each other? Obviously in the hospitalization bundles there are—the whole point is that the hospital payment and physician payment are linked. And so there has to be contracts between the hospitals and the physicians. And then there are issues that pertain to hospitals with other providers. And when we get to Model 3, you'll see that it's providers among each other.

The way the bundle binds the providers is either truly with actually one payment that is made to one entity that then allocates it or you can have virtual bundles, which are really a budget but each participant gets paid individually. That's the model that Prometheus uses, which is a budget with reconciliation. And a couple of the models that CMMI is offering are those kinds of issues.

The upside and downside issues are what make or break these kinds of innovative projects. Upside means you have the opportunity to get more money and downside means you may have to actually write a check to somebody, meaning in this instance Medicare. I don't consider the business risk of whether you managed the clinical processes effectively to be downside risk. While it's true that you may not be paid for a preventable readmission, that's not the same as actually having to write a check out of your pocket to repay someone. So upside and downside mean different things in different settings.

So the first issue is what are the kinds of entities that can play? And obviously a big multispecialty physician group or if you're doing a cardiology bundle only, a large cardiology group that is already dedicated to a single hospital could drive the organizational structure. The participation in these bundles does not have to be exclusive, which to me is cutting off your nose to spite your face. I've seen transactions where a hospital will take a position that cardiologists who participate in four different institutions in town can't participate in their innovative project because they're participating in other hospitals. I think that's not... It has nothing to do with what the point of the bundled payment actually is and it doesn't have to be created that way.

An IPA is a network of otherwise independent physicians who have come together, can play in this environment. And bundled payments if they work effectively, drive clinical integration. So some of the antitrust issues go away in a bundled payment setting that otherwise exist in other environments. There are still some IPAs that are viable that have emerged out of the mid-90s, even outside of California where the IPAs play a very different role because they have traditionally taken on far more of the functions that managed care organizations play. But an IPA of physicians could contract with hospitals in those models where the hospital is the primary focus of what the payment is going to be about.

To my way of thinking bundled payment requires real clinical integration. And real clinical integration is not the antitrust concept of clinical integration. I've given you a link to a clinical integration self-assessment test that can be used within a physician practice, between a hospital and physicians in one of these kinds of bundled payment environments. It can be used within the organized medical staff. And it looks at 17 attributes of clinical integration across 3 sort of evolutionary scenarios. Barely in the game to sort of moving further along the continuum to really being able to play these more sophisticated kind of payment games more easily.

My point is that the architecture of the mechanisms, whether it's a PHO or any other kind of entity really doesn't matter. Clinical integration is the sine qua non for being able to succeed in any of these bundled transactions.

So another kind of entity that could play and take the money from Medicare for allocation in bundled payment is a co-management entity. These are increasingly popular ventures that are created sometimes among otherwise independent physician practice groups that are dedicated to a hospital. Typically they're set up as a limited liability company that gives corporate protection for liability purposes. If you are in a state that's a corporate practice state like Pennsylvania or California, then the only kinds of entities that can practice medicine are professional limited liability companies. But the reason these limited liability companies are used is that you get corporate protection from business liability, but you are taxed as a partnership, which means that the profits and the losses go directly to the income tax returns of the investors.

Often these co-management entities are condition or service line focused. They are probably the most favored version of them is cardiology and cardiovascular disease in part because these are big-ticket items for the hospital. They are also very high on the list of the conditions that are the subject of value-based purchasing. And so cardiology and cardiovascular disease is a typical co-management entity. Also there's a pretty good number of them in orthopedics. I've seen them in neurology. I've seen them in oncology. They can be done in virtually any condition or service line setting.

Usually they are set up with a small investment from the physicians. They are usually set up so that as a for-profit entity the physicians share equally based on their ownership on any return on investment. You could do that in a different way, which I'll talk a little bit more about a little further on.

The governing document for a limited liability company is a single operating agreement that establishes the responsibilities of the managers who run the company and are typically also the investors in the company. Usually in a co-management transaction there is an agreement between the hospital and the co-management entity where the hospital pays the entity some fair-market value amount for the management services, which are clinical management services that the physicians provide to improve the hospital's results on any of a number of bases.

The next kind of entity and there are still some that exist, is a PHO, a physician hospital organization. These are typically a corporation which is different from a limited liability company in which there is either a small dollar investment by the participants who by name are physicians and a hospital. And some of them have been set up as a membership model where there really is not a return on investment so to speak because they're not for profit in the typical sense. Not that they're tax exempt, but they're not designed for profit. They're designed to drive dollars into the participants' pockets.

The physicians and the other providers who are either invested in this or are members participate by contract and they have issues that will come up in traditional PHO models that have to do with antitrust laws where they are only allowed to be messengers because there isn't enough financial integration in the old line PHOs. They didn't take financial risk in the form of withholds and significant capitation dollars or global risk or percent of premium or something like that. But one of the thing...

And in a messenger model, which is a very weak model, what happens is that it's like AOL, you have mail. The messenger, which is the PHO, is not allowed to negotiate with the payer for fees. It is only allowed to say to the payer what the participating physicians are willing to accept individually on their fee schedules. That problem goes away when you have a truly clinically integrated environment under the antitrust rules. And if a bundled payment project is working the right way, it is based foundationally on the idea of clinical integration. So the antitrust issues are far less and in fact mostly go away.

The controlling documents in a PHO are typically the articles of incorporation, the bylaws, shareholders' agreements if it's for profit, and then the participation agreements for the providers. In this situation where a PHO might be playing for only a defined number of bundles around defined conditions for the CMMI pilot, you likely would have to think about setting up a sub-network of physicians that would participate through the PHO just around the conditions that the bundles pertain to. There will be the issues around governance of the sub-network within the PHO and the physicians who are in the sub-network would have additional participation agreements that would drive the way the CMMI bundled payment would be handled within the sub-network within the PHO.

Under the CMMI Model 2, you could have a PHO take the bundled payment directly from Medicare. That's where it's the combined hospital and physician services together being paid under the bundle. For Models 1 and 4, which are more oriented around the hospital side of the street, the PHO could still be a mechanism to share gains even though the hospital is directly getting the payment from Medicare to the PHO.

In addition to those kinds of entities, there might have to be new entities that would be formed. For Model 3, which is the post-discharge, post-acute care CMMI model, you would clearly have to have home health agencies, skilled nursing facilities, long-term acute care hospitals potentially. And if you were setting up a new network, you would have all of the same issues associated with establishing an IPA so to speak, which is how people come together; what does the investment look like; what is the capital that's necessary. And since in these in the post-discharge model CMMI is going to impose downside risk, which means potentially repayment to Medicare, the entity is going to have to be able to demonstrate its ability to bear that downside risk. So there has to be some kind of capital.

Which providers would you include in the ownership of an entity if you were going to set it up so it was an owned model? The providers who are delivering the predominant volume of care could be owners, but everything could be done by contract just as easily. You might want to think about setting up a new network of physicians. As I have traveled around the country talking to physicians about alignment

strategies in places as disparate as Houston and Wichita, I have found cadres of independent physicians who would like to come together and play some of these clinical integration games. I've given you the link to a different clinical integration self-assessment tool that otherwise independent physicians might want to use in looking at how they would come together around a bundled payment model.

And then in today's world if you're forming a new PHO, chances are it's likely going to be some version of an accountable care organization (ACO) or an integrated delivery network kind of entity. That's what the new version of a PHO would likely look like.

So let's move to some of the governance issues. If you already have a co-management entity, sometimes the hospital is in the co-management entity and sometimes it isn't. The hospital doesn't have to be an owner and in my experience hospitals ask to be owners as a matter of exercising control and input. You don't have to do that and you can set up a governance structure where the co-management entity is owned only by the co-managing physicians, but the governance is a joint governance. Remember it's called co-management so that there are physicians and administrators that are working together in order to improve the hospital's results.

Some people focus on the issue of whether there is an odd number of directors that are on the Board of Directors. This tends to be an issue that physicians will raise. They don't... The hospital may want an odd number of directors. If the physicians are looking at an odd number of directors, they want to have more directors than the hospital does. The idea is that if you have even numbers of directors, you can get caught in a war of the roses and I don't mean the English one. I mean the one that was the Michael Douglas movie where you can't come to a resolution on anything and you end up with deadlocks.

Another issue that comes up in these co-management entities is should it be one man, one vote in terms of participation by physicians or by groups? Or since you may have a larger group that really is contributing more to the work of the bundle or the co-management entity, that they should be able to get more power in terms of their voting rights? Smaller physician practices will be very threatened by that and feel that they've been disenfranchised by the power of the larger groups. These are one of the things that you have to come to grips with in setting up these kinds of programs so that you don't end up having everybody having a food fight later on.

One of the other issues that comes up is whether—and typically it's the hospital that wants to do this – you should allow in-kind contributions for the capitalization of what the company will need so to speak in order to be able to operate.

So one of the issues that I foreshadow as a really significant one to address as you are considering making a bundled payment project real, is on what issues are you going to require a supermajority vote? For the participants who are playing, whether it's hospitals and physicians, primaries with specialists, other kinds of providers, a supermajority is typically used when you want to make sure that there is more than just a majority consensus on what needs to be done.

And so in any corporation or any governance structure, typical supermajorities are needed in order to dissolve the company or to incur debt or get a credit line or to amend the basic agreements by which the company operates or to get approval of a budget or to change the legal form. We're going to change from an LLC to a corporation. We're going to not be a Subchapter S corporation anymore.

In this bundled payment context, I would suggest that you think about topics on which you ought to have supermajority votes from a governance perspective. And these would absolutely include changing the compensation or allocation metrics by which the dollars on the upside or the payments on the downside are to be allocated. Adding providers might require a supermajority vote. Adding classes of providers, both in participation or in governance; terminating a provider could be subject to a supermajority review. We'll talk about appeals in a little bit. Resolving appeals could require a supermajority. And certainly terminating pilots should require a supermajority.

There are an additional range of issue that will track very directly to what the episode that drives the bundle is about. Which classes of providers are allowed to buy in if it's an LLC or a corporation? Which classes of providers, I mean types. Skilled nursing facilities; home health agencies; physical therapists; rehab; pharmacy are involved in governance and voting. Remember that you can have governance that is separate. In other words, the representation in the governance does not have to reflect precisely what the ownership structure is.

What drives who should be sitting at the table in terms of participating in the upside value of the investment so to speak or in the governance depends on what the episodes are about. Some providers are more important in some settings than others. As an example, in avoiding hospital readmissions home health is really important. They might be owners in one of the CMMI models that would be focused around that, but in treating a Medicare patient for pneumonia, physical therapy may not be as important as—by analogy as the home health services. And so they might participate by contract only, which brings me to the topic of contracts.

Probably the most important thing to address in the contract is the downside risk. Who is going to have to participate in coming up with the funds to write the check to repay any lost dollars that Medicare is going to require be repaid? This was the killer issue in the mid-90s. Generally speaking, hospitals took the position that they would take the risk, in the PHOs, but I participated with groups that really had horrendous situations.

One that I can think of that's just an example of exactly what not to do that was a super PHO that involved seven hospitals and medical staffs. They lost a boatload of money on a commercial transaction and one of the hospitals turned to their primary care physicians to make up the downside risk. We're almost 20 years away from that and the animosities still linger from the problems associated with trying to get the dollars back.

Another approach might be to say well, okay, we'll escrow so to speak or set aside some funds for the potential of a downside risk. But where physicians are already getting paid discounted fee-for-service in the CMMI models that are focused that way, holding back additional money within the playing entity is a real problem on a cash flow basis for the physicians.

In an ACO under the waivers that have been made available for the Medicare shared savings ACO, the problem of the hospital fronting the money has been waived as a Stark and fraud and abuse issue, but it hasn't been waived in the CMMI bundled payment. CMS says that they can waive it and I would recommend that to the extent that the hospital wants to front this money that you absolutely ask for a waiver from CMS to make this work.

The upside distributions are also a problem. And in the very few instances in the mid-90s where there were PHOs that actually got money, the most critical problem was there were not predetermined

metrics documented in the agreements that said who was going to get what kind of money. Those food fights were what made the PHOs fall apart.

Clinical practice guidelines can help. The Prometheus Payment model that is based on clinical practice guidelines can help because they take into account which provider is supposed to be and is expected to be rendering which services. The real issue in avoiding food fights here, which is why it's really important that the lawyer who's drafting these documents understands what the bundles mean is to go back and look at the issue of what the budget expected people to be doing and then who actually did those things.

Other issues to address in contracts among providers is what are the grounds to throw somebody out, involuntary termination? I mean obviously using your—losing your basic qualifications like your license to practice or your clinical privileges or your Medicare participation would be something that should be grounds for involuntary termination; but in the current environment, if you have a physician who's been put on prepayment review where his cash flow is completely disrupted based on a Medicare determination that there is a suspicion of fraud, which may or may not be right, that physician is going to function differently when his cash flow is disrupted. So that may be a reason to have an involuntary termination of a provider during the term.

Becoming the subject of an investigation that could lead to being sanctioned, meaning paying civil money penalties or being excluded. Physicians who "cherry pick," which means that they pick only the healthiest patients to treat or "lemon drop," which means that they get rid of the really complex patients.

Probably the most critical issue to throw people out involuntarily is their failure to comply with standards, which means what are the standards of the network that's going to be providing the bundled payment? That's clinical standards and where are they documented? Should you give them an opportunity to cure the problem depends on the nature of the problem.

Then comes the issue of what happens if somebody wants to get out? Well, you may not want to let people get out all that easily because if you're getting money from Medicare on one of these pilots, it's predicated on the fact that you have a network that's sufficient to deliver the services that you said you're going to provide. How much notice should somebody be allowed to give for this? And should you restrict them so that they can't get out other than before the end of some specified term? In other words, you can't get out until 90 days before the end of the first year.

What should you say in the contract about whether anyone else can join the pilot? And you may want to put this in the governing documents as well. Can new participants join the governance entity or can they just participate contractually? If so, who's eligible to participate during the term and what are the criteria? Do you want to require that they have enough business that you know that they actually deliver quality care? Do you want to say we don't let newcomers into our entity? You have to have been part of the hospital medical staff or the system or the IPA or the PHO or have had staff privilege for at least a year.

How does somebody new coming in affect the distribution of upside rewards or collecting money for downside contributions? Obviously if you have new participants and there's a loss that people have to repay, it spreads the risk on the downside, but it dilutes the reward on the upside.

Post-termination. Do you go after somebody who used to participate and contributed to part of the loss? What happens to somebody who has voluntarily gotten out? Would you let them have a pro rata participation on the upside at the end? I think my instinct is that I wouldn't, but that's a cultural issue that needs to be determined. Does that decision, either of those two decisions, turn on when the termination occurred? In other words, they hung in to very close to the end and then got out, maybe for reasons that weren't really within their control. Voluntary terminations by providers can undermine the whole project, but on the other hand, who wants disgruntled participants involved?

What are you going to do if two providers claim the right to payment for the same part of the episode? There are a number of options. You could say if you can't figure it out, this is the dreaded attribution problem. If you guys can't work it out, neither of you gets the bonus. You could say the guy with the most visits is the one that gets the bonus. You can say you have to work it out or you can say there should be an appeal.

Most co-management agreements today typically pay all physicians in accordance with their ownership, which is one man, one vote. So the reward from the upside isn't pro rata. And one of the problems with that is that the "lay abouts" don't really contribute as much or work very hard, get as much money as the people who are working very hard.

I think that the things that ought not be subject to appeal in the bundled payment are the definition of an episode; which part of the episode the provider contracted to provide; the rules pertaining to when an episode is triggered, broken or ends; and obviously Medicare's direct payment to the provider.

Things that you might make subject to dispute resolution are things that are driven by data. Whether an episode was triggered; two providers want the same piece of the budget; whether the episode is broken or ended; whether severity adjustments would apply; whether quality thresholds have been met.

If you're confronting the issue of dispute resolution, you may -- you have to look at who is going to engage in this. Should there be reconsideration by the same decision maker? For example, a leadership council that consists of the representatives of the participants as in a co-management arrangement. Or reconsideration by a different internal body that wasn't involved in the first decision that led to the appeal, ultimately subject to a board or the managers of the same class of providers review. Would you want to give a full fair hearing? I wouldn't, but doctors traditionally ask for that. Or do you want to send the dispute resolution to an external body like the American Health Lawyers Association Dispute Resolution Service? There's no one answer to these questions. They're all issues that have to be dealt with though.

Finally, you want to consider timeframes for appeals; what kind of evidence is permitted; whether attorneys should be allowed. You don't have to involve them. This is not a constitutional law forum. Whether this is a review of the record or you allow oral argument or a face-to-face review and what types of records will be maintained. If you don't address dispute resolution in the contracts, you will end up in court over disputes, which is a bad, bad result. On that note, I'll close my formal presentation and turn it over to the moderator.

WESLIE KARY: Thank you so much. It's been a great presentation. We just got a note from someone saying it's been a great presentation. So we appreciate those as well as questions. We have a few questions lined up, but there's still time to ask an additional question by pressing the "ask a question" button at the bottom of your screen.

And I'll just say the very first question that we got was the request that I restate the reference to the paper that I mentioned at the beginning of the meeting. And so this is the paper that Alice Gosfield wrote and it's posted on the HCI3 website, which is http://www.hci3.org.

ALICE GOSFIELD: And I believe that the paper is embedded in the implementation toolkit.

WESLIE KARY: Yes.

ALICE GOSFIELD: 'Cause it's not the most... It's not the easiest website to navigate around.

WESLIE KARY: Okay. All right. And then we do as always have a couple of questions that are really better directed to CMS. And we will not ask those questions of our speaker, but just so you know, if you have a question that needs a CMS answer, you should send it to BundledPayments@cms.hhs.gov. Okay. I'm going to ask my associate, Maggie, to read some questions to you.

MARGARET SAVAGE: So the first question is must your bundled... Must your bundle account for every physician who touches the patient while hospitalized? Or can the bundle be for just certain doctors: cardiologists, pathologists, etc., but exclude say a rheumatologist?

ALICE GOSFIELD: I think it depends on the—what it is that you're claiming you're getting paid for. In other words, if a patient has a comorbid condition that occurs that's outside of what your episode is about, traditionally that person would be paid fee-for-service by Medicare. The answer in the bundled payment context to me is, are they participating in the reward opportunity that comes from the bundled payment exercise? So you can exclude people. And I think that that is driven by what the conditions are that you're playing for.

MARGARET SAVAGE: Great. Thank you. Our next question is could you provide a source for more information about co-management arrangements? May the hospital pay the entity on the basis of dollars saved at the hospital level even without winning a CMMI bundled demonstration arrangement?

ALICE GOSFIELD: So co-management contracts are done in a variety of ways. One of the things that's problematic under Medicare law is there's this bizarre provision that was enacted into law that gets waived on the ACO side of the street but does not get waived anywhere else that says a hospital is not permitted to pay physicians for reducing services to patients and parenthetically you should understand that that means even off of a baseline of overuse of which we have vast quantities in this country. So the payment can't be for reduced length of stay as an example. If you pay purely on the basis of dollars saved, that is a gain sharing model and the OIG has approved certain of these things, but they come with a lot of bells and whistles.

If you're asking me, the best way to quantify the dollars in a co-management arrangement, there are two ways you can get paid. One is the physicians can get paid for the time that they spend. I tell my clients you don't want to get paid by the hospital for an hour working for them because the last thing that you have as your scarce commodity is time. What you really want to get paid for is non-CPT work and so the way you do that is by getting paid for results.

Now, one of the concepts that we kind of came up with in the Prometheus model that drove everything else is the value, the economic value of potentially avoided complications. There's actually available at the HCI3 website ECR analytics, which can take any claims database and sift through it and report to the hospital where potentially avoidable complications exist. Potentially avoidable complications are all

kinds of things. They're unplanned returns to the OR. They're blood loss. They are readmissions. They are all of the kinds of things that in a quality-driven environment you would not want to see.

And so these are now quantifiable by valuators who know what they're doing of which there are really a relative few who live on the quality side of the street who can really look at what the dollar implications are of these avoided costs. To me getting paid for those kinds of results is a better way to go.

There are other kinds of metrics that have dollars associated with them. All the stuff that's in the hospital-based—the hospital value-based purchasing metrics that CMS is using, which is the skip measures and the performance on the cardiology measures, all of those are quantifiable as well. So allocating dollars to the co-management entity that come from that pool of money is a far better way of doing it and it doesn't get you crosswise with other aspects of the law than paying for shared savings literally just on that basis, where you certainly can pay for a reduced length of stay.

WESLIE KARY: Okay. Thank you. I'm going to read the next question then and I want to editorialize on it a little bit too. So here's the question, do you know if CMS will offer concessions or waivers to implement bundled payment structures in Maryland since by federal law rates are set by the regulatory body and all payers pay the same amount? So if you, you know, whatever you feel you can answer to that question specifically, but I'd appreciate if you could talk a little bit about the interaction between state law and how they might –it might affect these arrangements versus the bundled payment program at CMMI.

ALICE GOSFIELD: Ay yi yi. Okay. Medicare... Medicare as a federal law is a preemptive law and so I would think that the way it would be handled as a demonstration project, which is the way these kinds of things have been handled in the past, is through some negotiated waiver that would occur at the state level. That's not really my area of expertise I have to say.

You know, Medicare preempts on certain aspects of the law, but it doesn't preempt the police powers which, you know, we're in a republic where we have states that have police powers. That's how they license hospitals under the state police powers and the physicians and all that. So the intersection around this issue I have no idea what the answer is. I would think it would have to be negotiated.

WESLIE KARY: Okay.

MARGARET SAVAGE: Great. So our next question is how do you feel of having providers being given an admin fee as opposed to negotiating upside downside for participating given the May 16th application due date?

ALICE GOSFIELD: An admin fee? I'm not sure what that means. If you're saying you're going to pay them for the time that they put in or the administration that they performed in the development of the program or the operation of the program, if physicians want that, that's fine. But that to me is not a whole lot different from paying them for an hour of their time like a medical directorship. It's okay, but I think that physicians have, you know, time is the one thing that they don't have. And the fair-market value of an hour in a physician's time pales by comparison with the amount of money that physicians can earn by helping hospitals save money by improving their quality and their value.

MARGARET SAVAGE: Excellent. So this next question comes from an academic medical center and they ask are there concerns or limitations around gain sharing with referring specialists who may not directly

care for the patient on an inpatient basis but may have a post-acute care role in the bundle? I am specifically concerned about violating legal restrictions around paying for referrals since the referring physician may only be eligible for gain share if they refer their patient to us rather than other hospitals in the region.

ALICE GOSFIELD: So this is one of the issues that's been addressed in the ACO Medicare Shared Savings Program waivers where they say, you know, we're going to waive the prohibitions under Stark and the anti-kickback statute. I said I wasn't going to talk about this, but I don't mind answering questions about it. CMS has said that in the CMMI bundled payment pilot that they will consider doing that. I think definitively you should ask for it because otherwise there's going to be a question mark as to what really goes on. There's only been a definitive statement made with regard to ACOs.

And the problem is that in point of fact that the whole issue around the essence of Stark and part of the essence of anti-kickback is they were really utilization control statutes. The idea behind Stark was –and it came off of a study that was done in 1991 down in Florida that showed not very surprisingly that physicians who invested in imaging centers used them more. And so I recently made the argument that the Stark statute was completely misguided for the issues that it was supposed to address, which are are we paying too much money for this service, which is determined on a fee schedule because of the fact that, you know, physicians are invested in the thing? The most critical question is did this patient need this service on this day? And the Stark statute says nothing about that.

In a bundled payment model the incentives are the opposite of what the incentives are around what Stark and the anti-kickback statute were getting at on the overuse side of the street so there's every good reason to believe there should be waivers with regard to this. You're not getting paid for referrals if you participate in gain sharing. You're getting paid for what the quality metrics are in a hospital you are already related to. And as long as the dollar amount is fair-market value, then it should fall under the personal services exception under Stark and the anti-kickback statute.

MARGARET SAVAGE: Great. Thank you. And I think you might have started to address this next question in your previous answer, but how will gain sharing and related payments impact fair-market value for physician compensation considerations in the local market?

ALICE GOSFIELD: So fair-market value is a very, very wide pathway to drive through. Fair-market value is a range. It's not a number as defined in the regulatory environment. It's general market value with reference to what it would cost to obtain something on the street. So the role of valuators, really good valuators in these transactions is really, really important. I'm talking about people who are creative, who understand quality, who don't live purely in a CPA kind of frame of reference, that aren't just bean counters because gain sharing is kind of a loosey-goosey word. It originally... It comes out of worker compensation concepts originally.

In the Medicare world there was a period of time when the OIG said this is a horrifying thing that we'll never approve and they put out a fraud alert on it that said we think gain sharing is bad and because you can't pay people to reduce services, we're not going to allow it to happen. And then somebody came forward, Jane Goodroe got the first opinion, which had a gain sharing model that had all kind of bells and whistles and safeguards associated with it. And the government said well, you know, maybe we would let something like this happen.

There have since been probably about ten gain sharing opinions that say that yes, you can pay out of savings. Gain sharing also has come to be used as a word that simply describes the opportunity for an upside reward. I think of it more in the narrow paying out of savings kind of concept in which case you have to be very careful what the metrics are that you're using because as I said, you can't pay for reducing services.

Now, you can get as an example, you can get very close to what a reduced length of stay looks like when you get in and analyze the data as to what is causing the undesirable length of stay that you're trying to reduce. And if you find that it's unplanned return to the OR, or unavailability of beds on the unit or something along those lines, you can come up with a surrogate for what the length of stay itself is and you can compensate people for reducing untoward events. That's not the same as reducing services. So there's... It really is a relatively sophisticated kind of approach and I will tell you that lawyers who don't understand quality and lawyers who don't understand bundles shouldn't be playing this game.

MARGARET SAVAGE: Okay. We have time for one last question and here it is. With a Model 3 awardee only as a skilled nursing facility in which we will need to reduce hospital readmits and length of stay, is gain sharing with key doctors who can assist us to avoid hospital readmits the major factor? And can we also include an acute hospital in gain sharing if they assist us to reduce hospital readmits from the skilled nursing facility?

ALICE GOSFIELD: I think you can include all of them. I don't think there's any reason to exclude any of them. What you really have to look at is how much are they bringing to the party? I mean if you want them engaged with you in a significant way, then they should, they're probably going to want to play for the upside risk. Negotiating how much they get as opposed to how much you get should turn on what everybody is contributing. But I see no reason not to include them.

WESLIE KARY: All right. Great. Thank you very much. Good questions. Good answers. And other comments that people really enjoyed this presentation so we're happy.

ALICE GOSFIELD: Good. Thank you. I'm happy to hear that. If I said something that was really confusing or that people think about later and go, "What was that?" my contact slide gives you my email. You can send me an email.

WESLIE KARY: Okay. And that gives me an entree to remind people that you can actually download the slides right now as a PDF by hitting the "supplemental materials," "supporting materials" bucket on your screen. And also before any of you sign off, please do take the survey.

And I just want to mention that we do have another session coming up on April 6th that will be at 11:30 a.m. Eastern and the topic will be gain sharing. And currently our last session will—that we have planned will follow this one. I don't have a date yet, but the topic is going to be on financial issues, pricing and other risk mitigation strategies.

In your survey I'd really appreciate it actually if... There's a question in the survey which asks, you know, what additional topics would be interesting to you. If you want to give me an opinion about specifics within gain sharing or specifics around financial issues that you would like our speakers to address, that would be very helpful to me at this point and we can try and make sure we have another couple of presentations which you believe are right onto your needs. So I'll just make a plug for that and ask you to remember that the views that were expressed today are the views of Alice Gosfield and me to the

extent that I said anything, and do not necessarily reflect the views or policies of the Centers for Medicare and Medicaid Services and the materials we have provided are for educational use only.

Another way to suggest topics or additional topics for ADLS sessions or specifics for the topics within those sessions, send me an email and you can do that by sending that to bpci-web@air.org and that is everything for today. We thank you very much for your participation as always and please take the survey before you log off. Thank you.

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