BUNDLED PAYMENTS

Comprehensive Care for Joint Replacement (CJR)

GAINSHARING

How gainsharing works in Medicare’s CJR model and considerations for hospitals when engaging providers in a gainsharing program

The material herein describes various models of physician-institution gainsharing relationships in the context of the Medicare Comprehensive Care for Joint Replacement program and is presented for informational and educational purposes only. It is not intended to address specific arrangements and is not intended to constitute legal or financial advice. You should always consult with your own business, legal, and financial advisors concerning any health care delivery relationships that you are considering.
Gainsharing: A Tool for CJR Success

Successful transitions to bundled payments require aligning providers and clinical processes. The most common downfall of hospitals entering bundled payment arrangements is failure to gain clinician buy-in.¹

In its CJR model (see below), the Centers for Medicare and Medicaid Services (CMS) waives certain gainsharing regulations for participants.² CMS recognizes that gainsharing can be a vital tool for engaging inpatient physicians in internal cost-reduction and care-redesign strategies and for motivating outpatient healthcare professionals (HCPs) to align clinical processes with those of the hospital.¹

Gainsharing encourages efficiency and allows providers to refer patients to others with whom they have financial arrangements.

CJR model: the first mandatory bundle from CMS

On April 1, 2016, a total of 794 hospitals in 67 metropolitan statistical areas began taking responsibility for episode costs for Medicare joint replacement patients. In selecting joint replacement as its first condition for mandatory bundled payments, CMS focused on cost variation in a high-volume population that typically has few outliers in terms of complexity.¹

<table>
<thead>
<tr>
<th>DRGs</th>
<th>469/470 (Major joint replacement of lower extremity)²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode</td>
<td>From <em>index admission</em> to 90 days after discharge²</td>
</tr>
<tr>
<td>Bundle</td>
<td>All spending, including index admission, physician fees, post-acute care, outpatient services, and readmissions¹</td>
</tr>
<tr>
<td>Payment</td>
<td>CMS assesses FFS claims over 1 year against a <em>target price</em>. Depending on the difference, hospitals either receive a <em>reconciliation payment</em> or repay the difference to CMS³</td>
</tr>
<tr>
<td>Quality</td>
<td>CMS raises target prices for hospitals that score well on complication rates and <em>HCAHPS</em>⁴</td>
</tr>
</tbody>
</table>

DRG=diagnosis-related group, FFS=fee for service, HCAHPS=Hospital Consumer Assessment of Healthcare Providers and Systems. Words in *italics* are defined in the *Glossary & Resources* brochure.
The Use of Gainsharing in Bundled Payment Programs

The Department of Health and Human Services’ Office of the Inspector General (OIG) defines gainsharing as follows:

“An arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital’s costs for patient care attributable in part to the physicians’ efforts.”

Initially, OIG advised that most forms of gainsharing between hospitals and HCPs were illegal, but over time it has permitted gainsharing under certain circumstances. For physicians and other clinicians who follow the ground rules (see page 6), gainsharing is permitted under the CJR model.

Hospitals participating in CJR may enter into financial arrangements with other institutions and HCPs that support their efforts to improve quality and reduce costs.

Called collaborators, these providers include the following:

- Physicians, nonphysician HCPs, and providers and suppliers of outpatient therapy
- Inpatient rehabilitation facilities
- Home health agencies
- Physician group practices
- Long-term care hospitals
- Skilled nursing facilities
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HCPs and facilities eligible to participate in a CJR gainsharing agreement

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Bundled payments help to resolve gainsharing concerns

Given traditional legal complexities about gainsharing, hospitals and HCPs have been cautious about embracing it. When hospitals did enact gainsharing programs, some saw a plateau effect in which initial bonuses diminished over time. Often, this effect was because programs were narrowly focused, such as on device costs; when savings were achieved, bonuses disappeared.⁷

Bundled payment programs may help to overcome these obstacles. For both the Bundled Payments for Care Improvement (BPCI) and CJR programs, OIG addressed legal concerns by issuing safe harbors.²,⁸ As for the plateau effect, bundling for episodes of care provides multiple opportunities for cost savings by reducing unwarranted variations in care among collaborators (see case study below). Moreover, as long as HCPs maintain their initial successes against target prices, they will continue to be rewarded rather than see gainsharing rewards evaporate.⁷

Case Study
Multiple avenues for sustainable cost savings

A New York City–area health system sought to bring down costs without compromising quality. Using various cost drivers in orthopedics, ranging from OR charges and surgical supplies to care processes, hand hygiene, and the completeness of documentation in the medical record, the hospital defined “best practice” as the top quartile of physicians.⁹ It challenged staff to meet this standard, setting up a gainsharing arrangement as an incentive to reduce costs.

A total of 184 physicians enrolled in the program. Over 3 years, the hospital saved $1835 per admission, which was largely attributable to shorter lengths of stay and lower supply costs.⁹ Infection rates decreased, accuracy and timeliness of medical documentation improved (both of which are important today for the CMS Value-Based Purchasing program and The Joint Commission accreditation), and discharge planning took place earlier in the episode.⁹
Why Would Hospitals Consider Gainsharing in CJR?

For a hospital, sharing CJR savings with HCPs may accomplish the following:

<table>
<thead>
<tr>
<th>Motivate partners</th>
<th>Engage physicians</th>
<th>Reward collaborators</th>
<th>Incentivize PAC facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPs have financial incentives to improve care protocols and quality</td>
<td>Gainsharing encourages inpatient and outpatient physicians to be active participants in care redesign</td>
<td>Shared savings recognize clinical staff's efforts to make care more cost-efficient</td>
<td>Helps long-term care and skilled nursing facilities to make up revenue lost due to shorter stays and fewer referrals</td>
</tr>
</tbody>
</table>

PAC=post-acute care.

Would providers go along with it?

In thinking about whether or how to develop a gainsharing protocol, it can be useful to assess the culture of your organization and your market’s readiness for risk.

- Is the relationship between the hospital and its staff physicians cooperative?
- Are physician opinion leaders open to clinical redesign?
- Are community providers familiar with bundled payments and gainsharing?
- Do these entities have an appetite for risk?
- Does a hospital or health system have strong vertical integration with outpatient providers in terms of alignment on care processes and quality?

If the answer to each of these questions is “yes,” then a gainsharing program might be designed to take an already strong established relationship ready for more between the hospital and PAC providers to the next level. If, on the other hand, physicians in a market are skeptical about gainsharing or have traditionally “done things their way,” they may need encouragement to join.

Designing for your culture

- Take it to the next level!
  - Bonuses for system improvement
  - Tiered model based on total cost savings
  - Downside risk included

- Experience the journey!
  - Bonuses for individual improvement
  - Constant savings distribution rate
  - Shared savings only
Gainsharing Requirements Under CJR

To facilitate effective CJR gainsharing programs, OIG and CMS will waive certain federal fraud and abuse regulations for participants. Waivers allow distribution of gainsharing payments from hospitals to collaborators. Under these waivers, CJR participants are protected as long as the ground rules below are followed.¹¹

### The ground rules for gainsharing

In general, the ground rules for gainsharing in CJR are similar to those under BPCI Model 2. But for safe harbors to apply, participants must be careful to follow requirements specific to CJR.

<table>
<thead>
<tr>
<th>Ground rules (applicable to BPCI Model 2 and CJR)</th>
<th>The fine print specific to CJR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed agreement should list who is eligible for gainsharing ³¹¹</td>
<td>‣ Selection criteria for collaborators must relate to quality of care¹²</td>
</tr>
<tr>
<td>‣ A collaborator’s opportunity to participate cannot be based on volume or value of services¹²</td>
<td></td>
</tr>
<tr>
<td>Participants are accountable for quality of care³¹¹</td>
<td>‣ Collaborators must contribute to clinical redesign¹²</td>
</tr>
<tr>
<td>‣ Payment formulas must incorporate criteria related to quality of care¹²</td>
<td></td>
</tr>
<tr>
<td>Bonuses based solely on verifiable cost savings³¹¹</td>
<td>‣ Gainsharing distributions may derive only from CMS reconciliation payments or measurable internal cost savings¹²</td>
</tr>
<tr>
<td>‣ Hospitals must specify the formula for calculating percentage of reconciliation payments and internal savings¹</td>
<td></td>
</tr>
<tr>
<td>Bonuses cannot exceed 50% of Medicare FFS reimbursement rates³¹¹</td>
<td>‣ Hospitals can also assign risk to collaborators¹²</td>
</tr>
<tr>
<td>‣ Risk cannot exceed 50% of hospital’s downside liability¹²</td>
<td></td>
</tr>
<tr>
<td>Patients must receive all medically necessary care³¹¹</td>
<td>‣ Psychiatric hospitalization* and hospice are included in the episode⁴</td>
</tr>
</tbody>
</table>

* Unless hospitalization falls under an excluded DRG.

### What if there is no applicable safe harbor?

OIG directs participants to consider the following “prudential factors” in assessing the risk:

- Will the arrangement lead to increased government program costs?
- Will the arrangement incentivize overutilization of a product (utilization unrelated to cost and benefit)?
- Will the arrangement skew clinical decision-making in favor of the manufacturer’s product(s)?
- Will the arrangement give rise to patient safety concerns?
Considerations for Setting Up a CJR Gainsharing Model

Hospitals interested in pursuing a legal gainsharing agreement with collaborators will have to do their homework—both on internal processes and on potential collaborators.

Internal considerations: look for inefficiencies

An internal audit can provide information about inefficiencies and PAC discharge patterns. This information can be used to identify opportunities for savings and to design gainsharing formulas for physicians and other hospital staff.

Simplified hypothetical internal cost-savings methodology and gainsharing structure

**Step 1: Identify opportunities for savings**

<table>
<thead>
<tr>
<th></th>
<th>CMS baseline cost per case</th>
<th>Projected episodes, Year X</th>
<th>Projected cost per case*</th>
<th>Potential savings, all cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician A</td>
<td>$10,000</td>
<td>60</td>
<td>$8000</td>
<td>$120,000</td>
</tr>
<tr>
<td>Physician B</td>
<td>$10,000</td>
<td>30</td>
<td>$8500</td>
<td>$45,000</td>
</tr>
<tr>
<td>Physician C</td>
<td>$10,000</td>
<td>10</td>
<td>$9000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

**Total cases=100 | Total internal cost savings $175,000**

Less CJR expenses† ($25,000)

**Net projected savings (100 cases) $150,000**

* Based on discussions with physicians about supply and treatment costs, population severity, and other factors.

† Examples of CJR expenses may include investments in information technology or contracting expenses.

**Step 2: Describe how those savings are shared**

<table>
<thead>
<tr>
<th>Sample distribution of savings per case</th>
<th>Division of savings</th>
<th>Projected savings per case</th>
<th>Projected savings over 100 cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>50%</td>
<td>$750</td>
<td>$75,000</td>
</tr>
<tr>
<td>Surgeon</td>
<td>30%</td>
<td>$450</td>
<td>$45,000</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>10%</td>
<td>$150</td>
<td>$15,000</td>
</tr>
<tr>
<td>Other clinical staff</td>
<td>10%</td>
<td>$150</td>
<td>$15,000</td>
</tr>
</tbody>
</table>
Decision points for determining potential internal cost savings

Gainsharing formulas based on internal savings should be based on supporting documentation. Some considerations:

- What is the severity (e.g., comorbidities or Oxford scores) of your patient population?\textsuperscript{12,13}
- What are the components (e.g., supply costs) of your cost-per-case baseline?\textsuperscript{12}
- What expenses are associated with CJR compliance?\textsuperscript{12}

Knowing which costs you can control can help you to negotiate the value of those savings.

External considerations: know your network

Nearly half of 90-day episode spending for lower-extremity joint replacement costs occur after discharge.\textsuperscript{14} Clinically inappropriate utilization and post-discharge complications can be a major driver of PAC costs.\textsuperscript{1,15}

Here are 4 considerations for establishing a gainsharing model with PAC collaborators\textsuperscript{12}:

1. **Who would make good collaborators?**
   Medicare claims and quality data can reveal high- and low-cost providers and high performers on quality measures.

2. **How should your cost-sharing methodology be structured?**
   (see table, next page)
   Does this methodology comply with CMS regulations?

3. **What are your goals for collaboration?**
   Which initiatives (e.g., establishing care pathways or discharge protocols) can help you achieve those goals?

4. **How will you share data; monitor performance, progress, and outcomes; and establish means for improvement?**
Simplified hypothetical external collaborator gainsharing criteria and structure

<table>
<thead>
<tr>
<th>Source of funds</th>
<th>Amount</th>
<th>% available to share</th>
<th>Amount available to share</th>
<th>Alignment (loss) repayment†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal savings</td>
<td>$150,000</td>
<td>0%</td>
<td>$0*</td>
<td></td>
</tr>
<tr>
<td>Reconciliation payment</td>
<td>$100,000</td>
<td>50%</td>
<td>$50,000</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaborator type</th>
<th>Breakdown %, ($ available)†</th>
<th>Gainsharing bonus to provider</th>
<th>Breakdown % (by provider type)</th>
<th>Loss repayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF, LTCH, IRF</td>
<td>20% ($20,000)</td>
<td>§</td>
<td>10%</td>
<td>II</td>
</tr>
<tr>
<td>Physician group practice</td>
<td>20% ($20,000)</td>
<td>§</td>
<td>10%</td>
<td>II</td>
</tr>
<tr>
<td>Non-physician providers, HHA</td>
<td>10% ($10,000)</td>
<td>§</td>
<td>5%</td>
<td>II</td>
</tr>
</tbody>
</table>

HHA=home health agency, IRF=inpatient rehabilitation facility, LTCH=long-term care hospital, SNF=skilled nursing facility.

* In our hypothetical example, internal savings are being shared with hospital clinical staff, as shown on page 7.
† For illustrative purposes only. Dollar amounts of reconciliation payments and alignment (loss) repayments are limited to stop-gain and stop-loss thresholds, respectively, in each year of the program.
‡ Providers must meet defined quality thresholds to share in the distribution of funds.
§ Bonuses must be distributed “actually and proportionally” related to care of beneficiaries in a CJR episode. Multiply dollar figure at left by % of episodes shared by the provider to determine provider’s share of the bonus pool.
II Loss repayments must be distributed “actually and proportionally” related to care of beneficiaries in a CJR episode. Multiply hospital’s repayment obligation to CMS by percentage at left, and then multiply product by % of episodes shared by the provider, to determine provider’s repayment obligation to the hospital.

**Decision points for determining PAC gainsharing methodology**

**CMS requires written methodology for gainsharing formulas. Some considerations for PAC provider formulas:***

- What quality metrics and thresholds trigger payments to PAC providers?
- What percentage of savings should be allocated to each provider type?
- Will collaborators be required to repay the hospital for losses?

**Under CMS regulations, payment amounts must be proportionally related to care of beneficiaries in a CJR episode.**
**Summary: Gainsharing in CJR**

In bundled payment programs, gainsharing encourages efficiency and allows hospitals to refer patients to providers with whom they have financial arrangements. In its CJR model, CMS and OIG have waived certain federal prohibitions on gainsharing, giving hospitals that follow CMS’s ground rules the freedom to develop a gainsharing program with collaborators.

**Hospitals entering into a gainsharing agreement with collaborators will want to consider the following:**

1. **Goals for gainsharing: Do you want to accomplish any of the following goals?**
   - Engage physician leadership in your hospital?
   - Improve quality and transitions of care?
   - Motivate staff and outpatient partners to adhere to care protocols?

2. **How to tailor the program to encourage participation**
   - Do your partners have ties to the institution that motivate them to engage in care redesign?
   - Are they comfortable with risk?
   - Do they have information technology capabilities to enable joint success?

3. **Federal requirements for safe harbor**
   - Selection of collaborators must relate to quality of care and cannot be based on volume or value of referrals
   - Collaborators must contribute to clinical redesign
   - Hospital must establish a governing body with oversight of the program

4. **A payment formula calculated on data-driven and compliant methodology**
   - Gainsharing distributions may derive only from CMS reconciliation payments or measurable internal cost savings
   - Payments must be proportionally related to care of beneficiaries
   - Thresholds for gainsharing payments and collaborator risk apply
References


