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January 10, 2014

Donna Kinzer, Acting Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Subject: Comments on Gainsharing

Dear Ms. Kinzer:

I am writing on behalf of The Johns Hopkins Health System (JHHS) and its member hospitals: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), Howard County General Hospital (HCGH), and Suburban Hospital (SH) to comment Gainsharing issue. Senior management at Hopkins has participated with MHA in the development of the MHA position on Gainsharing. We strongly support the position MHA has taken in respect to the Gainsharing issue.

The role of the academic medical center in unique in the health care system. In addition to the role of providing patient care, skilled professionals in our hospitals provide sophisticated, cutting-edge specialized services that cannot be delivered in community hospitals. The interrelationship between patient care, the availability of newly developed technologies, the research conducted in our facilities, and the teaching mission of the academic medical system differentiate our services from the rest of the hospital system. We serve as a resource to the entire State, and the cost of fulfilling that mission must be considered as we move forward under the State's demonstration model with CMMI.

The purpose of this paper is to address issues of gainsharing under the new demonstration model. JHHS generally agrees with the Maryland Hospital Association's paper, and this paper generally reflects the same points. We believe there is a central concept that must be stressed: ***For gainsharing to have its intended effect, the dollars under a gainsharing approach have to be sufficient to motivate physician behavior.*** Small potential rewards will not incentivize physicians to reduce their own volume and revenue, and gainsharing would fail to align incentives in any meaningful way. This is the major point we want to stress in developing a gainsharing approach.

Under Maryland's All-Payer Demonstration Model, Maryland hospitals will be operating under incentives designed to reward quality improvements and cost reductions. While the proposal defines a new payment model for hospitals only, successful hospital performance will be strongly tied to changing physician practice patterns. Changing physician practice patterns will be dependent on (1) aligning the hospital and its affiliated physicians with a common set of cost/quality performance targets, (2) allocating new resources to both in-hospital and out-of-hospital service settings to equip physicians to meet these targets, and (3) financially rewarding physicians for meeting these targets.

Historically, hospitals have been prohibited from incentivizing/rewarding their referring physicians on the basis of cost savings and utilization metrics; the Fraud and Abuse laws and provisions of the Civil Monetary Penalties have limited gainsharing activity to prevent overutilization and/or underutilization that might otherwise occur under different incentive models. More recently, however, CMS has acknowledged that these same Fraud and Abuse laws may impede physician-hospital alignment efforts, alignment that is increasingly identified as a formula for successful ACOs. Recognizing the need to reduce these barriers for ACOs, CMS issued waivers in 2012 to provide exemptions from Fraud and

Abuse laws to ACOs that participate in the Medicare Shared Savings Program and meet specified terms and conditions. These waivers allow eligible ACOs that meet the requirements for participation in the Medicare Shared Savings Program to distribute savings generated from ACO operations to participating providers and entities.

Purpose

The purpose of this paper is to discuss the key attributes for gainsharing models in Maryland and assess alternative options for incorporating gainsharing models in Maryland together with the new All Payer Demonstration Model. The objective of gainsharing is to promote physician engagement by aligning financial incentives with the hospital's incentives under the new payment models to be rolled out under the State's demonstration model. Gainsharing incentives would align hospital-physician performance targets and incentivize physicians to meet these important targets. While the HSCRC is changing the hospital reimbursement system away from fee-for-service incentives, physicians are often reimbursed on a fee-for-service system that continues to reward and incent volume growth. Because physicians are responsible for care delivery, the misalignment between hospital and physician financial incentives may limit the ability of proposed hospital changes to reduce readmissions and reduce preventable ambulatory sensitive conditions.

We would expect the first stage gainsharing performance targets to reflect four major improvement areas of emphasis, aligning directly with HSCRC performance measures and statewide performance goals. These include:

- 1. Reduce admission rates for Prevention Quality Indicators (PQIs)** - Similar to admission rates for ambulatory sensitive conditions, PQIs are nationally defined measures recognized as reflecting the availability and effectiveness of community-based care. Admission rates for specific conditions such as urinary tract infection, asthma, or pneumonia may be tracked, or composite scores for PQI conditions may be tracked to reflect broader community-wide population management. In TPR regions, featured by a sole community hospital and accountability for a sizable County population, a hospital might establish cohort-specific targets for reducing PQI admission rates (e.g. diabetes patients; COPD patients); a sole community hospital might also establish global targets for reducing the composite admission rate for a set of chronic PQIs. Hospitals with a smaller population base, or a patient base more widely disbursed across physician practices may define target reductions in chronic PQIs based on a "raw number" reduction in total PQI admissions.
- 2. Reduce readmissions rate** - Maryland must reduce its rate its readmission rate to the national average over the course of a five year period. There are several options for action to improve readmission rates:
 - Overall readmission rate – establish general procedures to improve readmission rates for all patients, such as providing clear instructions to patients upon discharge
 - Readmission rate for frequent, high-cost patients – identify repeat patients with particular clinical or socioeconomic issues that result in frequent and often high-cost use of services
 - Readmission rate by admission source (e.g. nursing home admissions) – Establish a target reduction in readmissions rate, invest in new resources/intervention strategies, and define a statistically meaningful number of patients to evaluate in aggregate.
 - Specialty care management – define a specialty patient population and a specialty base of physicians expected to case manage a population cohort (e.g. COPD; psychiatry)

3. Reduce complications rate in the acute care setting based on MHAC definitions (PPCs not present on admission)

Maryland must achieve an annual aggregate reduction of 6.89 percentage points off of the current rate in the 65 PPCs over the course of the 5 year period for a cumulative reduction of 30 percent in PPCs.

4. Improve performance on QBR metrics

Longer-term, hospital gainsharing models are likely to include additional performance targets:

5. Chronic disease populations: Reduce annual costs of hospital care – Long-term, hospitals/physician organizations will be expected to define episode management costs and annual cost of care targets for specific chronic disease cohorts. Readiness will depend upon use of home-based services and social services, use of extenders, adoption of telehealth services, and/or effective care transitions management

6. Cost per admission: Reduce costs of DRG-specific/CPT-specific cases with high degree of variation -

Based on hospital-specific data, individual hospitals and affiliated physicians may need to examine clinical practice variation and costs per admission for particular subgroups to identify opportunities to reduce unnecessary resource utilization. Similarly, specialty groups may need to consider new evidence/new protocols for routine ancillary utilization per admission.

7. Hospital-specific, local area health improvement targets

These targets would reflect opportunity areas where community-based intervention strategies have the potential to impact utilization and quality of care on a longer-term horizon (*e.g. new disease management efforts; access to 24 hour consult line; linkage to social services; etc.*).

Key Attributes of a Successful Gainsharing Model in Maryland

The key attributes of a successful model in Maryland include the following:

- **All payor model** so that incentives will be applied equally and gainsharing program does not encourage/result in disparities in care
- **Quality improvement targets** to serve largely as the basis for performance targets and incentives
 - The majority of quality targets should be aligned with HSCRC quality improvement targets to achieve hospital goals and ultimately the outcomes required under the hospital demonstration model
 - Allowance for hospital-specific defined targets in addition to the above to meet the specific needs of the community served by the hospital and its physicians
 - No allocation of financial incentives unless some percentage of quality targets are met to insure an appropriate balance between financial and quality performance under gainsharing arrangements
- **Hospital control/hospital authority for financial rewards**
The most effective design for these arrangements is to offer each hospital the flexibility it needs to construct such arrangements, subject to the appropriate legal parameters. The hospital would be responsible for designing these arrangements to meet its specific organizational and

community goals. Therefore, the design of these programs would depend on the specific circumstances faced by the hospital in terms of its patient population and physician relationships. Each hospital could face unique circumstances with respect to physician relationships, the services it offers, and the resources available to devote to financial incentives.

- **Eligibility for gainsharing**
 - Independent practitioners, hospital-employed physicians, ACOs, and providers managing patients in post-acute facilities
 - Primary care physicians, specialty physicians, and ER physicians affiliated with the hospital
 - Post-acute facilities and home care agencies
 - Allow home care agencies/post-acute facilities to determine how funds are distributed within facilities
- **Participation and distribution formulas should allow/reflect/credit:**
 - Role of community-based physicians in achieving performance targets
 - Intensity of care and increased reliance on post-acute settings
 - Increase in utilization, service intensity, and/or service complement of home-based services
- **Aggregate performance measures**
 - Sufficient size physician base and patient base to produce aggregate performance measures
- **Safeguards**
 - If quality declines, no dollars are allocated
 - Aggregate performance reviews (see above)
 - Upper limit on sharing incentives with individual physicians
 - Savings threshold for distribution (consistent with ACO model)
- **Legal protection**
 - Broad enough legal protection to allow hospital-specific models/innovation
- **Expediency:** Option that can be implemented in the near-term

A Framework for Maryland Hospitals

While the economic and legal issues are complex, there is an existing framework for Maryland to build upon in seeking federal authority for gainsharing. Under the Medicare ACO model, specific criteria are established for gainsharing. Application of ACO waivers to the State of Maryland under the Hospital Demonstration Model would provide a tested approach that successfully meets federal criteria. The State would seek CMS and OIG approval to extend the same legal protections already granted to ACOs for gainsharing to Maryland's Demonstration Model.

The premise would be that the Maryland payment model is conceptually similar to the ACO model (a "macro ACO"), operating with the same objectives and benefitting similarly from physician-hospital alignment. In addition, Maryland hospitals can adopt the same safeguards as are required by the ACO waivers, and the HSCRC can effectively enforce the same conditions required by the OIG. Until now, the legal constraints on gainsharing have centered on three basic provisions:

- **Physician Self-Referral Statute (the Stark law)** – Prohibits physicians from making referrals for designated health services reimbursable by Medicare or Medicaid to entities with which they have a financial relationship.
- **Anti-Kickback Statute (AKS)** – Prohibits providers from knowingly and willingly offer, pay, solicit or receive compensation in exchange for referrals or services that are reimbursable under Medicare or Medicaid.
- **Civil Monetary Penalty law provision (gainsharing or CMP)** - Prohibits a hospital from making a payment directly or indirectly to induce a physician to reduce or limit services to Medicare or Medicaid beneficiaries under that physician's direct care

Each of these laws reflects government concerns about clinical decision-making being affected by financial incentives in place of standards of care; government has been concerned about both overutilization and underutilization that may result from a physician's financial stake in utilization patterns. At the same time, each of these provisions can be barriers to physician hospital alignment and collective efforts toward care improvement. As ACOs have been launched and Shared Savings Programs have been operationalized, CMS and the OIG have had to re-balance the Fraud and Abuse laws -- designed to maintain independent clinical decisionmaking -- with the need to promote the goals of ACOs, i.e. care coordination and collaborative initiatives for quality improvement. In response (October 2011), CMS and OIG issued a set of 5 waivers that protect/exempt ACOs participating in Shared Savings Programs from each of these legal constraints. The waivers establish an exemption from the Fraud and Abuse laws above to allow the following activities (among others):

- **Financial relationships between ACO participants if “reasonably related to the purposes of the Medicare Shared Savings Program.”** The term “reasonably related” is defined by six characteristics:
 - Promoting accountability for the quality, cost, and overall care for a Medicare population
 - Managing and coordinating care for Medicare FFS beneficiaries through an ACO
 - Encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery (e.g. appropriate reduction in Medicare costs and expenditures)
 - Evaluating health needs of the ACOs assigned population
 - Communicating clinical knowledge and evidence-based medicine to beneficiaries
 - Developing standards for beneficiary access and communication
- **Distribution of shared savings among ACO participants during the year in which the shared savings were earned.** The waiver permits the ACO to distribute shared savings among individuals/entities within the ACO as well as those entities that assist the ACO in meeting the quality and savings goals for this Shared Savings plan.

These exemptions are accompanied by certain requirements/conditions:

- ACO eligibility for Shared Savings
 - Accountability for a minimum of 5,000 Medicare beneficiaries
 - Agreement to participate for at least 3 years
 - Governance, leadership, and management structure requirements
 - Senior level medical director in charge of clinical management
 - Reporting of cost and quality measures; promotion/adoption of evidence-based medicine guidelines

- Performance requirements (MSSP)
 - Quality targets
 - “Part of a documented program”
 - 33 quality measures across 4 domains
 - Care coordination/patient safety, preventive health, at-risk populations, patient experience
 - Minimum attainment level for at least one measure in each of the 4 domains
- Savings definition: “Minimum Savings Rate” (MSR)
 - Per capita expenditure benchmark defined for assigned Medicare enrollees
 - Savings target established based on number of beneficiaries assigned (2-4% savings rate)
- Physician participation
 - Pools of at least 5 physicians for each performance measure
 - Payment by hospital to group of physicians on an aggregate basis
 - Within a practice group, payment to each physician on a per capita basis based
- Distribution of savings
 - ACO must meet both the MSR savings requirement and the minimum quality performance standards
 - First dollar savings distribution once the minimal savings rate is achieved
 - Cap at 50% of cost savings on a first dollar basis, up to a maximum of 10% of the benchmark
 - May be distributed directly to ACO participants/providers or used for activities related to the Shared Savings Program
 - “The financial relationship must be reasonably related to the purposes of the MSSP and distributions are reasonably related to the purposes of the MSSP”
- Restrictions/Safeguards
 - Quality controls
 - No distribution of savings if quality metrics diminish / unless quality benchmarks are met
 - Annual rebasing of quality standards
 - Compliance plan in place
 - Transparency
 - Documentation fully available
 - Notice/disclosure to patients
 - Not based on volume or value of referrals

Evidence on Physician Gainsharing: An Overview of the New Jersey Model

In 2009, the New Jersey Hospital Association launched a physician gainsharing demonstration program at 12 hospitals, providing doctors with bonuses for saving the hospitals money when providing care to Medicare patients. The program included quality controls to protect patients, and three mechanisms to reduce costs: efficiency strategies, quality standards, and financial incentives.

In the first 18 months of the program, participating hospitals recognized \$38.6 million in cumulative savings, which equates to \$540, or 5.6 percent, per admission. The Centers for Medicare & Medicaid Service’s (CMS) Bundled Payments for Care Improvement Initiative allows gainsharing that is based on

the New Jersey demonstration. Model 1, an inpatient-only part of the CMS initiative, is a test of gainsharing.

CMS issued five criteria for gainsharing arrangements in the demonstration¹:

- Gainsharing must support care redesign to achieve improved quality and patient experience, and anticipated cost savings.
- Total incentive payments to an individual physician or non-physician practitioner must be limited to 50 percent of the aggregate annual Medicare payment amount determined under the Physician Fee Schedule.
- Incentive Payments must not be based on the volume or value of referrals, or business otherwise generated, between hospital and a physician or non-physician practitioner.
- Physician or non-physician practitioner participation in gainsharing must be voluntary.
- Individual physician and non-physician practitioners must meet quality thresholds and engage in quality improvement to be eligible to participate in gainsharing.

As noted above, the federal government has been careful about gainsharing, in part due to concerns about fraud and abuse laws, including the Civil Monetary Penalty Law, federal anti-kickback statutes, and federal physician self-referral (Stark) laws that address providers stinting on patient care or “cherry picking” healthier patients, and hospitals offering physicians bonuses that go beyond savings achieved, in order to generate physician loyalty and drive referrals. The Office of the Inspector General must approve physician gainsharing arrangements and, so far, has approved only those with a limited scope and only on a time-limited demonstration basis. New Jersey addressed these key concerns in its demonstration by operating within the parameters CMS outlined in its Bundled Payments for Care Improvement initiative.

The New Jersey program established broad guidelines for the redesign of patient care management, and quality monitoring and maintenance that complement the physician gainsharing methodology. This allowed hospital-based steering committees, which are at least 50 percent physicians, to work with medical staff, clinical departments, and hospital administrators to align provider interests and maximize the effectiveness of the gainsharing methodology.

The New Jersey program used the Applied Medical Software Performance Based Incentive System gainsharing methodology. During the first year, the maximum physician incentive was apportioned as one-third for performance and two-thirds for improvement. The total physician incentive was a combination of a surgical and medical incentive formula. Computations were performed at the case level for each admission. Descriptions of the incentive formulas follow:

- Surgical Improvement: Measures a physician’s current performance compared with the prior year, adjusted for case mix and severity of illness
$$((\text{Prior Year Cost} - \text{Current Year Cost}) / (90^{\text{th}} \text{ Percentile of Patient Cost} - \text{Best Practice Norm}^2)) (\text{Maximum Physician Incentive})$$
- Surgical/Medical Performance: Measures a physician’s resource utilization compared to their peers, adjusted for case mix and severity of illness.

¹ Bundled Payments for Care Improvement Initiative for Model 1 Parameters Document
<http://innovation.cms.gov/Files/x/BPCI-Model1Parameters.pdf>

² Best Practice Norm is set at the 25th percentile of patient cost.

$$\frac{((90^{\text{th}} \text{ Percentile of Patient Cost} - \text{Current Year Cost}) / (90^{\text{th}} \text{ Percentile of Patient Cost} - \text{Best Practice Norm})) \times (\text{Maximum Physician Incentive})}{(\text{Prior Year LOS} - \text{Current Year LOS}) \times (\text{Maximum Physician Incentive per Day})}$$

The medical incentive payment used the same performance incentive formula as the surgical performance formula (described above) but used a revised medical improvement incentive formula.

- Medical Improvement Incentive: Accounts for loss of physician income as a result of shorter lengths of stay

$$(\text{Prior Year LOS} - \text{Current Year LOS}) \times (\text{Maximum Physician Incentive per Day})$$

As part of their participation in the Model 1 demonstration, hospitals were required to provide Medicare with discounted care. Medicare required a discount of 0.5 percent in the second six-months of Year 1, 1 percent in Year 2, and 2 percent in Year 3. To maintain the financial health of the hospital and ensure the sustainability of the program, steering committees could tie incentives to the achievement of a minimum economic threshold based on specific hospital needs.

In the future, a methodology will be developed to measure year-over-year improvement at the hospital level. The physician incentive payment will be tied to overall hospital performance to ensure that hospital financial condition is taken into consideration.

Participating hospitals had to realize sufficient improvement in performance to enable them to make incentive payments. Additionally, physician involvement could be expanded to add ancillary physicians and consultants to the program beginning in Year two on a voluntary basis.

The New Jersey experience can be used to guide the construction of a gainsharing proposal to CMS and the OIG for Maryland under the Hospital Demonstration Model.

Maryland's Organizational Readiness for Gainsharing

Maryland hospitals face organizational and operational challenges in implementing physician-hospital gainsharing models, reflecting its early stage of physician-hospital organization. At this point, the health care system in Maryland is not featured by many ACO entities nor large physician organizations; excluding faculty practice plans, only a limited number of sizable physician organizations currently operate. This raises a number of implementation issues and policy considerations which must be anticipated:

- *Infrastructure requirements*
Calculation of savings and distribution methodology are data-intensive initiatives, and to the degree that hospital models include community-based providers and post-acute providers, these efforts will pose additional challenges. In addition, front-end development of performance targets and accompanying protocols typically are resource-intensive efforts.
- *Methodologies/policies for eligibility and savings distribution*
In the absence of a single cohesive physician organization affiliated with the hospital, it may be more difficult for the hospital to establish the distribution methodology across primary care, specialty, and hospital-based practitioners. More specifically, the methodology will need to credit community-based primary care providers who may be most responsible for utilization reductions and quality improvements but who are not organizationally tied to the specialty practices at the hospital
- *Allocation of funds for distribution*

At this early stage in the Maryland Demonstration Model, it will be difficult for hospitals to estimate the opportunity potential and available funds for shared savings. At the same time, policies will be required that establish minimum savings thresholds before distribution.

- o *Malpractice issues*
Finally, as hospitals extend gainsharing opportunities to non-employed physicians, issues of liability/concerns about malpractice may need to be weighed.

Remaining Questions

The alignment of incentives between hospitals under the new demonstration model and physicians who continue to operate in the fee-for-service world is necessary to achieve financial success and improve the quality of care. Financial incentives for hospitals reach natural limits to their efficacy without physician engagement because physicians direct clinical care. Gainsharing authority is crucial as a tool going forward.

If gainsharing is necessary to align incentives, the related question is how substantial the incentives need to be to align incentives and can hospitals afford the amount of money necessary to accomplish the intended goals. This is the central issue to achieving alignment between hospitals and physicians under a gainsharing approach.

We appreciate your consider of our thoughts in this process. If you have questions or require further information, please contact me.

Sincerely,



Ed Beranek
Senior Director of Finance
Johns Hopkins Health System