

**IHA Bundled Episode Payment Pilot**  
**Frequently Asked Questions about Gainsharing**  
**Subject Matter Expert: Kevin Bozic, MD, MBA**

**Introduction:**

On March 18, 2011, Dr. Kevin Bozic presented information on gainsharing program design to participants in the IHA bundled episode payment pilot. This document distills Dr. Bozic's key presentation points and the open forum discussion that followed his webinar presentation.

**Q1: What is the hospital's perspective on gainsharing?**

**A1:** Hospitals are responding to multiple factors, including rising supply chain costs, declining margins for inpatient orthopaedic procedures, and the need to objectively evaluate the clinical and financial merits of new technology. As a result, they are looking for strategies to actively engage and align incentives with their physicians. This alignment can take place through an employment model, service line co-management, a joint venture, or some form of episode payment model with gainsharing component. Hospitals should look to specialty groups that are interested in engaging with on incentives to improve quality and decrease cost.

**Q2: What are the fundamental differences in perspective that get in the way of hospital-physician alignment?**

**A2:** Cultural differences between hospitals and physicians engender mistrust on both sides:

**Physician Perspective:**

- Physicians believe goals of the hospital compete with their own.
- Physicians often don't understand the competing agendas and goals of various hospital hierarchies.
- Physicians have a service-line centric view of profitability and believe any profit sharing agreement should occur at the service-line level.
- Some physicians perceive that hospitals use two sets of books in rate negotiations.
- Physicians attribute failure of previous alignment schemes to lack of communication and transparency by the hospital.

**Hospital Perspective:**

- Hospitals function by cross-subsidizing profitable service lines (such as orthopaedics) with less profitable or unprofitable service lines (such as pediatrics) to break even.
- Hospitals don't have sufficient data or legal understanding to support gainsharing design. They want to gain this knowledge before engaging with their physicians in a transparent and meaningful way.
- Hospitals don't believe their goals compete with those of physicians, but often are frustrated by the lack of incentives physicians have to promote efficiency of care:
  - Surgeons are not incentivized to help the hospitals save money on device purchases.
  - Surgeons choose implants based on personal experience, consulting relationships with device companies and other financial incentives external to the hospital's vendor relationships.

**Q3: What specific problems have limited the effectiveness of past physician-hospital alliances?**

**A3:** Past arrangements between physicians and hospitals lacked detailed planning. Hospitals were motivated by the potential for "land-grab" and patient steerage, while physicians sought relief from the growing administrative burden of running independent practices. More specifically, many past arrangements lacked reliable quantitative measures of success and sustainability features to address changing landscape from year one to year two. As it pertains to initiatives similar to IHA's Episode Payment Pilot, surgeons believe they have more clout that they actually do. Surgeon profitability is not as high as it once was. What used to be a sellers' market for surgeons is fast becoming a buyers' market for hospitals.

**Q4: What are some guiding principles for structuring a gainsharing agreement?**

**A4:**

- 1) Hospitals and physician champions must clearly set expectations and roles /responsibilities of each party. For example, the hospital might own the decisions about funding the gain-sharing pool, where a physician-led group would establish inclusion-exclusion criteria for participants and the relevant quality metrics.
- 2) Both parties must agree to sustainable parameters for patient-centric, value creation and evaluation based on improving quality and decreasing the cost of care.
- 3) Proactively solicit legal input to understand impact of Physician Self-Referral (Stark) Law, state and federal anti-kickback and other laws in relevant populations.
- 4) Establish exit clauses for respective parties.
- 5) Identify physician leaders who can demonstrate interest in the bigger picture and can operate outside of silos of self-interest.
- 6) Create a culture of mutual trust and respect by engaging and partnering with physician leaders from the start.

**Q5: How should a hospital or physician group structure basic gainsharing operations?**

**A5:** One way to approach would be to:

- 1) Make any gainsharing arrangement continued on the realization of savings which can be shared/distributed among the stakeholders. Regardless of clinical measures and financial incentives, gainsharing isn't feasible until there are savings to share.
- 2) Determine who is eligible to participate. This decision is often left to physician champions or service-line leaders within individual physician groups.
- 3) Define thresholds for participation: two models
  - a. **Cost Threshold:** once savings are generated by participant efforts to reduce costs, payment is divided based on quality measures. Dr. Kevin Bozic recommends this approach as having more validity with physicians. The savings are implicit in that the pool is funded by cost reductions, but it is meeting quality metrics that drives payment.
  - b. **Quality Threshold:** once quality measures are met, payment is divided based on cost savings.
- 4) Eventually, the goal is to move to a shared-risk model between hospitals and physicians. However, risk-averse physicians may opt out of an episode project if the hospital doesn't protect them from down-side risk. Therefore, an initial gainsharing model that provides moderate upside potential only is more feasible.

**Q6: How do you determine inclusion and exclusion criteria for individual physicians interested in participating?**

**A6:** Volume thresholds are commonly used as a gate for participation in gainsharing agreements. For example, only orthopedic surgeons performing more than 50 procedures at a given facility are able to participate. Cost, efficiency and quality measures should not be used to determine participation in a gainsharing program.

**Q7: How do you encourage device standardization with orthopedic surgeons who have deals with suppliers?**

**A7:** Device standardization doesn't necessarily equate to lower cost. In fact, in research performed by James Robinson, PhD<sup>1</sup> found several instances where an inverse relationship exists between device standardization and price. The key is to get physicians to agree on a case price for each procedure on the basis that primary cost savings are derived from device selection. Then the hospital negotiates with device companies willing to offer products within an acceptable price range.

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<sup>1</sup> James C Robinson, "Confidentiality and Transparency for Medical Device Prices: Market Dynamics and Policy Alternatives" *Health Affairs* 27, (2008): 1544-1553.

**Q8: How do you break up gainsharing measures and payment by physician specialty?**

**A8:** If you consider IHA's total knee and total hip replacement bundles, orthopedic surgeons would be the primary focus of gainsharing measures and payments. Anesthesiologists, hospitalists, radiologists and other key players should also have incentives to participate in some form of gainsharing to encourage coordination of care. Assuming appropriate quality and cost measures are established for other specialty groups, a 10% bonus could be given to these physicians at the end of the year if quality and cost targets are met at the program level. A similar annual bonus could be established to engage a wider set of specialists.

**Q9: What measures should be used to determine gainsharing payment and program success?**

**A9:** There are three types of metrics that can be used to measure physician / hospital performance in a gainsharing program. The weight attributed to each type of measure is critical to engaging physician interest and involvement. Dr. Bozic recommended the following allocation:

- 1) Quality Measures: 50%
  - a. Structural
  - b. Process
  - c. Outcomes
- 2) Patient Experience Measures (preferably around functionality): 25%
- 3) Cost / Efficiency Measures: 25%
  - a. LOS
  - b. Utilization of services
  - c. Overtime
  - d. Cost per case
  - e. Direct cost in OR
  - f. Margins

**Q10: Why are quality measures so important?**

**A10:** Quality measures should have greater weight than cost and patient experience measures because physicians are more willing to align around the concept of quality improvement than around cost reduction. The big fear around physician incentive programs is that they will lead to rationed or substandard care; the gainsharing program must avoid supporting that perception.

**Q11: How can organizations link gainsharing payments to measurable quality improvement?**

**A11:** Quality measures should be broken down into three categories: structural, process and outcomes. Measuring quality is a highly-complex process that often involves use of both quantitative and qualitative measures. There is no clear-cut, foolproof means to benchmark what good quality looks like. Universally-accepted measures of quality aren't feasible given today's health care system, but the following types of measures are possible:

**Structural Measures:**

- **Examples:**
  - o Availability of EMR
  - o Nursing ratios
  - o Bed size
- **Pros and Cons:**
  - o Easy to define
  - o Difficult to manipulate
  - o Rarely actionable (EMR is a possible exception)

**Process Measures:**

- **Examples:**
  - o Surgical Care Improvement Project (SCIP) Measures

## Gainsharing discussion with Kevin Bozic, March 18, 2011

### - Pros and Cons:

- o Wide spread agreement that SCIP measures are a good idea
- o Studies show little correlation between achievement of SCIP measures and quality outcomes
- o Low ceiling effect: easy to meet most nationally supported metrics

### Outcome Measures:

#### - Examples:

- o 90 day complication rates
  - Infection rates
  - Hip dislocation rates
  - Readmission
  - Revision

#### - Pros and Cons

- o These measures hold the most validity with physicians
- o Require risk adjustment
- o Difficult to measure / nebulous:
  - Provide less feedback. You can tell a physician that he/she has the highest infection rate, but you can't explain why.
  - Lag time exists between point of care treatment and established outcome.

**Q12:** Gainsharing programs often fail after year one. How can gainsharing agreements be structured to ensure sustainability year after year?

**A12:** The primary reason gainsharing programs fail after year one is that sustainability was not addressed during the initial contracting phase. If a gainsharing program focuses only on easily implementable cost savings measures and quick efficiencies in care integration, it will work great in year one but fail to save additional money in year two. While some retooling of measures and targets should occur through a collaborative vetting process each year, this does not mean that fundamental baselines should change annually to capture savings that may not exist. Using the cost threshold model described above, program administrators should review annual cost inflation for targeted procedures. Gainsharing payment targets should be structured to flatten the cost curve year after year by targeting annual cost inflation as opposed to overall savings. The overall success of a gainsharing program is measured by the delta in cost inflation year over year.

### Conclusion:

The real advantage of bundled payment is through alignment of physicians and hospital administration in the coordination of high quality, efficient care. Gainsharing programs should pay all participants for high quality and efficient delivery of care. This is happening now...

In one Medicare's ACE demonstration site in year one:

- 10-12% cost reduction without explicitly targeting device payment or selection.
- Every participating physician received the maximum 25% bonus payment.
- Hospital improved its margin even though it had offered Medicare a lower price than its historical payment for the episode.
- Every patient received money back from Medicare for going to a Medicare "Value Center".

**Subject Matter Expert: Kevin Bozic**

Kevin J. Bozic, MD, MBA is an Associate Professor and Vice Chair in the Department of Orthopaedic Surgery and a member of the core faculty of the Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco (UCSF). Dr. Bozic is a graduate of the UCSF School of Medicine and the Harvard Combined Orthopaedic Residency Program. Additionally, he holds a Bachelor of Science degree in Biomedical Engineering from Duke University and a Masters of Business Administration from Harvard Business School. Dr. Bozic has fellowship training in Adult Reconstructive Surgery from Rush Medical College in Chicago.

Dr. Bozic's clinical interests are in adult reconstructive surgery of the hip and knee, with an emphasis on primary and revision hip and knee replacement. His research interests are broadly in the fields of health policy and health care services research, and specifically in the areas of health care technology assessment, cost-effectiveness analysis, shared decision making, and the impact of health care reform on cost and quality. In addition to his clinical and research activities, Dr. Bozic is actively involved in numerous regional and national health policy initiatives, including the Medicare Evidence Development and Coverage Analysis Committee (MedCAC), the Agency for Healthcare Research and Quality's (AHRQ) Effective Healthcare Stakeholder Group, the Integrated Healthcare Association's Value Assessment of Medical Technologies Program, and the California Health Care Foundation's orthopedic registry project.

**IHA Bundled Episode Pilot:**

The Integrated Healthcare Association (IHA) is implementing a demonstration to test the feasibility of bundling payments to hospitals, surgeons, consulting physicians and ancillary providers, for selected inpatient surgical procedures within the existing California delivery system and regulatory environment. The demonstration expects to:

1. Encourage financial alignment that will support delivery system and process re-engineering to improve patient care quality and efficiency.
2. Allow for shared savings among health plans, providers, employers, and patients to the extent bundled reimbursement improves quality and efficiency.
3. Develop and test solutions to bundled payment implementation issues.

The demonstration, funded by the Agency for Healthcare Research and Quality, expands a current small pilot that has focused on commercial PPO patients receiving total hip and total knee replacements in Los Angeles and Orange Counties. The demonstration will expand the effort over three years to ten acute conditions and procedures, 20 physician-hospital teams across California, and to HMO, Medicare Advantage and Medi-Cal Managed Care populations. In 2011, IHA will add additional procedures to the original orthopedic work, including: diagnostic cardiac catheterization; cardiac angioplasty with stents; and knee arthroscopy with meniscectomy.

The demonstration will include a rigorous evaluation of the impact of bundled episode payment on both clinical quality and healthcare costs in comparison to current payment mechanisms. These evaluations will be carried out independently by the RAND Corporation and by researchers associated with the University of California at San Francisco and Berkeley.