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Medicare Physician – Hospital Collaboration Pilot – Gainsharing that Works

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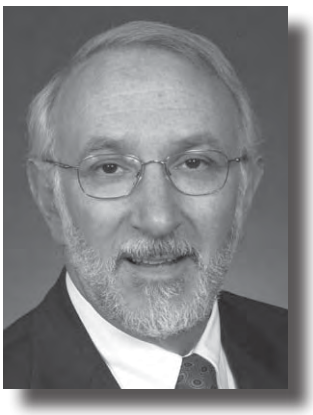

Michael Kalison

by Sean Hopkins, Jo Surpin and Michael Kalison

The industry initiative to enable hospitals to compensate physicians directly for efficient performance – "gainsharing" – commenced in 1999 with a meeting between the NJHA and the Health Care Financing Administration ("HCFA"). Concerns from lawmakers and regulators over quality of care and fraud had derailed all previous attempts to align provider interests, except for very limited exceptions. But NJHA felt that with the increasing calls for health reform, it was important for the industry to have a seat at the table. To accomplish this, the industry had to be "part of the solution." The solution started with a broad based, comprehensive framework that would enable doctors and hospitals to collaborate effectively at the institutional level on issues of cost and quality. But to be credible, NJHA's "unsolicited" application had to directly address the concerns in Washington and Baltimore that had killed or neutered previous proposals.

The New Jersey Physician-Hospital Collaboration Demonstration (the "Demonstration") was able to gain approval from CMS because of safeguards designed directly into the gainsharing methodology: the adjustment for *severity of illness,* limits on physician incentive payments, protections to insure that the tool would be used to promote improved performance, not payment for referrals, and so forth. But opening the door was just the first step. The Demonstration merged experience from an earlier New Jersey demonstration that had provided Medicare with the model for the Inpatient Prospective Payment System; basically, a set of design principles which required practical solutions, and allowed complexity only when necessary. These principles made sure that the ambitious project would get off the ground, and not crash and burn as so many before it had; that the methodology could be successfully implemented in virtually any setting.

With the basic methodology established, the focus turned to the doctors and hospitals. Substantial time was devoted to identifying fundamental issues that could harm participation or compromise effectiveness. So, for example, steps were taken to insure that the basic system could function without disturbing the existing form and process of provider payment, and an adjustment included to insure that doctors would not lose professional income as a result of helping hospitals to become more efficient. As to the hospitals, separate incentive formulae were developed to enable institutions to recognize physicians that performed efficiently, as well as encouraging improvement across the board.

Much was accomplished during the Demonstration: steering committees at each participating hospital customized the methodology to meet the unique needs of the institution; the linkage to quality improvement and care redesign was firmly established; data reporting tools improved and physician participation steadily increased. And, while almost all participating hospitals benefitted, certain hospitals developed strategies that clearly demonstrated the role of gainsharing. Improvements were made in areas including: admission planning, fewer marginal but costly diagnostic tests, timely first starts in the OR and reduction in turnaround time, cost effective use of critical care and telemetry units, increased use of CPOE and reliance on P&T recommendations, requiring consultants to show up within 24 hours, responding to outstanding chart queries and avoiding the delinquent chart list, evidence based selection of medical devices and hardware, effective discharge planning and post-discharge follow-up. As to the latter, NJHA developed a post-discharge tracking tool called Well on Track that improved the effectiveness of post-discharge outreach and care.

CMMI has linked the future of health reform to the development of new *structures,* like accountable care organizations.

Structures reorganize the way in which parts of the health care delivery system – people and business entities – relate to one another. Most have been tried before, many without success. For these structures to succeed, they must have a plan: a *program* that identifies an objective for the structure, effectively aligns the interests of the parties, and rewards behavior that furthers the objective. This is common to all successful businesses. In healthcare, this begins with effective collaboration between doctors and hospitals; without this foundation the venture – ACO or stand-alone - cannot succeed. The Demonstration provided the basic program; the New Jersey Model 1 Pilot, the next generation of the gainsharing, will build on this foundation.

The New Jersey Model 1 Pilot

The New Jersey Model 1 Pilot, now scheduled to start in 2013, essentially expands the current Demonstration and opens the program to all New Jersey acute care hospitals. Because of this, the physician eligibility requirements have been relaxed. Under the Demonstration, only physicians on staff at the beginning of the program were allowed to participate. Under the Pilot, physicians new to a hospital must wait 12 months (and have at least 10 admissions during that 12 month period). Admissions by physicians with multiple admitting privileges continue to be capped, but the cap is a "rolling cap," rather than one fixed at the beginning of the program. All participating physicians must be involved in the hospital's quality program. Perhaps most important in terms of physician participation, work will begin shortly on methodologies to extend eligibility to other physicians currently on staff. Specifically, participation under the Demonstration was limited to the "Responsible Physician," that physician identified on the uniform bill as most responsible for resource utilization while the patient was hospitalized. Although it was pointed out that other kinds of physicians were often involved in the management of certain kinds of cases – e.g., consultants in cardiology cases – the issue was deferred to insure the successful implementation of the basic gainsharing methodology. With the beginning of the Pilot, subcommittees will be formed to identify the specific classes of cases where this issue is relevant and, consistent with the objectives of the program, specific methodologies to insure that adding physicians will contribute to the improvement of overall performance.

Similar to the issue of expanding physician eligibility, the Pilot will allow hospitals to increase the level of incentive payments from 25% of professional fees, the allowable limit under the Demonstration, up to 50%. As to this, NJHA is well aware that a proper balance must be struck to insure that the program is sustainable: that participating hospitals must continue to realize sufficient improvement in performance in order to justify maintaining the program. Two steps are being taken to achieve this balance. First, the formula for the Improvement incentive has been modified: physician-specific improvement will now be measured from the prior year instead of the base year. This responds to the problem of continuously paying for "old improvement." Second, a methodology will be developed to measure year over year improvement at the institutional level. Increases in the amount of the incentive, from current levels up to 50%, will be linked directly to overall institutional performance. By linking overall physician performance to the overall financial health of the institution, the program insures that participating hospitals will not be forced to pay out monies they cannot afford.

Insuring "program integrity" extends to a new condition added to the Pilot by CMMI: Medicare will be entitled to a one half (½)% discount in the 2nd 6 months, 1% in year 2, and 2% in year 3. Data gathered from the Demonstration indicates that most hospitals should be able to comply with this. Nevertheless, like the two safeguards above, a threshold has been added to the program to protect participating hospitals. Beginning in year 2, overall institutional achieved savings must be at least equal to the Medicare discount. Individual institutions may implement a higher threshold – for example, the Medicare discount plus the incentive payments; but, at a minimum, participating hospitals will not be obligated to pay incentives unless the discount is met. Finally, and perhaps most important, a hospital may withdraw from the Pilot with 60 days notice.

In conclusion, it is helpful to view participation in the Pilot as a process. After years of legal and regulatory restrictions, there are tangible signs that the importance of gainsharing has finally been internalized. True integration cannot be achieved without effectively aligning provider incentives. References to gainsharing throughout the Accountable Care Act indicate an understanding that initiatives like accountable care and bundling will falter if providers are not unified in promoting organizational performance. But this is a long war with many battles to be fought along the way. For example, NJHA has made clear to CMMI that any future legislatively mandated reductions in Medicare payments, resulting in duplication of the savings required under the Pilot, would be unfair and unacceptable. Also, there is the focus on quality improvement and care re-design. Since quality improvement emerged from the Demonstration as the highest priority of the participating hospitals and their physicians, this could present an opportunity to help shape Medicare thinking and will be a primary focus of Model 1. Bottom line: Pilot hospitals will have a seat at the table in what will certainly be one of the most important discussions concerning the future path of the Medicare program. NJ hospitals have influenced national health policy dating back to the use of DRGs and the implementation of prospective payment. Model 1 is the next forum for the NJ hospital industry to continue its long standing role in shaping national health policy.

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