The New Jersey Gainsharing Experience

By Robert G. Coates, MD, MMM, CPE

In this article...

Examine results of a New Jersey gainsharing program and see how the cost savings used to pay the physicians were achieved.

In 1999, in an effort to begin the process of improving hospital/physician dialogue and collaboration, the New Jersey Hospital Association (NJHA) approached the federal Healthcare Financing Administration (HCFA) with a proposal to start a gainsharing demonstration project.

In 2003, NJHA began working, in association with Applied Medical Software (AMS), and received HCFA approval to start a physician/hospital gainsharing model, but later was stopped due to HCFA not having the ability to waive all the necessary laws to implement the program.

The next year NJHA continued to pursue the project by meeting with members of the House Ways and Means Committee. The Ways and Means Health Sub-Committee Chair Nancy Johnson (R-CT) came to New Jersey to meet with the participating hospitals to learn more about the concept.

The Medicare Modernization Act of 2008 gave CMS the authority to conduct limited gainsharing demonstrations under Section 646. NJHA applied to participate under this authority, and subsequently the New Jersey Care Integration Consortium was approved by CMS to use the New Jersey gainsharing model for Medicare fee-for-service patients.

Twelve New Jersey hospitals joined the program in 2009 and recruited 1,300 physicians. Physicians were required to be on the staff of the participating hospital in 2007 and to have had at least 10 admissions to that hospital in 2008 to be eligible to participate.

Physicians who admitted to more than one hospital (referred to as "splitters") were capped in subsequent years to their number of prior admissions. In this way, the program could not be used by one hospital, which had opted to participate, to induce admissions away from a neighboring hospital that did not participate. Physicians new to the market were excluded from participation.

Mechanics of the program

The theory behind gainsharing is to align the payment incentives of the physicians with the hospital. Gainsharing is the direct payment by hospitals to physicians based on performance — i.e., quality and efficiency.

CMS has paid hospitals on a case rate, based on diagnosis-related groups (DRGs), since 1983. Hospitals are paid a flat rate based on the diagnosis, and their financial incentive has been to lower length of stay and cost of care. Physicians have traditionally been paid a per-diem for inpatient care.

Gainsharing allows hospitals to work with physicians to lower the cost of hospital care and then to share savings with them to make up for the loss of their income for lost days of hospital billing.

For purposes of the demonstration, hospital cases are categorized into all-patient refined DRGs (APR-DRGs) rather than Medicare-severity DRGs (MS-DRGs). It was felt that APR-DRGs supplied a more robust method of severity adjustment, which would provide for more accurate comparison of like cases across time.

APR-DRGs had four levels of severity. APR-DRGs are divided into two categories — medical and surgical. For surgical APR-DRGs the physician for attribution is the surgeon of record for the principal procedure. For medical DRGs the case was attributed to the attending physician.

Physician incentive distributions were based on two parameters:

1. Performance
2. Improvement

Physicians continued to bill for fee-for-service for their hospitalized patients. This was not a bundled payment program.

Figure 1

	Cost saved per admission	Percent Cost reduction	Incentives Paid	Ratio of Incentives to Cost Reduction	Expected LOS	Actual LOS	Difference
2h 2009	$877						
1h 2010	$1,218	11.60%	121,563	8.6%	5.91	5.30	0.61
2h 2010	$1,369	13.00%	129,132	10.1%	5.66	5.08	0.58
1h 2011	$1,901	17.50%	137,067	7.4%	5.86	5.04	0.82
2h 2012	$2,301	20.00%	169,817	8.7%	5.86	5.11	0.75

Figure 2

Provider Number	310005	Provider Name	Hunterdon Medical Center	Responsible Physician	
	1003109828	Specialty		Physician's First Name	Physician's Last Name

Medical Improvement Incentive (LOI)	$0				
LOI Breakdwon by Severity of Illness	1: $0	2: $0	3: $0	4: $0	
Surgical Improvement Incentive	$0.00				
Performance Incentive	$6,111.01				
Total Physician Incentive	$6,111.01				
Total Unearned Incentive	$10,132.06				
Maximum Performance Incentive	$16,243.01				
Maximum Improvement Incentive	$0.00				
Total Eligible Cases	102 out of 107 cases				

Patient	APR/ SOI	Case Type	Actual LOS	Actual Cost	BP LOS	BP Cost	LOS Opport	Cost Reduction Opport	Max Perf Inc.	Actual Perf Inc
10735520	7204	Medical	8	$12,381	5.00	$8,734.32	3	$3,647	$391.36	$160.56
11111233	7223	Medical	13	$16,904	2.00	$2,969.94	11	$13,934	$79.98	$0.00
11113084	1423	Medical	8	$12,374	4.00	$6,364.05	4	$6,010	$208.78	$0.21
11114537	3473	Medical	13	$17,009	3.00	$5,172.86	10	$11,836	$149.46	$0.00
11115420	3833	Medical	3	$3,499	4.00	$4,888.15	0	$0	$219.02	$219.02
11115897	2441	Medical	1	$2,491	2.00	$3,064.50	0	$0	$106.56	$106.56
11119439	4222	Medical	1	$2,979	2.00	$2,927.22	0	$51	$108.04	$101.54
11125329	2532	Medical	3	$5,082	2.00	$3,666.71	1	$1,415	$127.51	$25.97
11125940	1374	Medical	8	$12,610	6.00	$10,345.83	2	$2,264	$339.40	$166.46
11126548	2541	Medical	2	$3,320	1.00	$2,220.42	1	$1,100	$77.21	$8.36
11126740	3832	Medical	4	$6,656	3.00	$3,431.08	1	$3,225	$153.74	$0.06
11126837	4253	Medical	3	$4,670	3.00	$4,380.29	0	$290	$161.67	$133.27
11126939	7203	Medical	5	$6,691	5.00	$6,794.63	0	$0	$304.45	$304.45
11127101	2792	Medical	2	$2,637	2.00	$3,339.11	0	$0	$116.11	$116.11
11128222	3833	Medical	6	$8,578	4.00	$4,888.15	2	$3,690	$219.02	$4.22
11129749	2494	Medical	22	$33,203	4.00	$5,954.13	18	$27,249	$207.05	$0.00
11129884	3462	Medical	3	$5,007	2.00	$3,770.04	1	$1,237	$108.93	$35.72
11129890	4633	Medical	2	$3,680	4.00	$4,884.76	0	$0	$179.53	$179.53
11131539	3833	Medical	6	$8,208	4.00	$4,888.15	2	$3,320	$219.02	$7.89
11131766	3411	Medical	2	$2,704	2.00	$3,141.97	0	$0	$90.78	$90.78

The base year for the project was 2007. The base year was used to create two standards — one for performance and one for improvement. The lowest 25th percentile cost per case was established as the benchmark for performance. Physicians would receive an incentive distribution if their performance in the demonstration was between the 90th and 25th percentile for the lowest cost of care in that APR-DRG.

The performance incentive grew as the physicians got closer to the 25th percentile. Physicians could not earn any additional performance incentive for cutting costs below the 25th percentile. Physicians could also obtain a distribution if their own cost of care during the demonstration (starting in 2009) was significantly improved over their cost of care for the same APR-DRG in 2007 (adjusted for inflation, case-mix, and severity of illness.)

The demonstration was set up to begin with two-thirds of the incentive being rewarded based on improvement and one-third based on performance. The reason for this was to encourage those who historically had higher costs of care to improve.

The incentive methodologies for medical and surgical discharges are slightly different. In both cases, the performance incentive is based solely on the physician's cost consumption compared to the best practice norm cost consumption by APR-DRG.

The improvement incentive calculation (a physician compared to his/her performance in the base year) for surgical cases is based on a physician's cost per case vs. their cost per case in the base year.

The medical improvement incentive, however, is not based on cost and is simply the physician's length-of-stay reduction vs. himself in the base year multiplied against the per diem rate — therefore, providing for loss of income.

The program was designed by CMS to be budget neutral. CMS would examine payments for all medical care within an episode of care, which was two weeks before admission and 90 days post discharge. The purpose of this was to be sure that lowering the cost of care and length of stay on the inpatient stay would not significantly add to the cost of post-acute care.

Quality measures

All hospitals were required to follow a minimum of three quality measures to ensure that patient outcomes were not negatively impacted by incentivizing physicians and hospitals to decrease the cost of care.

The minimum data set included the Hospital Inpatient Quality Reporting System (CMS Core Measures), inpatient mortality rates, and seven- and 30-day readmissions. The demonstration hospitals were also required to participate in any quality improvement collaboratives conducted by NJHA. These collaboratives included initiatives to reduce CAUTI's and CLABSI's and interventions for pressure ulcer reductions.

Outcomes

Costs for APR-DRG's were adjusted for inflation, case mix, and severity of illness, and the costs compared to the actual cost of care during the time of the pilot.

Over the course of the first five six-month periods running from the second half of 2009 through the second half of 2011, the pilot evaluated 125,569 Medicare fee-for-service admissions. The savings, compared to the base year, totaled $89,454,394 or $767 per admission. Savings increased every period through the first four cycles and then leveled off in the fifth:

Payment period 1=3.25 percent
Payment period 2=5.82 percent
Payment period 3=7.77 percent
Payment period 4=12.04 percent
Payment period 5=11.55 percent

Seven hospitals saved more than 10 percent per admission cumulatively. Four saved between 3 percent and 10 percent. One saved less than 3 percent. In the fourth payment period all hospitals had savings, and all but one did in the fifth period.

The Hunterdon experience

Hunterdon Medical Center is a 176-bed hospital in Flemington, NJ. Hunterdon has a unique medical staff model in that physicians who have active staff privileges at Hunterdon cannot have full privileges at any other institution without obtaining a waiver from the board and medical executive committee. Waivers are granted for those physicians who cannot support their practice at one institution. Because of this model "splitters" were not an issue at Hunterdon.

Hunterdon had about 85 percent of its admissions covered by physicians who participated in the first periods of the project. By the last period, that percentage was down to 73 percent, mostly due to turnover in the adult hospitalist program.

Hunterdon's results for the program (available thus far) are shown in the table Figure 1.

Physicians were given their results via reports provided by AMS. Examples of which are shown in Figure 2.

This report showed them on a case-by-case basis what their actual length of stay (LOS) was vs. the expected LOS, their actual costs vs. the best practice costs, and their incentive per case.

The dashboard report (Figure 3) showed them:

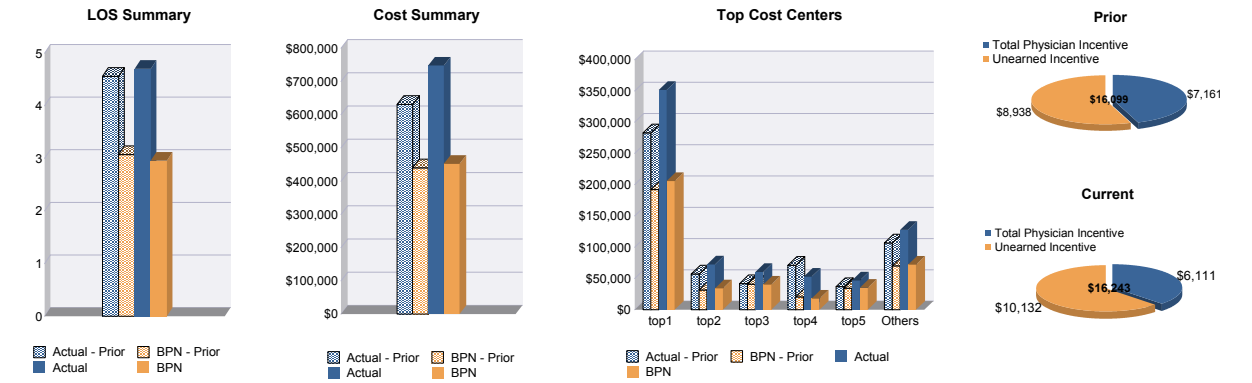
1. On the upper segment their cumulative average LOS vs. the best practice LOS; their total possible incentive for performance vs. their actual incentive for performance (vs. the best practice costs); their total possible incentive for improvement vs. their actual

Figure 3
Sample Dashboard Report

Responsible Physician	1003109828		**PAR Status**	Non PAR	**Specialty**		
Physician's First Name			**Physician's Last Name**				

QUICK STATISTICS	Cost		Average LOS		INCENTIVE	Performance		Improvement		Total	
	Prior	Current	Prior	Current		Prior	Current	Prior	Current	Prior	Current
Your Information	$631,228	$748,068	4.56	4.71	**Maximum Incentive**	$16,099	$16,243	$0	$0	$16,099	$16,243
Best Practice Norm (BPN)	$440,012	$452,189	3.07	2.96	**Your Incentive**	$7,161	$6,111	$0	$0	$7,161	$6,111
Variance	$191,215	$295,879	1.49	1.75	**Unearned Incentive**	$8,938	$10,132	$0	$0	$8,938	$10,132

Admissions by Complexity Level (SOI)		SOI 1:	SOI 2:	SOI 3:	SOI 4 :	Total:
	Current	19	41	34	8	102
	Prior	11	41	37	7	96



Cost Center Summary		Your Cost		BPN		Variance	
		Prior	Current	Prior	Current	Prior	Current
Top1	Adult-Peds Room Board Cost	$283,086	$351,635	$192,287	$205,971	$90,799	$145,665
Top2	Drugs Sold to Patients Cost	$57,035	$72,458	$31,546	$34,171	$25,488	$38,287
Top3	Radiology Cost	$41,573	$60,271	$40,701	$40,064	$872	$20,207
Top4	Coronary Care Units Cost	$71,185	$52,654	$20,473	$17,608	$50,712	$35,046
Top5	Laboratory Cost	$36,932	$46,692	$34,521	$34,878	$2,411	$11,814
Top6	Emergency Room Cost	$39,822	$39,725	$40,364	$42,051	$-542	$-2,326
Top7	Med/Surg Supplies Sold Cost	$27,516	$38,737	$8,510	$9,417	$19,005	$29,320
Top8	Electrocardiology Cost	$14,503	$19,993	$11,836	$10,380	$2,667	$9,613
Top9	Physical Therapy Cost	$18,147	$18,887	$5,141	$5,173	$13,006	$13,714
Top10	Respiratory Therapy Cost	$6,918	$10,375	$4,260	$5,043	$2,658	$5,332

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improvement incentive (vs. their own costs in the 2007 base year); and their total incentive paid.

2. In the middle segment graphic depictions of their incentive earned vs. total possible incentive and their top cost centers.
3. The bottom segment shows what their top cost centers were for the period and the difference in cost, per center, to the best practice costs.

Hunterdon's experience was that, for medical patients, the top cost center was consistently "adult room" costs that represent the per diem for the hospital stay. Very often the second was cardiac unit costs that were per diems for telemetry beds. For surgical patients the top cost center was often surgical supply costs.

When we received the individual physician incentive reports, which are independently calculated by NJHA/AMS acting as a third party, we required that each physician meet with the program director to review their reports and discuss ways to try to lower cost without negatively affecting quality.

Consequently, we concentrated on lowering our LOS on the medical units. This was, as one might expect, a day-to-day endeavor. Our patient care management department worked with physicians to lower length of stay. The program director made length-of-stay rounds weekly looking at all patients with LOS over five days to see what barriers were preventing discharge. We also encouraged physicians to discontinue telemetry when patients had stable rhythms for an appropriate period of time.

Length of stay was less of a factor for the surgical DRGs. For surgery, particularly orthopedics, supply cost tended to be the greatest driver of cost. After the first year of

the program, one of our orthopedists approached the administration about ways to improve our joint replacement program.

We looked at best practices and worked with all our orthopedists to decrease the number of joint prostheses that we used, along with creating clinical best practices and order sets that led to greater standardization of practice among all our orthopedists.

At about the same time, we created a value analysis committee. Led by our material management department, this group looked to lower costs across the institution taking suggestions from front line workers and management.

There were four teams:

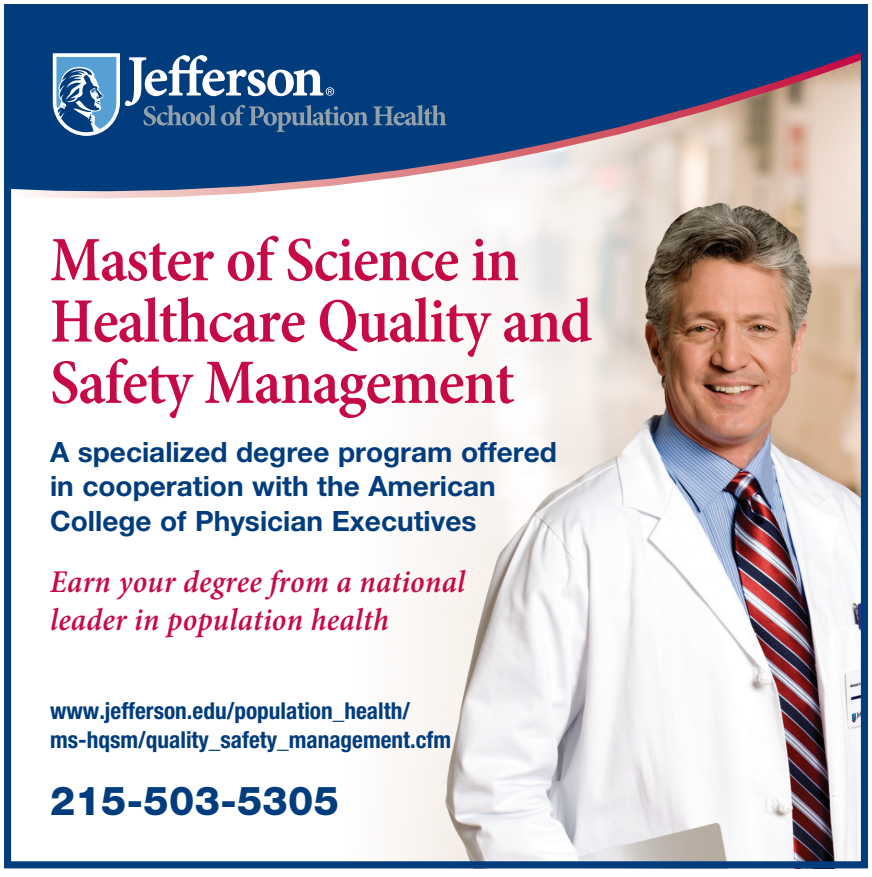
1. Nursing care
2. Surgical services
3. Clinical services
4. Support services

The teams met regularly and asked frontline workers to make suggestions for product or procedure changes that could cut costs. From 2010 to 2012 the teams were able to demonstrate more than $4 million in cost savings.

Hospitals were given the opportunity, with approval of the steering committee, to tie incentive payments to quality measures. Most did not do so in the beginning as they wanted to get physicians maximum rewards to generate enthusiasm for the program.

Hunterdon eventually made deductions from the incentive payments based on core measure performance. Our steering committee also voted to withhold the entire payment for physicians who appeared on the suspension list for medical records four times in a six-month cycle.

Our quality numbers did not deteriorate.



Bundled payment/ gainsharing

The original gainsharing program was due to end on July 31, 2012. After the passage of the Affordable Care Act, CMS Innovations Center announced the availability of four models for bundled payment trials under the Bundled Payments for Care Initiatives (BPCI).

Model 1 was modeled after the New Jersey program. In order to maintain the momentum, the NJHA petitioned CMS to extend the original project until they were ready to start the new program. Thirty New Jersey hospitals expressed interest in Model 1, presumably based on the experience of the original 12 gainsharing participants (several of the original hospitals opted not to continue and in most cases are participating in one of the other Medicare models).

However, there was apparently less interest nationally so in September, CMS announced that it was going to re-evaluate its intention to proceed with live implementation of Model 1. NJHA engaged in a round of robust discussions with CMS staff members in an effort to change their minds, and eventually it was announced that Model 1 would begin on April 1, 2013. In addition to the New Jersey hospitals there are two hospitals in California and one in New York that have been approved.

In the New Jersey program, which is slated to run from April 2013 through March 2016, the new base year for determining best practice is 2011. The comparison year for determining the rate of improvement will be the running year before the measurement period.

This was changed from the original model during which the comparison year was 2007 (the base year) for each year of the program. This change was made on the basis of feedback from the participating hospitals who felt that they were rewarding physicians each year for the

"same" improvement. NJHA is also exploring methods of including more physicians, specifically consultants and hospital-based physicians in the incentive program.

On the CMS side, the biggest change in Model 1 as compared to the original demonstration is that it has gone from being revenue-neutral to having guaranteed discounts to CMS.

In the second half of the first year of the program, hospitals will give back 0.5 percent of their base Medicare inpatient payment. The discount will increase to 1 percent in the second year and 2 percent in the third year.

Hospitals will have the option not to make incentive payments if they do not lower costs enough to make up the discount and also have the option to opt out of the program with 60 days' notice to CMS.

Conclusion

Many of the cost-saving measures that we used to succeed in gainsharing were expansions of programs that we had already instituted in an effort to save costs. Therefore it is hard to say to what extent the program, by itself, led to the cost savings.

It is reasonable to assume that it got the attention of the physicians to, at least, think about the cost of care. In many cases the program helped to integrate other initiatives so that incentives were available for improvements. There was a wide variety of opinion across the state as to the amount of money that was sufficient to change physician behavior, particularly for the better compensated surgical specialties.

However, most hospitals were able to show significant savings in the cost of care. Whether they will be able to sustain those savings year after year, particularly with the Medicare discounts, remains to be seen.

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Note: The statements contained in this document are solely those of NJHA/AMS and do not necessarily reflect the views or policies of CMS.

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