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# Modern Healthcare

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## WAIVER FAVOR

*N.J. hospitals get federal  
approval to share payments with  
high-performing docs / Page 6*

The top executives from the eight hospitals participating  
in the pilot project say the pay-for-performance program  
properly aligns incentives for care.

# New Jersey experiment

*Eight hospitals will participate in CMS 'gainsharing' project, in which doctors can earn bonuses of up to 25% on Medicare fees*



**'Here is an opportunity to look at incentives and make sure they are properly placed. The problem with skeptics is they'll do nothing.'**

—Gary Carter,  
president and chief  
executive officer,  
New Jersey Hospital  
Association

**T**he New Jersey Hospital Association has cobbled together an ambitious, controversial and financially risky experiment that aims to realign the competing economic interests of hospitals and doctors that, according to the association, have plagued Medicare for more than a generation.

The CMS has begrudgingly greenlighted the three-year demonstration project, which will officially launch on Jan. 1, but has limited the so-called "gainsharing" program to eight New Jersey hospitals, *Modern Healthcare* has learned. Under the pilot, participating hospitals—without fear of invoking antikickback laws—will be allowed to offer cash bonuses to physicians who help their hospitals reduce inpatient costs.

Top performing doctors could reap as much as 25% more in Medicare fees in addition to recouping income lost because of reduced lengths of stay and ordering fewer diagnostic tests. Participating hospitals are risking up to 2% of their Medicare fees should the effort fail in the second year to improve efficiencies as expected. For Medicare itself, the experiment is budget-neutral and risk-free.

"For me this is a gigantic experiment. Let's just see what happens," said Gary Carter, president and chief executive officer of the 107-member New Jersey Hospital Association. "Here is an opportunity to look at incentives and make sure they are properly placed. The problem with skeptics is they'll do nothing."

If successful, the project, which boldly extends the mushrooming pay-for-performance movement to doctors caring for fee-for-service Medicare patients, could be replicated nationally, hospital association officials said. But the participants first have a forbidding hill to climb under the jaded gaze of CMS Administrator Tom Scully, who is as unenthusiastic about this demonstration project as he is enthusiastic about the three-year pay-for-performance project launched in July with hospital alliance Premier (See accompanying story).

"I traditionally don't like (gainsharing). I view it as a

backdoor way to pay off physicians," Scully said. "But it's a demo. We're not letting this cat out of the bag. If it's legitimate, we'll expand it, but if we don't like the outcomes, we'll get it back in the bag."

Under gainsharing, doctors and hospitals share profits based on a predetermined formula.

Interestingly, New Jersey also is the state where an unusually high number of not-for-profit hospitals boosted their bottom lines with Medicare outlier payments, which are meant to compensate hospitals for unusual cases in which costs exceed standard Medicare rates (July 14, p. 4). The CMS since has tried to clamp down on the practice with new regulations.

## Rival financial incentives

At issue in the upcoming demo are what some describe as the rival financial incentives for doctors and hospitals inherent in the Medicare reimbursement system. Hospitals, paid by case, stand to widen their profit margins by treating patients quickly and efficiently. On the other hand, physicians, paid by the procedure, stand to earn more the longer a patient stays in the hospital and the more tests, sometimes medically unnecessary, a patient undergoes.

Though hospitals argue that the misaligned payment system results in inefficient care, others say rewarding physicians for essentially restraining inpatient hospital care might be likened to agriculture programs that pay farmers not to grow crops. Some also question whether by simply reducing costs, it's a natural leap to improve quality of care.

"I've got a better plan," said Rep. Pete Stark (D-Calif.), author of the physician self-referral laws that the CMS waived to get the New Jersey project off the ground. "We'll give doctors 25% upfront for those who don't let their patients go to the hospital at all. They'll give them an aspirin and make an appointment at the mortuary. It's a win-win deal."

Others believe financial incentives will spur improved quality from doctors just as in theory they will for hospi-



tals. "Gainsharing arrangements are not necessarily evil and can benefit all parties involved, including government and the patients, by ensuring good quality care and saving healthcare dollars," said Janet Nolan, a lawyer specializing in healthcare fraud at Fulbright & Jaworski, and a former assistant U.S. attorney in Newark, N.J. The Stark laws were



**Michael Kalison, left, and Jo Surpin of Applied Medical Software worked on the project's software. "It's a simple, elegant idea," Kalison says.**

created out of concern that, by gainsharing, hospitals "are in effect paying doctors to refer patients to that hospital," Nolan said. "My opinion is that gainsharing agreements can be structured so that they don't implicate Stark or antikickback statutes."

The New Jersey project is the brainchild of Michael Kalison, a lawyer and chairman of Applied Medical Software, a firm that developed the software that will be used to measure performance and determine the physicians' bonus

payments. In a sense the experiment brings some closure for Kalison, who helped design the state's DRG-based rate-setting system, which in 1983 was adopted by Medicare for its own diagnosis-based payment system.

"Though originally (the payment system) did call for aligning incentives, we felt getting the hospital payment piece off the ground was as much as we could do. ... The physician piece we considered a push. Now it's time," Kalison said. "This should have been tried years ago. It's a simple, elegant idea to align the incentives of doctors and hospitals. It's not rocket science."

Simple as it seems, similar efforts have been tried but have never gotten far off the ground. The last known attempt was in 1997 when hospitals in New Jersey, New York and Pennsylvania put together a demonstration project that aligned incentives by bundling physician and doctor payments under one fee paid by the CMS. That project "wandered in the wilderness" and died because hospitals were uncomfortable about "relinquishing payments," Kalison said.

This program solves that problem by keeping the current Medicare payment mechanism intact with no bundling of physician and hospital fees, though the physician bonuses will come out of the hospitals' Medicare Part A payments—in theory offset by what hospitals save through doctors' improved efficiency. Though the hospitals can choose to opt out after the first year of the program, if they don't achieve 2% savings to Medicare in the second year they will have to make up the difference. Participation by doctors is strictly voluntary and they will be judged on individual, not group, performance. Doctors run no risk of penalties and are



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**QUALITY** >> Cinda Becker

## Performance pay on the way

*279 hospitals in Premier, CMS project; Scully hints at expansion*

**H**ospital alliance Premier came up 21 hospitals short of expectations when it closed enrollment last week for the groundbreaking pay-for-performance demonstration project it launched last July with the CMS. But CMS Administrator Tom Scully already is discussing an expansion to every hospital in the nation if he gets his way.

"We may do some kind of project for non-Premier hospitals," Scully told *Modern Healthcare* last week. "A lot of organizations are clamoring to do what Premier is doing ... I would like to see 5,000 hospitals participating in (the Premier project), but obviously we don't have the legislative authority to do more than a demonstration project. This is the right way to go."

At the close of the three-month enrollment period on Nov. 24, Premier officials reported that 279 hospitals had agreed to take part in the seminal project. The program, announced in July, will reward top performing hospitals

with public recognition and added dollars in an attempt to ascertain whether economic incentives have a direct link to quality of care (June 30, p. 6). Under the project, hospitals in the top 10% in five clinical areas—coronary artery bypass graft, heart attack, heart failure, hip and knee replacement and pneumonia—will receive a 2% bonus Medicare payment. Hospitals in the second 10% will receive a 1% bonus.

Meanwhile, by the third year hospitals performing in the bottom 10% that show no improvement will be penalized with a 2% cut in Medicare payments.

Of the 279 hospitals that volunteered, 24 are non-Premier hospitals. Premier originally said it hoped to sign on as many as 300 hospitals. The hospitals volunteering to participate in the program were recruited from among the 470 hospitals that were subscribing to Premier's proprietary Perspective comparative database system as of March 31, 2003. Perspective is a fee-for-service

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ensured protection from any income loss.

Kalison said the project's cornerstone is an incentive program that evaluates physician performance according to costs per case, but adjusted for severity and case mix. In the meantime, the CMS said it would be monitoring the hospitals to ensure there is no erosion in the quality of care. An oversight committee—with physicians making up at least half of the members—will manage the project at each hospital.

For hospitals and physicians alike, one of the experiment's most attractive features is that it leaves managed-care companies out of the equation, putting the "clinical decisionmaking process back in the hands of physicians and the hospitals," Kalison said.

"The government has as one of its goals to save money, and the model that they seem to be relying on is managed care," Kalison said. "We're seeking to understand whether an alternative model which returns decisions to providers and patients and doesn't rely on the intervention of third parties can save money and provide cost-effective, high quality care."

### Diverse group of hospitals

The participating hospitals, which the hospital association and the CMS together selected with the idea of assembling a geographically diverse group of financially viable teaching and nonteaching, urban and rural hospitals, have not yet lined up participating physicians. But

## N.J. PILOT PARTICIPANTS

448-bed Jersey Shore University Medical Center, Neptune

435-bed Atlantic City Medical Center

362-bed University of Medicine and Dentistry of New Jersey-University Hospital, Newark

325-bed JFK Medical Center, Edison

320-bed Capital Health System at Mercer, Trenton

318-bed Holy Name Hospital, Teaneck

269-bed Mountainside Hospital, Montclair

180-bed Hunterdon Medical Center, Flemington

Source: New Jersey Hospital Association

they are cautiously optimistic the doctors will come on board once the program is explained.

Physicians on average can expect to gain as much as \$340 per Medicare admission in incentive payments, said Al Maghazehe, president and CEO of two-hospital Capital Health System in Trenton, whose 320-bed Mercer hospital is participating in the project. For Mercer, it could mean a financial and competitive edge, he said.

"First of all it's a definite push to improve quality of care, reduce expenses and it creates an opportunity for the hospital to make extra

money. We also should see an increase in utilization of services, but there's a lot of ifs here," Maghazehe said. "The concept is very interesting and something that is going to have to happen and by being in it first, we figured there was an opportunity to learn it first."

The project represents only the latest attempt to align doctor and hospital interests at 325-bed JFK Medical Center in Edison, which participated in the failed demonstration project of the late 1990s. John McGee, president and CEO of JFK's parent, two-hospital Solaris Health System, conservatively estimates the hospital stands to lose as much as \$1.5 million in the second year if the effort fails to save money. On the other side of the coin, improved efficiency could represent an \$8 million opportunity, he said. Believing that improved quality is an integral part of the project, McGee added that he refrains from calling it a "gainsharing" project.

"All of that time and effort we spend on approvals and utilization issues with HMOs—(instead) we'll be concentrating on dealing with the physicians and patients," McGee said. "The system is overly due for a modernization."

Unfettered by the CMS, managed-care companies have freely experimented in recent years with pay-for-performance efforts. Taking it a step further, insurers are now promoting cost-efficiency by limiting their provider networks to a carefully chosen few. Last month, for example, Blue Cross of California launched a so-called narrow-network HMO that is designed to save money by funneling patients to the most cost-conscious doctors (Nov. 24, p. 14).

As far as insurers are concerned, the more that participate in such efforts, the merrier—whether it involves the health plans or not.

"It's fantastic to see the federal government get engaged at this level to try to (motivate) quality," said Michael Chee, a Blue Cross spokesman. "This is the phase that the entire private industry is moving toward. I think it's very healthy to see the federal government use a quality incentive, especially for Medicare payments."

Similarly, Sam Nussbaum, executive vice president and chief medical officer for Anthem, which has launched several pay-for-performance projects, said any effort that brings hospitals and doctors closer is a good effort.

"I think this is one of many positive and exciting demonstration projects that CMS has going," Nussbaum said. "The greatest improvement in clinical outcomes will come when doctors and hospitals work collaboratively." <<

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repository that collects and then "scrubs" monthly clinical and financial data from hospitals to produce regular clinical performance reports that hospitals privately use for strategic purposes. About 15% of the hospitals participating in the service aren't among Premier's 1,500 members.

"Nobody knew how many hospitals might participate. But we always set high targets for ourselves. We're delighted that (279) hospitals have agreed to take part," Premier spokesman Hunter Kome said. "These hospitals are pioneers and deserve a ton of credit for their leadership."

Opting out of the program was not an option for the 11 hospitals that constitute the North Shore-Long Island Jewish Health System, said Yosef Dlugacz, senior vice president of quality management. The order came from the top of the Great Neck, N.Y.-

based system. Dlugacz conservatively estimated that North Shore-Long Island could receive up to \$2 million in bonus payments, but it's not about the money, he said. "We think we don't have a choice but to show we are better. In other words, CMS legitimized the process of quality management," Dlugacz said.

It also isn't about the money for 275-bed Rogue Valley Medical Center in Medford, Ore., said Mark Folger, executive vice president for two-hospital Asante Health System, Rogue Valley's parent. "It's a learning process for us. This is, I think, a wave of change that is not going to go away in terms of sharing (outcomes) with the community. I think it will help us improve our care. That's what we're going into it for."

The project now moves into the data collection phase, Kome said. The first data period started Oct. 1. Data on the top 50% hospitals in each clinical area will be publicly reported annually beginning in October 2004. <<

### What do you think?

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