AHRQ HEALTH CARE
INNOVATIONS EXCHANGE
Innovations and Tools to Improve Quality and Reduce Disparities

Policy Innovation Profile

Hospital Gain-Sharing Program Offers Incentives to Physicians Based on Their Efficiency, Producing Significant Cost Savings Without Decline in Quality

Snapshot

Summary

In a 3-year pilot demonstration program with the Centers for Medicare & Medicaid Services, 12 New Jersey hospitals known as the New Jersey Care Integration Consortium participated in a voluntary gain-sharing program that offered individual physicians upside (but not downside) incentives based on risk-adjusted performance on efficiency metrics, including performance versus peers and improvement over time. Through the New Jersey Hospital Association and Applied Medical Software, Inc. (the developer of the methodology), physicians received regular feedback on their performance, including an easy-to-read dashboard and more detailed patient-specific information. Various requirements and measurement systems were put in place to ensure that quality of care remained a priority. The program reduced costs per admission by roughly 8.5 percent, with these reductions generally increasing over time. Total savings for the 12 participating hospitals reached nearly $113 million, of which roughly 17 percent (just under $19 million) was paid out in incentives. Performance on various quality measures either remained the same or improved throughout the program. Based on this success, the New Jersey Hospital Association applied for and secured Federal approval for a second, larger demonstration program (known as "Model 1") under the Affordable Care Act's Bundled Payments for Care Improvement initiative.

Evidence Rating (What is this?)

Moderate: The evidence consists of pre- and post-implementation comparisons of inpatient costs and performance on various quality metrics in the 12 hospitals participating in the program.

Developing Organizations

Applied Medical Software, Inc.; New Jersey Hospital Association

Use By Other Organizations

After securing a waiver from the Centers for Medicare & Medicaid Services as part of the Deficit Reduction Act of 2005, Continuum Health Partners (which includes the Beth Israel Medical Center) implemented a similar gain-sharing program that ran between October 2008 and September 2011. This demonstration was

based on an ongoing program implemented in 2006 for commercial patients (i.e., excluding those covered by Medicare and Medicaid fee-for-service payments). An evaluation of this commercial program during a 3-year period (2006 to 2009) found that it generated meaningful cost savings, primarily due to reductions in length of stay and medical supply costs. Performance on quality measures improved during the program, but these changes did not meet the test of statistical significance.[1]

Hospitals in several other areas have won approval to implement the Model 1 gain-sharing program under the Affordable Care Act's Bundled Payments for Care Improvement initiative, including multiple hospitals in New York (through the Greater New York Hospital Association, which also facilitates a commercial gain-sharing program) and a hospital in Philadelphia. To date, however, these programs have not been implemented, which may be because hospitals have resisted the provision requiring a guaranteed discount to Medicare—something included in the Model 1 initiative that was not part of previous gain-sharing demonstration projects.

In addition, leaders in Maryland are currently considering putting in place a similar type of program as part of the State's all-payer system. (Maryland has a waiver that allows use of the all-payer system.)

Date First Implemented

2009

The initial 3-year demonstration began on July 1, 2009.

Problem Addressed

Physicians directly control the bulk of hospital costs, and many current payment systems for physicians are still based on a fee-for-service (FFS) model that encourages them to perform procedures and otherwise use hospital resources without regard to their cost. As a result, hospitals often find it difficult to improve efficiency, even when payment methods for hospital services encourage them to do so.

- **Little incentive for physicians to manage hospital costs:** Physicians directly control more than 80 percent of total medical costs.[2] Yet many payment systems for physicians still rely on FFS, meaning that physicians generally earn more money if they admit more patients, perform more hospital-based procedures, and use more hospital resources during the inpatient stay.[1]
- **Associated challenges for hospitals:** Because physicians are responsible for most hospital costs yet have little incentive to manage these costs, hospitals face significant challenges when they try to reduce costs in response to reductions in reimbursement and other payer programs that promote efficient hospital care.[1]

What They Did

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Description of the Innovative Activity

A consortium of 12 New Jersey hospitals organized by the New Jersey Hospital Association

(NJHA) participated in a voluntary gain-sharing program that offered individual physicians upside (but not downside) incentives based on risk-adjusted performance on efficiency metrics, including performance versus peers and improvement over time. Physicians received regular feedback on their performance, including an easy-to-read dashboard and more detailed patient-specific information. Various requirements and measurement activities were put in place to ensure that quality of care remained a priority throughout the program. Key program elements are outlined below:

- **Voluntary commitment by hospitals and physicians:** Hospitals and their affiliated physicians agreed to participate in the program on a voluntary basis. While hospitals could terminate their involvement by giving 60 days' notice to Centers for Medicare & Medicaid Services (CMS) and to participating physicians, all 12 hospitals in the initial demonstration project remained in the program for the full 3 years. To be eligible, physicians had to have active admitting privileges at a consortium hospital for at least a year prior to the program start date, and must have treated at least 10 cases at the hospital during that year. Those who did not qualify for the initial launch could join the program at the start of year 2 or 3 if they met the requisite criteria. To participate, physicians submitted a signed form to their hospital; the form listed all hospitals at which the physician had admitting privileges and provided relevant information to allow for payment of the incentives. Those with active admitting privileges at multiple hospitals were subject to a cap on the cases included in the incentive program. Physicians could withdraw their participation at any time, although no physician who maintained privileges at an affiliated hospital did so during the demonstration program.
- **Consortium- and hospital-level governance and oversight:** Various committees oversaw different aspects of the program, both for the overall program and for individual hospitals that participate, as detailed below:
    - **Consortium-level steering and quality oversight committees:** NJHA facilitated a consortium-level steering committee that provided overall governance and oversight during the pilot program. Made up of representatives (including physicians) from each participating hospital and NJHA, this steering committee oversaw and monitored the quality component of the project, including reviewing regular reports to identify and address any potential quality problems (e.g., large, unexplained variations in practice patterns). The committee also provided a forum to exchange ideas and best practices and otherwise support hospital-specific quality initiatives. The committee could also recommend changes to quality-related requirements, the quality and safety monitoring system, or the gain-sharing methodology if committee members felt such changes were needed to safeguard quality of care. (More information on the quality requirements and gain-sharing methodology appears later in this section.)
    - **Hospital-specific steering committees:** Each hospital had an internal steering committee that oversaw program administration. As specified in the agreement with CMS, physicians had to make up at least half of the committee's membership, and at least one consumer representative had to serve as well. Varying in size from 8 to 15 members, these

committees met regularly (at least quarterly and sometimes monthly) to prioritize program-related initiatives, review performance on quality measures, discuss proposed changes to the incentive system (such as shifting the structure to put greater emphasis on comparative performance rather than improvement), and approve all payments to the physicians. (These committees are also part of the second, ongoing demonstration project.)

- **Incentive structure based on program requirements and principles:** Program-level requirements and principles largely determined the size and structure of incentive payments to physicians, although participating hospitals had some input on certain aspects, as outlined below:
    - **Maximum incentive pool:** As part of its approval, CMS set a maximum incentive payment of 25 percent of professional fees and subsequently monitored adherence to that maximum. (With the current Model 1 program, the maximum increased to 50 percent of professional fees.)
    - **Risk-adjusted measurement of individual (not group) performance:** The program required that incentives be paid based on the performance of individual physicians rather than groups or departments. To avoid penalizing physicians who treated very sick patients, performance was risk adjusted based on severity of patient illness.
    - **Inclusion of ancillary physicians:** Participating hospitals could decide to include additional physicians (i.e., other than surgeons and attending physicians) who come into contact with patients, such as consultants, radiologists, and other ancillary physicians. Applied Medical Software, Inc. (AMS) and NJHA developed payment methodologies for these physicians. However, during the initial demonstration program and thus far under the Model 1 program, no hospital has elected to extend the program to these other physicians.
    - **Incentives tied to relative performance and improvement over time:** Initially, all hospitals set up incentive structures to reward doctors based on their risk-adjusted performance in two areas: comparative performance versus peers and improvement over time. The initial structure specified by the program-level steering committee based one-third of the incentive payment on comparative performance and two-thirds on the degree of improvement. Program leaders encouraged hospitals to shift this mix over time to place a greater emphasis on comparative performance, with the ultimate goal being to eliminate the improvement component. During the initial demonstration project, hospitals altered the mix to varying degrees, with most either making no change or implementing a modest shift (e.g., to a 50–50 split). Additional details on the calculation of both components appear below:
        - **Relative performance versus peers:** Each participating physician's performance was determined by comparing risk-adjusted costs per case to a "best-practice norm" derived from a large local database covering all New Jersey admissions. Risk adjustment was based on the All Patient Refined Diagnosis Related Groups (APR DRG) patient classification system, which adjusts for case mix, severity of illness, and inflation. (APR DRG is a proprietary product of 3M Health Information Systems.) An algorithm identified the "responsible physician"—i.e., the physician most responsible for resource consumption during the patient's hospitalization.

NJHA and AMS detailed this algorithm and other program components in a physician handbook made available to participants.

- **Improvement over time, including compensation for lost income:** During the initial demonstration project, the improvement component was defined as current-year performance versus the base year (the 12-month period before the program began), adjusted for case mix and severity of illness. (Under the Model 1 gain-sharing program, current performance is compared to that of the previous year rather than the base year.) In addition to rewarding physicians for improving their performance, this component served as a mechanism to compensate physicians for potential loss of income when their performance improvements resulted in declines in length of stay (LOS) for medical admissions. Shorter LOS tends to reduce the associated fees paid to physicians who make patient rounds every day. To compensate doctors for this loss of income, the improvement component restored per-diem payments to physicians who were successful in reducing LOS, with the payments intended to match what they would have received if LOS had remained the same.

- **Twice-a-year performance reports**: In partnership with AMS, NJHA distributed various hospital reports identifying cost reductions achieved and opportunities for additional reductions, including two reports to participating physicians during every 6-month performance period. The first "dashboard" report provided the following information: a summary of the physician's risk-adjusted costs versus the best-practice norm (by APR DRG), total incentive payments for the period, what the maximum incentive could have been (to highlight money "left on the table"), changes in LOS during the period, and a list of improvement opportunities (i.e., areas where costs seem out of line with those of peers). This information appeared in easy-to-read graphic format. Physicians also received a second, more detailed report that provided patient-specific detail, compared with best practices. Each participating hospital also received twice-a-year summary reports that detailed performance by cost center, APR DRG, and responsible physician.
- **Twice-a-year incentive payments:** Physicians received their incentive payments in conjunction with distribution of the performance reports. For employed physicians, payments were typically part of regular paychecks; for others, the incentive came in the form of a separate check. During the 3-year demonstration program, payments for most physicians ranged between $5,000 and $10,000 every 6 months, with some high-volume physicians earning as much as $25,000 to $30,000.

- **Multiple hospital requirements to monitor and improve quality:** As a condition of participation, hospitals in the initial demonstration program had to engage in various quality-related activities and monitor a wide array of quality indicators, with the goal of ensuring that both the participating hospitals and their physicians remained focused on providing high-quality care throughout the program. The various quality-related requirements are detailed below:
  - **Participation in quality improvement initiatives:** Throughout the pilot, Consortium members had to participate in all collaboratives offered by the NJHA Quality Institute or

their equivalents. Examples include efforts focused on the following: reducing the incidence of pressure ulcers across the care continuum; reducing the incidence of antimicrobial resistance, with an initial focus on catheter-associated urinary tract infections; improving care for African-American and Hispanic patients with heart failure; reducing the incidence of catheter-associated bloodstream infections in intensive care unit patients; and fall prevention. Participating hospitals also agreed to adopt the World Health Organization Surgical Safety Checklist.

- **Tracking and monitoring:** The waiver with CMS specified that participating hospitals had to track a set of 42 standard measures used by the CMS Hospital Quality Alliance. In addition, each hospital had to develop physician-specific metrics consistent with these measures. At a minimum, hospitals had to track physician-specific mortality, readmissions (within 7 and 30 days of initial discharge), and LOS. Hospitals could also adopt other physician-specific measures as they saw fit, such as unplanned returns to the operating room (OR), timely switch from intravenous to oral antibiotics, patient experience scores, delinquent medical records, and written complaints. Finally, to minimize the risk that inpatient efficiencies might be achieved by shifting costs to the postdischarge setting, CMS required hospitals and the Consortium as a whole to track and monitor stroke and congestive heart failure patients after discharge. These conditions were chosen because they represent a significant opportunity to reduce costs and improve quality due to high readmission rates. NJHA and AMS assisted hospitals in meeting these requirements, including calculating performance and submitting information to CMS.
- **Required focus on high-priority, nonclinical aspects of quality:** The program steering committee identified six nonclinical priority areas. Each hospital-specific steering committee had to choose at least three of these areas as a target for quality improvement, including developing metrics to gauge progress. The six areas are listed below:
    - Improving planning related to elective admissions, with the goal of avoiding unnecessary use of inpatient resources and payer denials by reducing the time between the admission and the attending physician's note justifying it.
    - Identifying and addressing emergency department (ED) bottlenecks to reduce ED LOS, particularly related to patients waiting to be admitted to the hospital.
    - Reducing the time between ordering and availability of results for diagnostic tests, endoscopic procedures, and specialist consultations, with the goal of reducing delays and duplicate testing.
    - Improving OR scheduling and use, including bottlenecks related to late-starting first cases, slow room-turnaround time, and physician/anesthesiologist delays.
    - Improving discharge planning processes, including communication, to reduce delays that unnecessarily use hospital resources.
    - Developing a tracking system to record and monitor results of at least one initiative, with these results being made available to other members of the consortium.

Context of the Innovation

Founded in 1918, NJHA is a not-for-profit trade organization that provides various forms of support to hospitals and other health care providers in New Jersey. NJHA has over 400 member organizations, including hospitals, health systems, nursing homes, home health agencies, hospice providers, and health care–related business and educational institutions. For these members, NJHA provides leadership in advocacy, policy analysis, quality and financial data, education, and community outreach.

AMS provides software-based support to health care organizations that are trying to align the economic incentives of hospitals, physicians, and payers. The program now operates in almost 40 hospitals, including those involved in commercial gain-sharing programs in New York and participants in the NJHA Model 1 gain-sharing program approved by CMS under the Bundled Payments for Care Improvement initiative within the Affordable Care Act.

The impetus for the initial gain-sharing demonstration program stemmed from New Jersey's long history of influencing health payment policy. New Jersey hospitals tested the diagnosis-related group (DRG) payment system in the late 1970s and early 1980s, with these tests ultimately convincing the Health Care Financing Administration (HCFA) to adopt DRGs nationwide in 1983. (HCFA became CMS in 2001.) Because the DRG system did not link hospital and physician incentives, it became clear over time that this lack of alignment remained a major driver of rapid increases in health care costs across the country. In 1999, leaders at AMS (which played a central role in New Jersey's DRG demonstration) approached their peers at NJHA about the idea of having member hospitals continue their tradition of testing new payment approaches. NJHA leadership liked the idea. Together, NJHA and AMS approached HCFA about sponsoring a demonstration project to test a model where physicians would receive incentive payments based on their performance on various efficiency metrics for inpatient care.

Did It Work?

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Results

The initial demonstration program reduced costs per admission by roughly 8.5 percent, with these reductions generally increasing over time. Total savings for the 12 participating hospitals reached nearly $113 million, of which roughly 17 percent (just under $19 million) was paid out in incentives. Performance on various quality measures either remained the same or improved throughout the program.

- **Significant cost reductions that increased over time:** During the 3-year period, the 12 hospitals and roughly 1,300 physicians participating in the demonstration program (which involved more than 125,000 Medicare admissions) reduced costs by roughly 8.5 percent, equivalent to almost $113 million in cumulative savings. Savings steadily rose over time, from 3.2 percent in the first six-month period to between 11 and 12 percent in periods four, five, and six. These savings do not take into account the incentive payments to physicians; accounting for these payments reduces the total by 16.8 percent ($18.9 million), leaving just under $94 million in net savings. (This analysis compares actual costs to base-year costs, adjusted for inflation, case mix, and severity of illness; NJHA and AMS conducted the analysis, which does not reflect the views or policies of CMS.)

- **Savings by all participants:** All hospitals achieved some degree of cost reduction, with eight generating cumulative savings that averaged more than 10 percent, three achieving cumulative savings that averaged between 3 and 10 percent, and one achieving savings of less than 3 percent. All 12 hospitals saved money in the fourth period, while 11 did so in the fifth and 9 did so in the sixth.
- **No decline (and some improvement) in quality**: Performance on the various quality measures either remained the same or improved throughout the 3-year demonstration project.

Evidence Rating (What is this?)

Moderate: The evidence consists of pre- and post-implementation comparisons of inpatient costs and performance on various quality metrics in the 12 hospitals participating in the program.

How They Did It

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Planning and Development Process

Key steps included the following:

- **Obtaining initial waiver from CMS:** Conversations with Federal regulators went on for a number of years, with CMS approving a waiver for an eight-hospital demonstration project in late 2003 and implementation occurring on January 1, 2004.
- **Experiencing delay due to hospital-initiated lawsuit:** Four hospitals not included in the program filed a lawsuit, and in April 2004 the judge ruled that CMS did not have the authority to waive some of the laws and regulations that were part of the approval. As a result, the demonstration project was effectively shut down. This lawsuit led to a forceful lobbying effort by NJHA, including an appearance before the Subcommittee on Health of the House Ways and Means Committee, which subsequently contributed to passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This legislation remedied the shortcomings revealed in the lawsuit.
- **Forming program-wide steering committee to prepare second application:** In preparation for submitting a second waiver application to CMS, NJHA formed a steering committee made up of representatives from 12 hospitals that wished to participate. These representatives typically included the chief executive officer, chief financial officer, chief medical officer, and a designated program coordinator. This informal consortium met on a regular basis (at least quarterly) to review relevant provisions of the laws under which the waiver would be granted and to make sure that the application would be acceptable to CMS. In 2009, the committee submitted the application and subsequently received a waiver from CMS under section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- **Planning led by steering committee:** After securing the CMS waiver, the program-wide steering committee continued to meet regularly to prioritize issues, review methodological issues, and generally discuss and share ideas across participating hospitals. (The program-wide committee does not exist as part of the expanded Model 1 gain-sharing program.)
- **Forming hospital-specific steering committees:** As noted, each hospital set up its own steering

committee for the program, with physicians making up at least half of the membership.

- **Training for participating hospitals led by NJHA:** In collaboration with AMS, NJHA took charge of providing participating hospitals with the tools they needed to succeed. The two organizations jointly led a half-day session at the beginning of the program and provided additional training and support as needed via webinars and inperson meetings held at NJHA's offices. (This type of support continues as part of the Model 1 gain-sharing program.)
- **Creating task forces to tackle specific issues:** NJHA created task forces to work on specific program-related issues as they arose, such as methodological issues associated with extending the incentives to doctors other than surgeons and attending physicians (e.g., consultants, radiologists, ED physicians), quality improvement and care redesign, and data integration. Established on an as-needed basis, these task forces typically consisted of experts in the area being addressed. In some cases, each participating hospital designated one or two representatives to be on the task force, while in others all task force members came from a smaller set of hospitals with more experience tackling the issue at hand. Typically these task forces developed recommendations and proposals for consideration by the program-wide steering committee.

Resources Used and Skills Needed

- **Staffing:** The program required no new staff, as existing personnel at NJHA and the participating hospitals work on the program as part of their regular job responsibilities. At NJHA, the senior vice president for health economics serves as the lead person responsible for the program, with assistance from several other employees.
- **Costs:** As noted, the program generated net savings, with cumulative savings of nearly $113 million and net savings of roughly $94 million (after accounting for incentives paid to physicians).

Funding Sources

Participating hospitals paid the incentives to eligible physicians out of the cost savings generated by the program.

Tools and Other Resources

Additional background on the early history of the program, including the initial approval by CMS and the subsequent lawsuit, can be found in the following articles:

- Becker C. New Jersey experiment. Eight hospitals will participate in CMS 'gainsharing' project, in which doctors can earn bonuses of up to 25% on Medicare fees. Mod Healthc. 2003;33(48):6-7,14,1. [PubMed]
- Becker C. Pilot crashes: Lawsuit by four N.J. hospitals shuts down experimental gain-sharing program designed to reward docs for controlling costs. Mod Healthc. 2004;34(16):6-7,1. [PubMed]

Adoption Considerations

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Getting Started with This Innovation

- **Form hospital-level committees with significant physician representation:** The hospital-level steering committees proved critical to the success of the initial demonstration program. Much of this success stemmed from the requirement that half of committee members be physicians. These committees helped to gain buy-in from hospital administrators and physician leaders, who in turn garnered support among medical staff.
- **Designate a facilitator:** NJHA plays an important role as a facilitator and convener, providing critical training and other support to the participating hospitals, including bringing them together periodically to discuss issues and share ideas and best practices. By taking charge of these activities, NJHA keeps the costs of participation affordable and ensures consistency across the hospitals.
- **Provide adequate incentive to motivate behavior change:** While debate exists on the optimum size for any physician incentive program, the potential payout must be enough to encourage behavior change. Physician interest in the initial program (with a 25-percent maximum) was quite high, and interest levels have risen further with the 50-percent maximum in the Model 1 gain-sharing program.
- **Build in mechanism to compensate medical doctors for loss of income:** As noted, the initial demonstration program had a mechanism in place to compensate physicians for lost per-diem payments as LOS declined for medical admissions. This mechanism helped counter potential resistance from these doctors about the program. It can likely be phased out over time as physicians adjust to shorter hospital stays.

Sustaining This Innovation

- **Provide regular feedback to physicians, including money left on table:** Programs should provide regular, easy-to-read reports that help physicians understand their performance (including opportunities for improvement), the level of incentive payment they will be receiving during the current period, and the amount of money "left on the table' (i.e., the gap between their payment and the maximum possible payout). Many physicians are less concerned about the size of the incentive than about earning the maximum possible amount.
- **Consider measuring improvement versus prior (not base) year:** Over time, calculating improvement as current performance versus the base year will result in physicians being rewarded on this component year after year, even if their performance levels off. (The performance component of the methodology already recognizes and rewards sustained, efficient performance.) By contrast, calculating improvement as the change from the prior year rewards them only for continued improvement. (As noted, the Model 1 program calculates improvement in this manner.)
- **Encourage hospitals to shift incentive mix over time:** The ultimate goal of the program is to reward "best-practice" performance. However, many physicians may not be performing at or near this level at the start of the program. Consequently, to engage doctors in the program, it likely makes sense initially to reward both comparative performance and improvement. Over time, the

balance can shift toward comparative performance. As noted, the first demonstration program initially tied a third of the incentive to comparative performance and two-thirds to improvement, with hospitals being encouraged to adjust this mix during the 3-year program.

- **Elicit and respond to feedback from physicians:** Regular group sessions and one-on-one meetings with physicians will likely be necessary, as questions and concerns will inevitably arise.
- **Integrate program with other initiatives:** Ongoing physician engagement is critical to the success of any gain-sharing program. To achieve maximum impact, leaders should integrate it with other quality/performance improvement initiatives within the organization.

Spreading This Innovation

On January 31, 2013, NJHA won approval from CMS to run the Model 1 gain-sharing program, which initially included 30 hospitals and health systems that collectively have 33 hospital sites. As of the launch date for the program (April 2013), 23 of these hospitals/health systems had implemented the gain-sharing program. However, as part of this project, CMS required that participating hospitals "guarantee" a certain level of savings to Medicare. The guarantee (a discount on hospital payments) kicks in after 6 months, initially at a level equal to 0.5 percent of inpatient payments, and subsequently increasing to 1.0 percent in year 2 and 2.0 percent in year 3. In other words, CMS payments to the hospitals are automatically lowered by these amounts, under the assumption that hospital costs will decline by even more. Because of this provision, some hospitals that initially implemented the program decided not to continue it after the first year. As of the start of the second year of the Model 1 program (April 1, 2014), 7 of the 23 hospitals have decided not to continue.

Use By Other Organizations

After securing a waiver from the Centers for Medicare & Medicaid Services as part of the Deficit Reduction Act of 2005, Continuum Health Partners (which includes the Beth Israel Medical Center) implemented a similar gain-sharing program that ran between October 2008 and September 2011. This demonstration was based on an ongoing program implemented in 2006 for commercial patients (i.e., excluding those covered by Medicare and Medicaid fee-for-service payments). An evaluation of this commercial program during a 3-year period (2006 to 2009) found that it generated meaningful cost savings, primarily due to reductions in length of stay and medical supply costs. Performance on quality measures improved during the program, but these changes did not meet the test of statistical significance.[1]

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In addition, leaders in Maryland are currently considering putting in place a similar type of program as part of the State's all-payer system. (Maryland has a waiver that allows use of the all-payer system.)

More Information

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Innovator Disclosures

Ms. Surpin reported being employed by and owning stock in AMS, which receives payments from the NJHA under subcontracts for services provided as part of the initial and ongoing gain-sharing demonstration projects. AMS owns patents related to the methodology used in these projects.

References/Related Articles

Moore RJ. New Jersey pilot demonstrates reduced costs through better care coordination. Healthcare Finance News. February 20, 2013. Available at: http://www.healthcarefinancenews.com/print/65196.

Footnotes

[1] Leitman IM, Levin R, Lipp MJ, et al. Quality and financial outcomes from gainsharing for inpatient admissions: a three-year experience. J Hosp Med. 2010; 5(9):501-7. [PubMed]

[2] Leff B, Reider L, Frick KD, et al. Guided care and the cost of complex healthcare: a preliminary report. Am J Manag Care. 2009;15(8):555-9. [PubMed]

Comment on this Innovation