Gainsharing – Inpatient Hospital Cost Reduction and Post-Acute Synergies: The Maryland Care Redesign Program Experience

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New Jersey has been in the forefront of gainsharing initiatives since the first Medicare Gainsharing Demonstration in 2009. The NJ Gainsharing Program continued with the Medicare Bundled Payment for Care Improvement (BPCI) Model 1 through 2016 and now with the New Jersey Hospital Association (NJHA) Gainsharing Program to Align Physician and Hospital Incentives. In 2017, an exception to NJ state legislation governing physician relationships, referred to as the "Codey" bill, was passed (S-913) allowing programs like the NJHA Gainsharing Program to be used by hospitals for its Commercial (i.e., excludes Medicare and Medicaid Fee-for-Service) patients. Based on the success of the early demonstration, gainsharing is part of Medicare BPCI, Comprehensive Joint Replacement (CJR), Accountable Care Organizations (ACOs) and the Maryland All-Payer Model. The Centers for Medicare & Medicaid Services (CMS) and the state of Maryland are collaborating to modernize Maryland's unique All-Payer rate-setting system for hospital services that will improve patients' health and reduce costs.

Alignment of physician and hospital incentives is best accomplished if the hospital successfully engages physicians in the process. Gainsharing, whether focused on internal cost savings (i.e., the NJ Demonstration and Commercial Program) and/or reductions in payments compared to a target price (i.e., shared savings), is an essential component to any effective physician engagement strategy. This is particularly true as reimbursement or provider payments transition from fee-for-service to value-based payments. The NJHA Program provides a broad based, comprehensive gainsharing methodology, and includes physicians regardless of specialty or employment status. It also includes all inpatient costs, and not just those limited to a specific area such as supplies. NJHA collaborated with Applied Medical Software, Inc. (AMS, Collingswood, NJ) in executing its Medicare and now Commercial Gainsharing Programs. The AMS Performance Based Incentive System® (AMS PBIS®) provides an all-inclusive system of targeted, highly defined financial incentives covering all inpatient cases and costs.

Maryland Care Redesign Program Objectives

In 2017, the Maryland Health Services Cost Review Commission (HSCRC) included Care Redesign Programs (CRPs), as part of its All-Payer Model. The first initiative was the Hospital Care Improvement Program (HCIP), an inpatient gainsharing Program similar to the NJ Model, and administered by AMS. In 2019, they expanded the CRPs to include the Episode Care Improvement Program (ECIP), which is modeled after the Medicare BPCI-A. Maryland hospitals participating in both Programs have leveraged the synergies between the Programs to affect Care Redesign Initiatives and reduce inpatient costs. Hospitals also found that using the gainsharing data to identify Cost Reduction Opportunities could: (1) influence episode selection since the gainsharing Program looks at an entire Service Line while the episodes are a subset of a Service Line, and (2) drive Care Redesign to focus on inpatient activities that influence post-acute services. Understanding the synergies between inpatient and post-acute services and identifying the differences in practice is critical to reduce cost and influence Care Redesign. To succeed in these efforts it is key to take advantage of the gainsharing opportunities to increase physician engagement.

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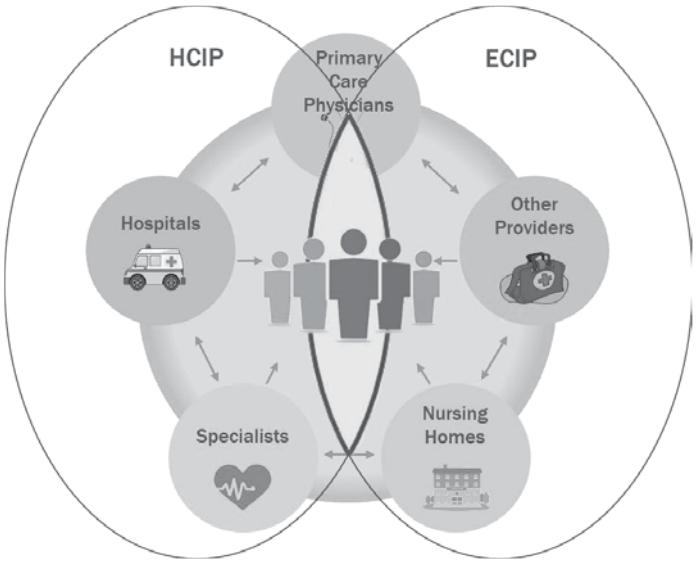
The goal of the HCIP Program is to reduce the total cost of care on the inpatient side by engaging physicians in actions designed to reduce resource utilization and streamline care being delivered. In an effort to reduce utilization, but maintain or improve quality of care there are two key components that are part of the Program – Care Redesign Interventions and Conditions of Payment. Care Redesign Interventions are identified by an Oversight or Steering Committee to gain efficiencies in the delivery of care. Often these are developed when an issue is identified in achieving an organization's strategic goals.

These interventions measure the performance of the hospital as a whole, not individual departments or physicians. In Maryland, a number of hospitals recognized the need to reduce variance in the care of septicemia patients. Antibiotic stewardship programs were instituted and standardized order sets developed to address the issue. Overall compliance with these interventions was tracked quarter to quarter, with modifications being made as necessary to meet the goals established. The Conditions of Payment, the measure used to assess individual physician performance, were developed in conjunction with the Care Redesign Interventions. Conditions of Payment are used to adjust a physician's calculated incentive based on their performance.

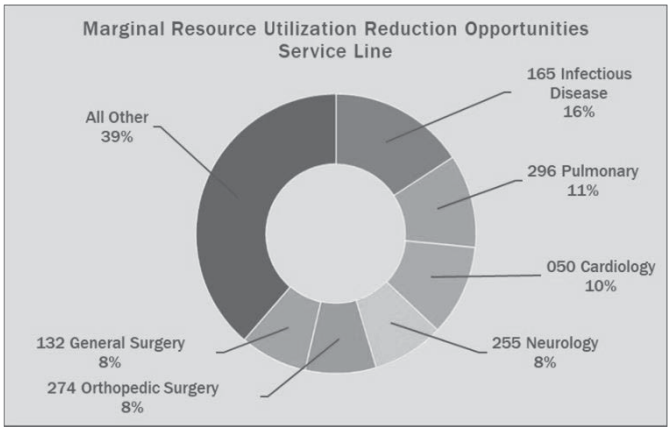
The ECIP complements HCIP since the focus is on the post-discharge period. The episode is triggered by the inpatient admission. HCIP limits incentive payments to participating physicians. ECIP may include physicians, but can also include nurse practitioners, nurses, home health agencies, physical therapy providers, inpatient rehabilitation facilities and skilled nursing facilities. Care interventions are developed to deal with patients in specific episodes after discharge. For septicemia patients these might include expanded use of remote monitoring, scheduling follow-up appointments and enhanced communication with home health staff. Incentive payments to Care Partners are based on shared savings or reconciliation amounts achieved and their performance on the agreed upon goals.



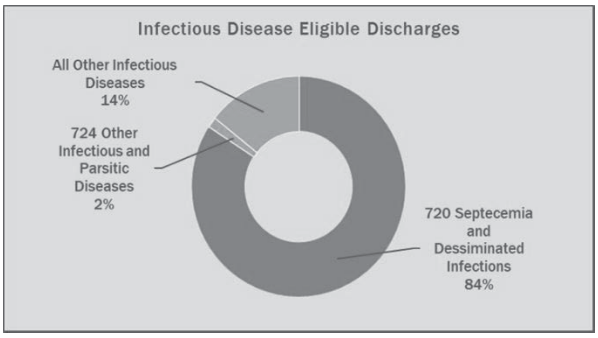
Program Synergies – Service Line/Episode Data is Key

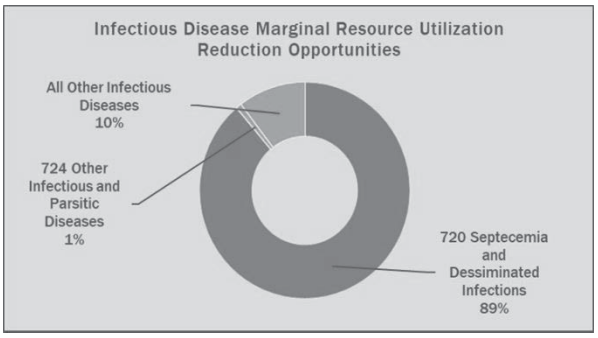
Hospitals that participate in both HCIP and ECIP afford the organization tremendous opportunity to reduce costs while improving the care delivered to patients. It is important to remember that HCIP includes all the cases within a Service Line, while ECIP contains limited cases within a Service Line based on the episode definition. For example, in the case of the septicemia patient, on the inpatient side, all cases in Infectious Disease would be considered while in ECIP only cases of sepsis would be – that is cases of Septicemia (APR DRG 720) and Other Infections (APR DRG 724). Using opportunities identified on inpatients through the HCIP Program can provide a roadmap to episodes to pursue post-discharge.

HCIP calculates the hospital Marginal Resource Utilization Reduction (i.e. cost reduction) Opportunities. This is the difference between a statewide Best Practice Norm (BPN), a financial standard set at the 25th percentile of lowest costs at a severity adjusted DRG level. In order to reflect marginal costs, 50% of the variance is used. In the example shown here, this hospital has more than 60% of the Marginal Resource Utilization Reduction Opportunity in six (6) Service Lines. Three (3) Service Lines constitute more than one third (1/3) of the opportunity. The next step was to identify which of the three (3) Service Lines might provide a target episode that they could impact.



Looking at Infectious Disease, the Service Line with the greatest opportunity, a comparison of the cases and the Marginal Resource Utilization Reduction Opportunities was done, as shown below. Notice that while APR DRG 724 constitutes 84% of cases; it comprises 89% of the opportunities. All Other Infectious Disease cases constituted 14% of eligible discharges but dropped to 10% of the opportunities.





Recognizing this relationship can be extremely beneficial to the hospital and physicians may be more engaged in interventions when inpatient and post-acute care is considered. Patients who are well managed post-discharge are less likely to require readmission. Post-acute providers who share in the savings are more likely to adhere to established guidelines. All of these measures can reduce the total cost of care.

Care Redesign Interventions

By looking at certain diagnoses/episodes, especially those with high costs, the protocols or Care Redesign Interventions can be revealed. For example, many hospitals have a population of chronic obstructive pulmonary disease (COPD) patients in their service areas. These patients tend to have higher readmission rates and consume significant resources on the inpatient side. In the HCIP Program, interventions can be tailored to the issues that arise, such as frequent chest x-rays, blood gases, and other laboratory testing. A standardized set of orders can ensure that there is less variance in the care delivered. Post-discharge the ECIP Program can be used to make sure the patient is adequately followed. These interventions might include scheduling follow-up appointments, telehealth to allow assessment, and physical therapy to improve patient condition.

Physician/Provider Engagement

Once Care Redesign Interventions and Conditions of Payment are agreed upon it also important to communicate and provide data to participating providers, and to monitor and reassess the impact of the Program. This is typically done in conjunction with a Steering or Oversight Committee established at the hospital. The Committee can evaluate that the steps taken are addressing the issues and that costs are declining. The Oversight Committee needs to do this on an on-going basis, tweaking interventions as needed or adding/eliminating others as appropriate. By sharing results routinely, physicians are engaged and part of the solution.

Conclusion

Physician engagement is key to successfully aligning physician and hospital incentives. A key to an effective engagement strategy is sharing relevant data. Agreeing upon priorities and objectives is critical to achieve reductions in resource utilization, while maintaining and possibly improving quality of care. Monitoring and communicating with participating providers also affords a vehicle for hospitals to respond quickly and work with providers as circumstances may require. By taking advantage of the synergies of Programs like HCIP and ECIP, physicians are afforded the opportunity to improve performance and maximize their incentive opportunities across a broad range of cases and hospitals can achieve internal cost savings.

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