Aligning Physician and Hospital Incentives - A Key Strategy to Support Recovery, Reimagination and Transformation Efforts

Jo Surpin

by Jo Surpin

Given the uncertainty hospitals are now facing, this is not a time to stand still. Facing the future requires a strategic approach to the recovery, reimagination and transformation of hospital services. Data will be critical in assessing initiatives and to providing support for the hospital decision process. Equally important is effective physician engagement.

Engaging physicians starts by coordinating efforts with the medical staff and the hospital. But to fully accomplish physician engagement, physician and hospital financial incentives must be aligned. Alignment is a proven strategy to achieve increased physician engagement, but effective implementation is not easily accomplished. Physician and hospital administration are often at odds with each other. Physicians focus primarily on patient care while hospital administration must also consider financial performance. But what if you could leverage those differences and focus on initiatives that can achieve both improved financial and quality performance, i.e., initiatives that affect care redesign and reduce inpatient costs?

New Jersey has been in the forefront of aligning physician and hospital incentives with its gainsharing initiatives (i.e., incentive payments to physicians based on hospital internal cost savings) since the first Medicare Demonstration in 2009. Based on the success of this demonstration, gainsharing is now part of Medicare bundled payment initiatives, CJR and in the Maryland All Payer model. Recognizing the need for collaboration with physicians, Stark regulations were issued that provide greater flexibility in compensating physicians in various collaboration efforts. The work to refine performance based incentives continues with the NJHA Gainsharing Program to Align Physician and Hospital Incentives.

IMPLEMENTING A REALIGNMENT STRATEGY CANNOT WAIT FOR POST COVID-19 - THE TIME IS NOW

Volumes have declined across all services - inpatient admissions, outpatient visits and emergency department visits - compared with pre-COVID-19 levels. This has had a significant financial impact on hospital operating margins - something that has been considered fragile, even before the pandemic. As noted in the ***NJHA CHART Bulletin Series (VOL 18, February 2021)*** "with inpatient admissions accounting for more than half of all patient revenues, even a modest reduction in volume can wreak havoc on hospital budgets."

Looking at third quarter data from 2020, the CHART Bulletin shows "the pandemic's deep, sustained impact on hospitals when compared to the same time frame in 2019, before COVID-19 sparked the greatest public health threat in a century. The data reveals:

- Hospital emergency department cases plummeted 27 percent.
- Outpatient visits dropped by 20 percent.
- Inpatient admissions decreased 9.6 percent.

- Total expenses jumped 10 percent.
- Patient revenues and average operating margins declined.
- The percent of hospitals posting operating losses nearly doubled."

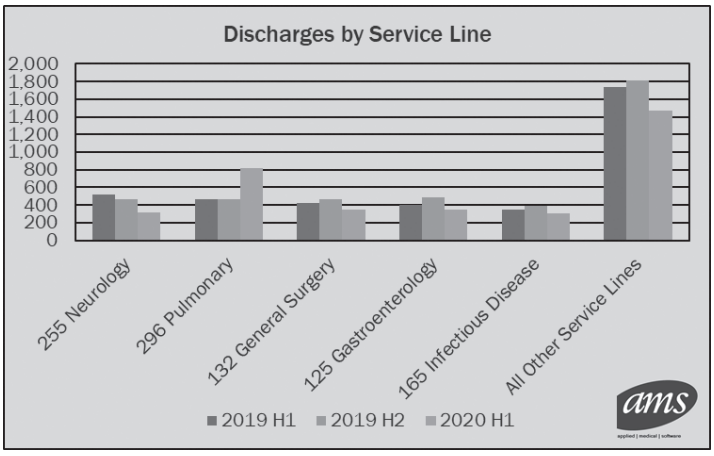
The numbers show that COVID-19 is exerting a considerable toll on hospitals. Perhaps more troubling, is that the impact on hospital financial performance is likely to be significant and, in some cases, permanent. Hospitals cannot delay a post COVID-19 strategy; the time to look forward is now.

MAINTAINING VIABILITY IN A CHANGING ENVIRONMENT - WHAT SHOULD BE CONSIDERED?

Hospitals have always been dynamic but changes that result in improved performance do not happen easily. The role of the physicians and their relationship to the hospital is a major factor to a successful strategy. Flexible strategies need to be developed that can be modified as circumstances change, and updated information becomes available. Continuous review and assessment will be critical.

To evaluate this we must go back to basics. It starts with analyzing the needs of your service area and the changes in demographics. It will also be important to review historical and current data to understand changes in service lines and case mix. Particularly considering the experience with COVID-19 it will be important to account for severity of illness. Figure 1 shows an example of changes in volume by service line.

FIGURE 1 - Discharges by Service Line:



This presents an opportunity to look at what is working and what isn't: What changes occurred due to COVID-19? What services will revert back to pre-pandemic levels, and which may not? What services should the hospital continue, grow, or scale back? For example, Figure 2 shows service line volume for 2019 H2 (July - December) while Figure 3 shows service line volume for 2020 H1 (January - June). The early effects of COVID-19 are seen in the rise in the Pulmonary Service Line.

FIGURE 2 - Discharges by Service Line - 2019 H2:

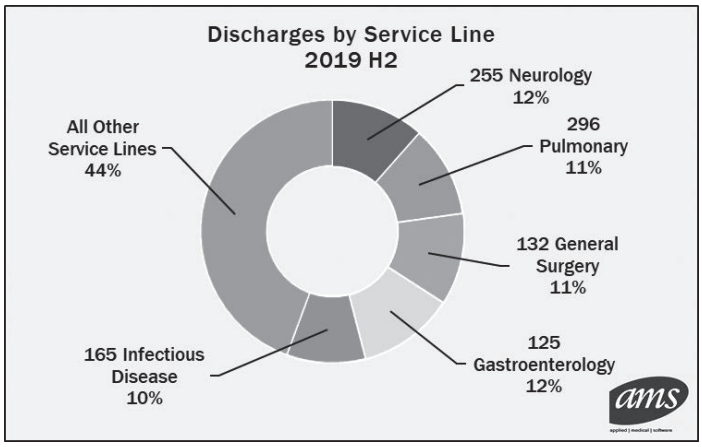
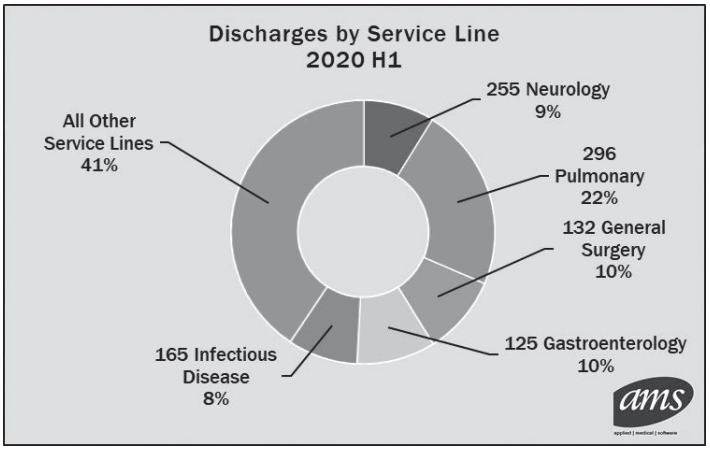


FIGURE 3 - Discharges by Service Line - 2020 H1:



In addition to the service line analysis that focuses on volume changes, it will be important to identify service line opportunities - particularly cost reduction opportunities. It can be assumed that utilization patterns will have changed dramatically, but understanding the detail about these changes will be required in order to develop effective strategies. Figures 4 and 5 show an example of cost reduction opportunities by service line using the NJHA Gainsharing Program "best practice norms" (BPNs). The norms are based on state-wide discharge data for all inpatients. BPNs are established at the 25th percentile (lowest costs) for each specific APR DRG to account for case mix and severity. (APR DRGs are a product of 3M Health Information Systems.) The marginal cost reduction opportunity is 50% of the difference between actual cost and BPN.

Once the opportunities for cost reductions are identified, it is important to look at physician utilization - volume, cost and opportunities for improvement. Figure 6 shows variation in cost by service line. This shows that there are differences in physician practice patterns - differences which could provide opportunities for cost reductions as well as care re-design initiatives.

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FIGURE 4 - Cost Reduction Opportunities by Service Line - 2019 H2:

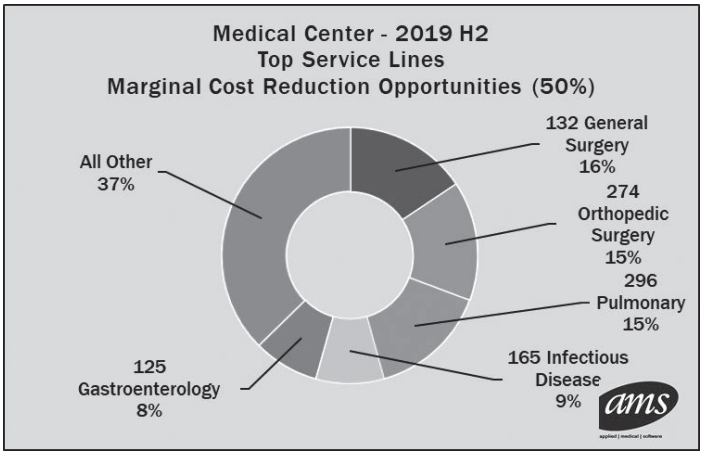


FIGURE 5 - Cost Reduction Opportunities by Service Line - 2020 H1:

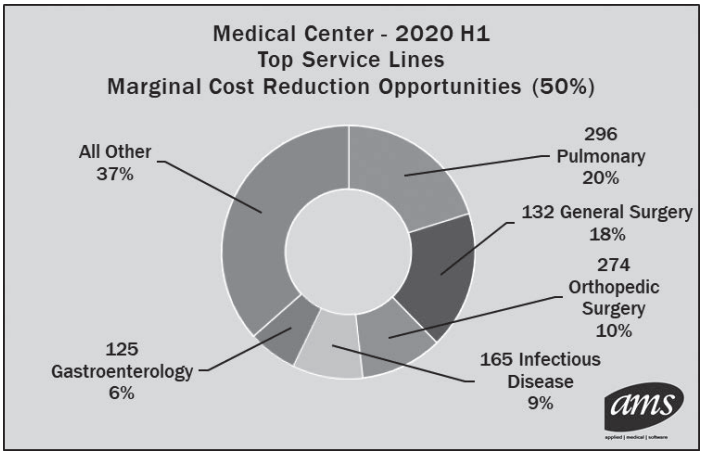


FIGURE 6 - Variation in Cost by Service Line:

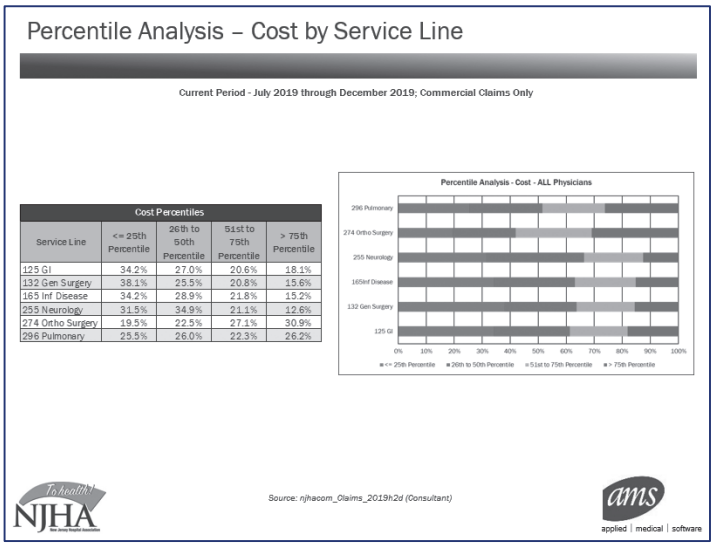
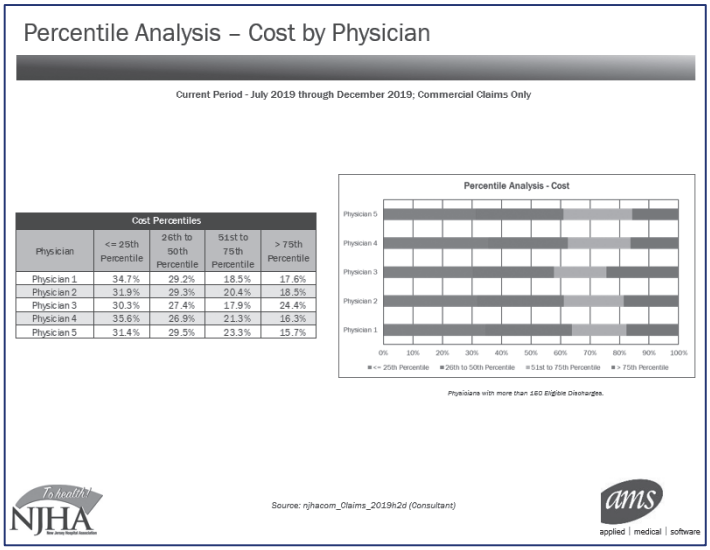


Figure 7 shows the variation in cost by physician. This will help to identify physicians that perform well. In particular, these data can provide a good set of benchmarks for encouraging other physicians treating similar cases to improve their performance. It will also help to determine whether or not you have the right mix of physicians to meet future needs.

FIGURE 7 - Variation in Cost by Physician:



ALIGNING PHYSICIAN AND HOSPITAL INCENTIVES - IMPROVING QUALITY AND FINANCIAL PERFORMANCE

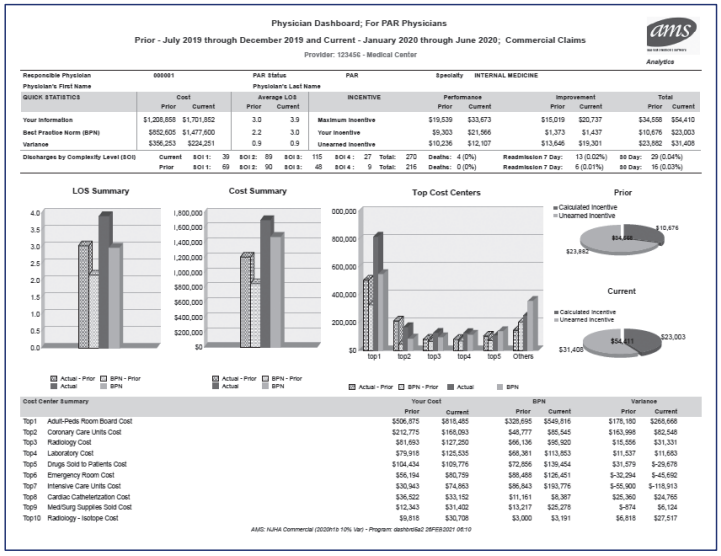
Aligning physicians and hospitals through a gainsharing approach is particularly appealing now as physicians are also facing economic and clinical challenges. Gainsharing addresses operational inconsistencies and complexities. Once costs and clinical standards are established, incentives encourage partners to work together to meet common goals.

To incent physicians to improve their historical financial performance and to reach the BPN, the NJHA Gainsharing Program calculates incentives based on two factors:

1. Performance - actual cost compared to the BPN.
2. Improvement - actual cost compared to each physician's historical costs.

Physician dashboard reports are provided to show each physician their costs, improvement opportunities, calculated incentives, and the incentive opportunity if financial performance improves. (See Figure 8.) But meeting individually with physicians to review results is critical to driving change.

FIGURE 8 - Physician Incentive Dashboard:



The NJHA Gainsharing Program is designed to meet the state legal and regulatory requirements. As such, an oversight or Steering Committee that consists of at least 50% physicians is required. The committee ensures the fair administration of program requirements, prioritizes institutional initiatives, and sets conditions for incentive payment regarding quality and performance issues specific to the institution. The Steering Committee has proven integral to the success of the Gainsharing Program and, given the current environment, should prove to be the perfect forum to discuss, identify and organize the changes needed to go forward.

CONCLUSION

Gainsharing has evolved from a standalone initiative to engage physicians and align hospital and physician incentives, into a program that can be integrated with other initiatives. This widens the focus to the total care provided to patients. The element of success common to any of these initiatives is physician engagement. Financial incentives to physicians provide this key ingredient. Given the uncertainty in the current healthcare environment, leveraging all the tools available will be critical to recovery, reimagination and transformation.

About the Author

Jo Surpin is President of Applied Medical Software, Inc., Collingswood, NJ. She oversees the NJ Gainsharing Program in partnership with NJHA, as well as other Gainsharing Programs offered by state/metropolitan hospital associations in FL, NY, PA and the All-Payer Program in MD. She can be reached at jsurpin@appliedmedicalsoftware.com.

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