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James Reynolds
Daniel Roble

combining pay for performance with gainsharing

Does high-quality, efficient care cost less to deliver?

Recent analyses suggest that it does.

Earlier this year, an analysis by Premier, Inc. showed that hospital costs could have been as much as $1.4 billion lower in 2004 if all pneumonia, heart bypass, heart attack, and hip and knee replacement patients nationally had received 76 percent to 100 percent of a set of widely accepted care processes. The findings were based on the results of Premier's Hospital Quality Incentive Demonstration project with the Centers for Medicare and Medicaid Services.

Several other studies, most notably those by John Wennberg, MD, of Dartmouth, have shown that eliminating medical waste and implementing evidence-based practices of care can reduce consumption of resources and length of stay, cutting cost per case (Wennberg, John E., Fisher, Elliott S., Stukel, Therese A., and Sharp, Sandra M., "Use of Medicare Claims Data to Monitor Provider-Specific Performance Among Patients with Severe Chronic Illness," *Health Affairs*, Oct. 7, 2004).

The CareScience Information System permits its user hospitals to compare their mortality, morbidity, complications, length of stay, and case cost values for each diagnosis-related group, and across all DRGs, with two kinds of benchmarks. The values of these benchmarks, which are severity adjusted to match the characteristics of the user hospital's inpatients, correspond to the average hospital in CareScience's extensive database and to those hospitals in the top 16 percent for both clinical and cost performance. Our comparisons of "average" versus "best practice" performance in our work for clients this year indicate a cost differential of 20 percent to 30 percent for most of the DRGs that are high in frequency for U.S. hospitals.

These findings make intuitive sense, because efforts to redesign a clinical care process to reduce deaths or complications can focus simultaneously on improving the effectiveness and efficiency of care in the hospital setting. Progress toward achieving these benefits has been slow and uneven because the varied interests of key stakeholders—hospitals, physicians, insurance companies, vendors, and regulators—create situations in which positive outcomes for all stakeholders are difficult to come by.

Combining gainsharing with pay for performance offers the potential to deal simultaneously with the nation's healthcare quality, affordability, and profitability issues by better aligning the financial interests of key stakeholders.

Providing Incentives for Clinical Improvements

Recent pay-for-performance demonstration programs are rewarding hospitals for improving processes of care. For example, Premier's demonstration project with the Centers for Medicare and Medicaid Services awarded $8.85 million in incentives to the top-performing hospitals in the project last year. Meanwhile, the Leapfrog Group's Hospital Rewards Program offers participating hospitals the opportunity to receive a portion of accumulated cost savings if they meet specific quality and efficiency criteria. Health plans and employers determine the amount of cost savings that may be distributed to participating hospitals.

But some question exists whether the financial incentives provided to hospitals through pay-for-performance programs are large enough to make a difference. Pay-for-performance programs require major investments in IT, redesign of clinical pathways and operating methods, physician leadership in the hospital setting, and financial rewards for successful results. The major disincentive of pay-for-performance programs for hospitals, as currently structured, is the meager share of cost savings that is expected to be distributed to participating hospitals, given the expense and effort involved in implementing such programs.

Combining pay for performance with clinical gainsharing offers a way to produce win-win-win results for patients, purchasers, and providers. A combined clinical gainsharing and pay-for-performance program would more equitably reward contributions toward enhanced quality of care, increased efficiency, and reduced case costs—and result in higher-quality, more affordable care.

Gainsharing Plus Pay for Performance

Here's how a pay-for-performance clinical gainsharing program could work:

- The hospital and its physicians would identify opportunities to simultaneously improve clinical outcomes, reduce case costs, and share part of the savings with the participating health plan.
- The health plan would also agree to a rate of payment per case that is lower than the current level, but still sufficiently higher than the targeted level for cost per case under the gainsharing agreement in order to increase the hospital's operating margin.
- The hospital and physicians would compare the severity-adjusted clinical outcomes and associated cost per case of targeted DRGs during the baseline year and the program year. Comparisons would be based on independent reporting from an outside, objective web-based retrospective clinical information system that would be linked to the hospital's cost accounting system and monitored by an objective third party.

Involvement of a Medicare or Medicaid healthcare insurer makes available several additional exceptions under the Stark law[a] and safe harbors under the anti-kickback statute[b]; this helps to ensure the arrangement does not implicate the Civil Monetary Penalty Law while allowing for physician incentive plans. Quality sharing programs among a commercial healthcare insurer, a hospital, and physicians that do not involve Medicare or Medicaid beneficiaries do not implicate the anti-kickback statute and the Civil Monetary Penalty Law and can be structured to comply with the Stark law.[c]

This combination could benefit virtually all of the key stakeholders. Patients, insurers, employers, physicians, and hospitals that participate in mutually successful programs would all be better off in terms of health status, affordability, and profitability. Hospital costs could be lowered while reducing deaths, complications, and readmissions.

Case Study: Rady Children's Hospital of San Diego

Rady Children's Hospital-San Diego serves as a case study of a pioneer in clinical performance improvement and, more recently, in reward sharing.

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SIX APPROACHES TO GAINSHARING

Administrative gainsharing. Hospitals pay participating physicians a capped percentage of cost savings derived from creating administrative efficiencies that do not relate to clinical services.

Supply cost gainsharing. Hospitals pay participating physicians a capped percentage of cost savings associated with standardizing, substituting, or using only as-needed supplies and devices for specific kinds of clinical interventions.

Case-based gainsharing. Hospitals pay participating physicians a capped percentage of per-case cost savings plus the recouping of lost income associated with reduced length of stay, fewer diagnostic tests, and generic pharmaceuticals for their patients.

Clinical gainsharing. Hospitals pay participating physicians a capped percentage of a pool of cost savings associated with a specific set of patient problems, but only if they simultaneously improve clinical performance for the same set of problems and do not reduce or limit services.

Protocol-based quality incentive program. Hospitals pay participating physicians on a capped-formula basis to follow evidence-based clinical protocols and achieve associated clinical outcome goals.

Managed care-based quality sharing program. The managed care organization, hospital, and participating physicians share financial risk with respect to agreed-upon clinical quality, patient satisfaction, and efficiency measurements. Various approaches to risk sharing could be agreed upon, including the sharing of per-case cost savings.

a. See the Personal Services Physician Incentive Plan Exception (42 C.F.R. § 411.357(d)[2]), the Risk Sharing Exception (42 C.F.R. § 411.357[n]), and the Exception for Services Furnished by an Organization to Enrollees of Specified Plans (42 C.F.R. § 411.355[c]).

b. See the Eligible Managed Care Organization Safe Harbor (42 C.F.R. § 1001.952[t]) and the Safe Harbor for Certain Financial Arrangements with Qualified Managed Care Plans (42 C.F.R. § 1001.952[u]).

c. See the Fair Market Value Compensation Arrangements Exception (42 C.F.R. § 411.357[l]), the Personal Services Exception (42 C.F.R. § 411.357(d)[2], and the Indirect Compensation Exception (42 C.F.R. § 411.357[p]).

Pay-for-performance demonstrations have been difficult to design because the state Medicaid program pays on per diems, and the insurance companies that serve the area's many small employers all have small market shares and pay on per diems. Nevertheless, Rady Children's Hospital and some other children's hospitals in the state are proposing innovative approaches to improving clinical outcomes and reducing case costs in NICUs if the state's Medicaid program is willing to share the cost savings. Similar approaches are contemplated for hospital-acquired infections as well.

Since 1997, Rady Children's Hospital has achieved phenomenal improvements in clinical quality and financial performance. Over a seven-year period, from 1997 to 2003, Rady Children's Hospital:

> Reduced its mortality and complication rates by more than 30 percent
> Cut its direct variable costs per case by more than 50 percent
> Negotiated better rates with insurers
> Increased its market share by 30+ percentage points to 80 percent

For example, in the area of treatment for children who have asthma, Rady Children's Hospital cut its direct variable cost per discharge in half, from $1,800 to $900. The readmission rate fell from 2 percent to 0.1 percent over five years. And average length of stay in 2003, at 1.6 days, was down from 4.4 days in 1997.

All of these improvements flowed from establishing clinical best practices pathways and convincing physicians to adhere to them. Rady Children's Hospital's clinical leaders have already created more than 60 best practices clinical pathways by documenting clinical interventions and associated outcomes, identifying which interventions produced the best outcomes, and motivating physicians to adhere to them.

Rady Children's Hospital is an example of how hospitals can increase quality and efficiency of care while aligning the interests of key stakeholders.

Although Rady Children's Hospital did not involve a health plan in its initial performance improvement efforts, it is an example of how hospitals can increase quality and efficiency of care while aligning the interests of key stakeholders.

Initially, before the term *gainsharing* had been coined, the hospital found that two benefits of clinical performance improvement were powerful motivators for its physicians. First, clinical and financial results data, which were shared with physicians, clearly demonstrated that patients whose physicians followed the clinical pathways had better clinical out-

GAINSHARING TO IMPROVE CLINICAL OUTCOMES

Gainsharing arrangements try to align the financial incentives of physicians and hospitals to achieve better clinical and financial outcomes by utilizing hospital resources more effectively and efficiently.

In getting started, a hospital and its participating physicians identify opportunities to reduce the case costs of patient care while maintaining or improving clinical results. They then identify required changes in the care process, agree to adhere to them, monitor results, and share in cost savings if clinical performance goals are met.

Gainsharing has undergone tremendous ebbs and flows since this concept was first introduced in the late 1990s. In 1999, the Office of Inspector General warned that gainsharing, particularly as it related to Medicare and Medicaid, violated the Civil Monetary Penalty statute because it could potentially encourage physicians to reduce or limit care for Medicare and Medicaid patients. Hospitals and physicians that benefited financially from gainsharing could face civil penalties of up to $2,000 per patient, the OIG declared in a special advisory bulletin.

The announcement effectively killed gainsharing for two years—until the OIG softened its position when it permitted a limited gainsharing arrangement at one hospital. Last year, the OIG approved six gainsharing arrangements, each of which have safeguards built in to limit the risk of patient or program abuse. And U.S. Rep. Nancy Johnson, R-Conn., chairman of the House Ways and Means Health Subcommittee, proposed six federally funded demonstration projects that would evaluate various methods of gainsharing over the next three years. This proposal was included in the FY06 budget act.

These demonstrations will test whether Medicare should allow hospitals and physicians to share some of the savings that are expected to result from the delivery of less expensive, higher quality care. If the demonstrations prove successful, the Centers for Medicare and Medicaid Services is likely to call for modifications of relevant regulations to make the most desirable form of gainsharing legally permissible.

The Deficit Reduction Act also calls on CMS to put in place a value-based payment methodology for Medicare patients, which recognizes differentials in clinical effectiveness, by 2009. Many industry watchers expect that the results of these demonstrations will help set the framework for revamping payment policies to reward hospitals that deliver lower mortality, complication, and readmission rates to their patients.

comes, used fewer hospital resources, experienced shorter stays, and produced higher margins. As more physicians began to follow the pathways, the pathways were adopted as the default method of care, and the standing order sets reduced the time spent by attending physicians and allowed nurses to execute standing orders without physician interventions. Physicians benefited because of reduced demands on their time.

Second, the rapidly improving reputations of the hospital and its physicians moved market share, and physicians accommodated the incremental rise in service volume to substantially increase their revenue. Although these physicians did not share in the hospital's cost savings as clinical performance efforts got under way, they did benefit from the effectiveness and efficiency improvements in the hospital, which influenced the financial performance of their professional practices. The reductions in physicians' average time requirement for treating hospitalized patients freed up sufficient time for the physicians to treat additional patients and contributed to reducing the unit variable costs of their practices. Furthermore, recognition by purchasers and patients in the marketplace of the physicians' superior clinical effectiveness and efficiency in the hospital setting produced increases in their practices' market share and patient case volume. These changes in turn increased their practice revenue volume and produced higher net revenue margins for all of the patients they treated.

More recently, Rady Children's Hospital has explored ways to share cost savings in the cardiac catheterization lab with its invasive cardiologists and has also begun to pay medical director fees that are directly tied to performance improvements.

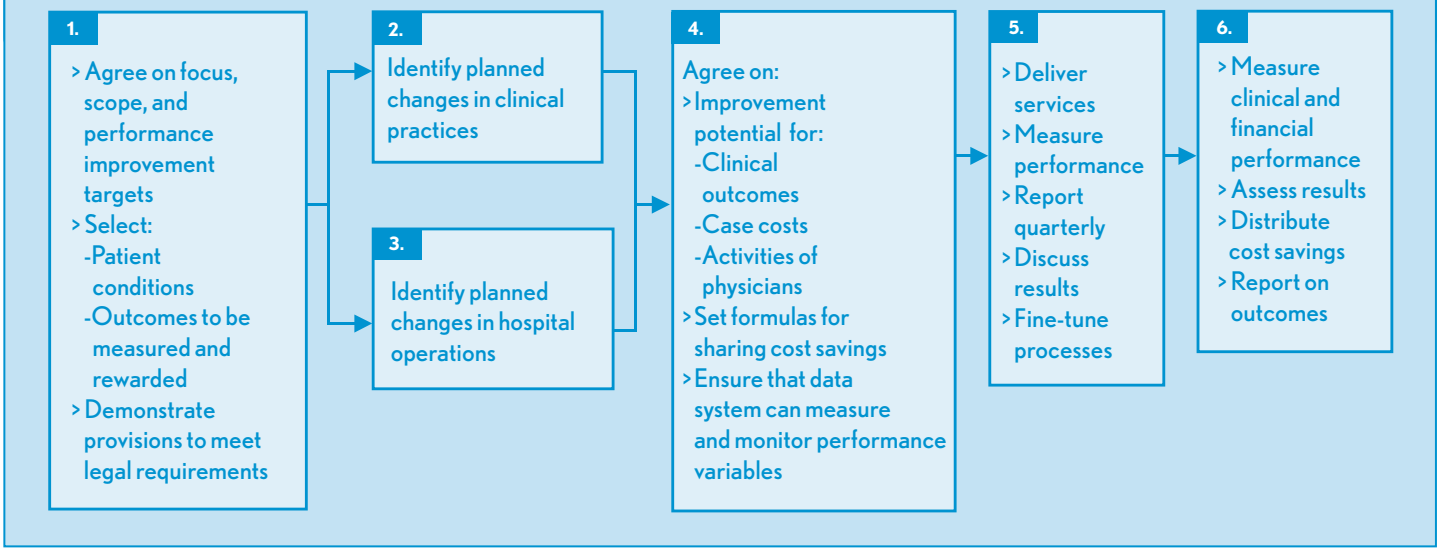
Clinical performance improvement has become part of Rady Children's Hospital's culture, and progress is continuing. Fortunately, the infrastructure required to launch a combined clinical and financial performance program does not require major capital investments. A web-based retrospective clinical information system, used to monitor clinical process and outcome variables and to compare severity-adjusted outcomes among patients and physicians, can be acquired for a modest annual fee. For example, the annual fee for one web-based clinical information system, exclusive of any training fees, might range from $50,000 for a 100-bed hospital to $75,000 for a 300-bed hospital. The other major prerequisite is a fairly inexpensive cost accounting system that can monitor resource consumption, direct costs per case, and net revenue per case by payer contract.

Part of the savings associated with these programs could be used to help pay for developmental investments in IT applications that would eventually lead to real-time clinical decision making—and even greater improvements in clinical and financial performance down the road.

The Most Important Success Factor Is Trust

Ultimately, the most critical factor for the success of a combined clinical gainsharing program is that all of the key stakeholders must be able to trust that their contributions to quality improvement and cost reduction will be equitably rewarded into the foreseeable future. Additionally, a successful program requires hospital leaders, particularly the chief medical officer and CFO, who are willing to take the lead in convincing physicians that they and their patients will benefit from participation.

LAUNCHING A GAINSHARING DEMONSTRATION FOCUSES ON SIX TASKS



What else does it take to effectively implement a clinical gainsharing program? An innovative health plan willing to align the pay-for-performance aspects with the program's cost saving targets—and strong execution to deliver on promised benefits.

The elephant in the room is the potential for significant cost savings. Finding a fair way to distribute the potential cost savings to all of the participating providers and purchasers is probably the most difficult topic for negotiation. ●

James Reynolds is president, Reynolds & Company Management Consultants, New York (jreynolds@jxreynolds.com).

Daniel Roble is a partner, Ropes & Gray, Boston (droble@ropesgray.com).

By establishing clinical best practices pathways and convincing physicians to adhere to them, Rady Children's Hospital has dramatically improved asthma care for children.

TREATMENT OF CHILDREN FOR ASTHMA ADMISSION, RADY CHILDREN'S HOSPITAL—SAN DIEGO