Gainsharing: Pay-for-Coordination in Health Care

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OVERVIEW

- Efficiency-based pay-for-performance
- Coordination problems: physicians and hospitals
- Payment alignment alternatives
  - Gainsharing and the cottage industry
  - Capitation and the integrated delivery system
  - Case rates and service lines
- Principles of pay-for-coordination
First-Generation Pay-for-Performance

A modest bonus linked to quality when the biggest challenges are cost (uninsured, access), laid on top of dysfunctional payment system (fee-for-service), doled out to fragmented physician practices and hospitals (without reference to their linkages), emphasizing primary care (when most serious cost and quality concerns arise in specialty services)

Aside from that, it’s been great
Second-Generation Pay-for-Performance

- Extending focus from quality to include efficiency
- Extending focus on PCPs to include specialists
- Extending focus on payments by insurers to include financial relations within delivery system
  - Tests, procedures, devices, hospital services
- Basic principle: Quality and efficiency happen within the delivery system, not in the insurance system or between insurers and providers
The individual acts of individual physicians and other participants are important, but most important is the coordination (or lack of coordination)

- Primary care, specialty tests and procedures
- Ambulatory surgery centers, hospitals, rehab, subacute
- Drugs, implants, radiology, surgical robots
- Post-acute rehab, SNF, home health, PT, wellness
Key Coordination Challenges between Physicians and Hospitals

- **Choice of facility (hospital, ASC, specialty facility)**
  - Physicians choose facility, capacity utilization

- **Choice of drug and device**
  - Physicians/surgeons chose costly clinical inputs

- **Process analysis and redesign**
  - Physicians must be involved in clinical process re-design
Policy Concerns Lead to Regulatory Restrictions

- Unnecessary tests? Ban self-referral.
- Cherry picking? Ban specialty hospitals.
- Conflicts of interest? Ban interests.

- Whatever is not prohibited is mandatory.
Rethinking Payment Options to Promote Coordination

1. Gainsharing within fee-for-service
2. Capitation and physician organization
3. Case rates (beyond DRGs)
1. **Gainsharing: The Ban**

- Medicare bans “gainsharing” programs in which hospitals financially reward physicians for participating in initiatives that reduce hospital costs
  - Concern over incentives for under-treatment
- There is no commensurate ban on financial rewards to physicians for participating in initiatives that increase costs
  - Drug, device, vendor consulting, CME, etc. etc. etc.
Gainsharing: The “Goodroe” Exemption

- Recent exemption from ban for gainsharing programs that fit stringent Goodroe model
  - Savings must be quantified, limited
  - Quality must be measured, assured
  - Most gainsharing will be only for one or two years

- Designed to fit with prevailing fragmented system
  - Fee-for-service for MD; DRG for hospital
  - No ownership linkage between MD and facility
Goodroe model deserves respect for navigating the regulatory ban; favoring MD/hospital coordination

Under continual attack from device manufacturers

Raises MD expectations but is very limited

Hard to generate enough dollars for MDs, relative to huge consulting fees (devices) and returns on investments in ASC

With all due respect, let’s keep thinking
2. Capitation

- Capitation payment to IPA or IDS provides budget (PMPM payment) and incentive for efficiency
- IDS: Hospital and medical group share capitation
  - Individual MDs usually paid via salary
- IPA: Medical group capitated for physician services, share savings from hospital “risk pool”
  - Individual MDs paid FFS or sub-capitation
Capitation: Strengths

- Capitation provides broad efficiency incentive, not limited to narrow (gainsharing) model
- Physicians have incentive to seek least costly site of care (facility), inputs (devices), etc.
- Physicians share hospital savings from physician initiatives (usually 50%) without limit on duration
- Capitation has worked well with some major physician organizations (especially in California)
Capitation: Limitations

- Capitation places high demands on physician organizations for financial management and culture of cooperation among MDs and with hospitals
  - Many not up to the test; frequent IPA bankruptcy
- IPAs negotiate higher base rate with insurers and leave less in “risk pool” as incentive
- IDS act as conglomerate, with internal conflicts and lack of transparency among units
Capitation: More Limitations

- Premise of capitation is that patient receives (almost) all care from limited panel of providers
- This assumption is valid if and only if this limited panel is very cost effective and accessible
  - Otherwise consumers demand broad choice of providers
  - Why have limits on choice if there is no reward?
- Weakness of IPA/IDS has contributed to weakening of HMO networks and capitation
3. Case Rates

- Payment for episode of care, bundling payment to physician (surgeon), inputs (devices), and facility
- Compare to DRG:
  - Includes rather than excludes physician fees
  - Can extend to ambulatory and not merely hospital care
- Most easily constructed for costly acute episodes
  - Invasive cardiology, ortho/neuro/cardiac surgery
Case Rates: Strengths

- Case rates do not seek to bundle care for all forms of care (population health), which shifts too much risk and places excessive demands on providers.
- They follow the clinical logic (at least for acute conditions) of episodes of care.
- They bundle together all the components of care, creating single point of accountability for efficiency.
- Support quality measurement at the episode level.
Experience with DRGs has been difficult
- Payments for particular categories responds sluggishly to changes in the underlying costs of care, especially new technology (cost increasing or decreasing)

Payments favor surgical and device-intensive care over chronic and medical conditions
- Major incentive for specialty hospitals and ASC
  - Cardiology, orthopedics, general surgery
Case Rates: More Limitations

Who will be paid the case rate?
- Easiest is when MD and facilities are in unified organization, but this is where it’s least needed
- If hospital paid the case rate, it controls physician fees
  - History of physician resistance to hospital control
- If surgeon paid case rate, must bear risk and management responsibility to allocate to facility, other MDs, device purchases
Hospitals are organizing internally by service line to accommodate consumer choice, comparative performance measurement, case rates.

Case rate payment to hospital (extending DRG to cover physician fees) supports coordination.

But hospital is less and less the clinical and organizational center of medicine.

Nonprofit hospitals have conflicted incentives.
Physician entrepreneurs are creating specialty groups, investing in ASC and specialty hospitals. Many observers are critical. But case rate payment shifts responsibility for efficiency to these entities (service line capitation). If coupled with episode-based quality measurement, could support informed consumer choice and provider coordination.
Conclusions

- P4P needs to move beyond primary care, quality, and FFS to engage specialists, efficiency, and alternative forms of payment
  - This is where the dollars and the quality problems lie
- It is important to balance incentives for over-treatment and under-treatment
- It is important to think broadly about options
Concerns for physician conflicts of interest are well-intentioned but can be counter-productive.

- Gainsharing, Stark, specialty facilities

Principle of P4P is that physicians should face financial incentives for performance.

- Quality and efficiency
- Choice of device and site of care
- Analysis and redesign of services lines, course of care

Incentives versus Conflicts-of-Interest
The Alternative to Provider Incentives

- If physicians are disengaged from cost and efficiency concerns, those legitimate social concerns will be implemented by others
  - Ever-stronger consumer cost sharing?
  - More intrusive insurer administrative controls?
  - More and more litigation?
  - More and more regulation?
Hobbes on Uncoordinated Care

- “Whatsoever therefore is consequent to a time of war, where every man is enemy to every man; without other security, than what their own strength, and their own invention shall furnish them withall…And the life of man solitary, poor, nasty, brutish, and short.”

- Leviathan (1651)
Extend the focus of payment incentives
- From quality to include efficiency
- From primary care to include specialists
- From individual performance to cooperation with others

Extend the range of payment experiments
- Fee-for-service and gainsharing
- Capitation for renovated IPA and IDS
- Case rates with service line organization