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

It’s the System that Matters

- 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

- Under-treatment? Ban gainsharing.
- 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

Gainsharing: Limitations

- 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

Case Rates: Limitations

- 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

Case Rates and Service Lines: Hospital as Locus of Coordination

- 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

Case Rates and Service Lines: Physician Entrepreneurs as Locus

- 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

Incentives versus Conflicts-of-Interest

- 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

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)

Pay-for-Coordination

- 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