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## Gainsharing Can Reduce Hospital Costs While Improving Quality of Care

With increasing pressure on hospitals to manage effectively with less revenue, finding ways to reduce costs while improving the quality of care is a constant challenge. Physician engagement is essential to a hospital's success in this endeavor and most related initiatives have fallen short of truly aligning the goals of all involved. Since physicians directly control more than 80% of total medical costs, finding the right incentives to gain their active participation is key. The current fee-for-service system encourages higher utilization of resources, and not necessarily appropriate or optimal utilization. Therefore, hospitals must take steps to counter the consequence of this reimbursement structure and influence physicians to practice more efficiently. In addition, standardization toward 'best practice' in terms of cost and quality for each diagnosis must also be a goal, not just for hospital administrators but for the physicians managing the day to day care.

While several pay-for-performance programs with these objectives have been attempted around the country, gainsharing has demonstrated real and significant results. Programs focusing on the highest cost of care – the hospital inpatient unit – have proven capable of engaging physicians and reducing costs in short timeframes. By sharing the dollars it saves through enhanced collaboration and behavior changes in patient management, hospitals actually reward physicians rather than simply acknowledge their participation in these efforts and give physicians a financial stake in achieving greater efficiencies and improved quality.

Over a dozen hospitals in New York City and New Jersey have been operating a gainsharing program for several years that demonstrates these achievements. The program compensates physicians who reduce costs as well as improve the quality of service and patient safety on inpatient units. The hospitals in New York City include large urban teaching hospitals in Manhattan as well as a small non-teaching community hospital in Brooklyn. When the program began in New York, it was the largest comprehensive gainsharing model to have been implemented at hospitals that included a broad mix of medical and surgical cases, managed by hundreds of physicians of varying specialties.

Physicians were asked to participate in the 'pay for performance' gainsharing program voluntarily without any downside risk or penalties from participation. Benchmarks were established for both cost and quality, and physicians were rewarded financially for moving toward and/or hitting the benchmarks. The cost benchmarks were set at the 25th percentile (lowest cost) by severity adjusted APR-DRG, based on actual experience of physicians within the



hospital system. The data was transparent and reliable. Incentive payments would be made based on individual performance and both improvement in cost per case against a physician's own historical performance and cost per case compared to the benchmark for each APR DRG. The severity adjustment of each case, and the ability to compare the more complicated cases within a DRG to other similar complicated cases, gave physicians the reassurance that their performance was being fairly evaluated.

As documented in a study described in the *Journal of Hospital Medicine*<sup>1</sup> one of the tertiary hospitals in New York City, Beth Israel Medical Center, reduced its costs for inpatient commercial/managed care discharges included in the program (29,535) by \$25.1 million over 3 years. Cost reductions were found in various cost centers including medical/surgical supplies and implants (35%), daily hospital costs reflective of lower length of stay (28%), intensive care unit costs (16%) and coronary care unit costs (15%), and operating room costs (8%). The average cost reduction per admission for the participating physicians was \$1,835. Annual payouts to participating physicians ranged from \$0-\$27,631, and represented 9.4% of the achieved hospital savings.

One important component of the incentive payment for physicians who admitted medical versus surgical cases, was the incorporation of sufficient dollars to offset the loss of income related to a reduced hospital length of stay (LOS). As the physicians more effectively managed the patient's stay in the hospital over fewer days, the physician had no reason to be concerned about a reduction in his or her collections for the eliminated days, as the incentive payment compensated them for missing days previously billed to the third party payor. The result was positive for the physician, as well as the hospital and payor, which both saw costs decrease. Some physician behavior changes that contributed to the lower LOS were earlier and more frequent rounding on the patients, earlier consultation with discharge planning, and shorter time between request for a specialty consult and the occurrence of the consult.

As for quality, there was no diminution identified. In fact, improvements were noted in several areas. Compliance with core measures improved in several areas and the number of incomplete medical records decreased significantly. Since incentive payments were conditioned upon hitting quality metrics established before the program began, physicians who failed to meet the targets did not receive checks. Some or all of the gainsharing income was withheld from 8% of participating physicians due to various quality issues, incomplete medical records, or administrative reasons. Hospitals have the

ability to adjust the quality goals to compliment and support initiatives



<sup>1</sup>Leitman IM, Levin R, Lipp MJ, Sivaprasad L, Karalakulasingam CJ, Bernard DS, Friedmann P, Shulkin DJ. *J Hosp Med.* 2010 Nov-Dec;5(9):501-7. doi: 10.1002/jhm.788. Epub 2010 Aug 17.

underway at the hospital, some specific to clinical departments, others hospital-wide.

Over the past few years, these gainsharing programs have motivated many physicians to practice more efficiently while maintaining/improving the quality of medical care. Gainsharing aligns physician and hospital incentives and rewards physicians through positive reinforcement, which is more effective than issuing warnings or financial penalties to underperforming physicians. Through the development and operationalization of the program, the hospitals learned what data was most beneficial and empowering to physicians and generated reports that allowed the physicians to focus their behavior modification efforts most productively. Hospitals also realized a new level of engagement among its physicians, with greater participation in the planning and implementation of process improvements, as well as negotiations with vendors for implants and equipment. Reductions in practice variation were visible, as were improvements in documentation.

Using financial incentives to have a favorable impact on physician behavior is not new. Unlike many withhold or vague quality bonus programs, the inpatient focused gainsharing programs with well-defined goals and rewards, demonstrate that physicians are willing and able to help hospitals reduce hospital costs while maintaining or improving quality. Gainsharing has been recognized as an effective tool for use in various physician-hospital collaboration efforts aimed at improving efficiency, quality and patient outcomes. But, programs with complicated and long term monitoring processes, unreliable data, and mysterious incentive payment calculations will fail. This gainsharing program is easily implemented with standard hospital billing data, predetermined local benchmarks and reasonable bonus payments, and can be replicated at small community hospitals and large academic medical centers alike, achieving similar results. It is programs such as this that align incentives that ultimately bend the cost curve, improve quality and benefit hospitals, physicians, patients and payors long term.

#### About the Author

Ruth Levin, Managing Partner at Managed Care Revenue Consulting Group, LLC, worked as Senior Vice President at Continuum Health Partners and Beth Israel Medical Center for 22 years. She implemented the gainsharing program at Beth Israel Medical Center described in this article and led program operations for approximately 4 years.

#### For More Information

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