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Gainsharing Strategies, Physician Champions, Getting Physician Buy In

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ABSTRACT

As healthcare spending continues to outpace economic growth, legislators and healthcare economists have explored many processes aimed at improving efficiency and reducing waste. Gainsharing or the general concept that organizations and their employees can work together to continually improve outcomes at reduced expenditures in exchange for a portion of the savings has been shown to be effective within the healthcare system. Although gainsharing principles may be applicable to healthcare organizations and their physician partners, specific parameters should be followed when implementing these arrangements. This article will discuss 10 gainsharing strategies aimed at properly aligning healthcare organizations and physicians, which if followed will ensure the successful implementation of gainsharing initiatives.

Within the last decade, significant changes have been made to the US healthcare system in an effort to promote value-based care initiatives. These changes are largely representative of the shift from traditional fee-for-service models to the pay-for-performance (PFP) systems. Starting in 2009, the Centers for Medicare and Medicaid Services (CMS) began sanctioning alternative payment models, such as the Acute Care Episode Demonstration Project (ACE-DP), the Bundled Payment for Care Initiative (BPCI), and the Comprehensive Care for Joint Replacement (CJR), effectively ushering in a new era of healthcare policy aimed at enhancing the quality of care, reducing cost, while also permitting risk-reward arrangements among healthcare organizations and physicians [1]. Many of these innovative alternative payment models have successfully implemented value-based practices; however, maintaining stakeholder involvement has proven challenging. Yet, as we transition to a PFP healthcare economy, it has become crucial for healthcare organizations and physicians to align their interests through well-defined gainsharing strategies.

This article will define gainsharing strategies within the current healthcare system. We will also delve into gainsharing's tumultuous past and how it has helped define its current role. Additionally, the authors will highlight 10 approaches on how best to successfully implement gainsharing strategies within an orthopedic practice.

What Is It Gainsharing?

Gainsharing is an institution-wide program designed to improve productivity, enhance quality, and reduce cost. The benefits or savings realized by the organization are then shared with the physicians who developed and implemented the respective strategies [2]. Gainsharing within healthcare accepts and depends on the principle that physicians are uniquely qualified to improve quality and efficiency within the healthcare organization [3]. Moreover, gainsharing is designed to target numerous areas of small inefficiencies collectively resulting in substantial savings.

Physicians may be involved in gainsharing initiatives through the development and implementation of innovative treatment strategies [4] (ie, integrated care pathways or total joint arthroplasty service lines) or purchasing agreements aimed at reducing a healthcare organization's fixed pharmacologic and device costs. If successful, these initiatives may directly lead to improved efficiency and cost reduction. Indirect benefits may include shorter lengths of stay, reduced readmissions, and more satisfied patients. If quality metrics and savings are met physicians may be compensated for their contributions through several models. Physicians may receive a predetermined percentage of the savings, or flat rate for their participation. Indirect reimbursement may be

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Table 1
OIG Permits Gainsharing Initiatives if the Following Provisions are Adhered.

Provision	Description
1. Financial incentives limited to duration and amount	▪ Each proposal is limited to actual cost savings annually compared to the previous year (baseline) ▪ Aggregate physician gainsharing payments limited to a maximum of 50% of current CMS physician payment
2. Specific cost saving identified	▪ Each proposal clearly and separately identifies specific cost saving measures resulting in savings
3. No adverse effect on patient care	▪ Credible evidence demonstrating that the cost-saving measures do not adversely affect patient care
4. Applies to all payers	▪ Gainsharing payments are not limited to procedures reimbursed by Medicare, but instead all applicable categories of a procedure are included regardless of payer
5. Baseline thresholds set	▪ Protection against inappropriate reductions in services through the use of objective historical and clinical data establishing baseline thresholds - For example, if the volume of Medicare procedures in the current year changed significantly from the baseline year, this may trigger an audit and possible forfeiture of savings
6. No limit on product choice	▪ Although product standardization is encouraged, physicians must make decisions based on the patient's needs
7. Disclosure to patients	▪ Hospital and the physician groups should provide written patient disclosures describing the arrangement
8. No inappropriate "steering"	▪ A hospital committee should monitor baseline patient characteristics, case severity, and payers to ensure that participating physicians are not steering patients to certain hospitals ▪ Physicians knowingly adjusting their case mix may be terminated from gainsharing arrangements
9. No shifting of cost savings	▪ Preclude shifting of cost savings ▪ Assure that the savings generated by utilization beyond a set target cannot be inappropriately credited to physicians

provided in the form of additional clinical or laboratory space and increased research support. Although there is no formal definition for gainsharing, it is recognized that gainsharing initiatives are fiscal programs aimed at enhancing patient care while reducing resource expenditures [3].

Gainsharing—A Brief History

Gainsharing traces its roots back to the 1930s when Joe Scanlon, a labor leader and activist, designed the Scanlon Plan, an agreement which shares cost savings at several failing steel foundries with their employees [5]. It was not until 1988 that the Health Care Financing Administration (HCFA), now referred to as CMS, solicited bids from hospitals and their physicians to participate in the Medicare Participating Heart Bypass Center Demonstration [6]. The initiative was a pilot project assessing the financial feasibility of bundle payments and gainsharing principles within the American healthcare system. The HCFA concluded that through innovative payment arrangements between healthcare organizations and cardiac surgeons, cost savings and improved postoperative outcomes may be realized [6]. Later, in 1996, HCFA explored a similar demonstration project aimed at aligning the economic interests of orthopedic surgeons with healthcare organizations by again implementing bundle payments and gainsharing principles [7]. However, the program was never applied due to budgetary shortfalls and widespread opposition.

In 1999, the US Department of Health and Human Services Office of Inspector General (OIG) issued an advisory bulletin [8] stating that hospital-physician gainsharing in most forms was illegal under the Civil Monetary Penalties provisions of the Social Security Act [9]. Specifically, the OIG was concerned that surgeons would "steer" healthy or unhealthy patients to specific hospitals with the intent of developing an unfair financial advantage. However, in 2001 [10] and again in 2005 [11], the OIG ruled that gainsharing programs with certain design features and safeguards (Table 1) would not face federal sanctions. The OIG's recommendation was effectively retracted in March 2005 when the Medicare Payment Advisory Commission recommended that gainsharing should be permitted [9,12].

Although CMS elicited proposals for demonstration projects examining gainsharing principles, it was not until the passage of the Patient Protection and Affordable Care Act of 2010 that specific provisions were made available for gainsharing and bundled payment initiatives. Since then the BPCI and CJR programs have been the impetus for both gainsharing and bundle payment initiatives. Due to the success of these programs, starting in July 2017, bundle payments will be applied to hip fracture management [13]. Figure 1 illustrates the progression of events leading to the current gainsharing strategies within healthcare.

Why Gainsharing, Why Now?

The early demonstration projects of the late 1980s and early 1990s revealed the potential benefits of reimbursement arrangements closely aligning healthcare organizations and physicians. However, a myriad of structural and budgetary issues ultimately resulted in their abandonment. It took nearly 2 decades to re-

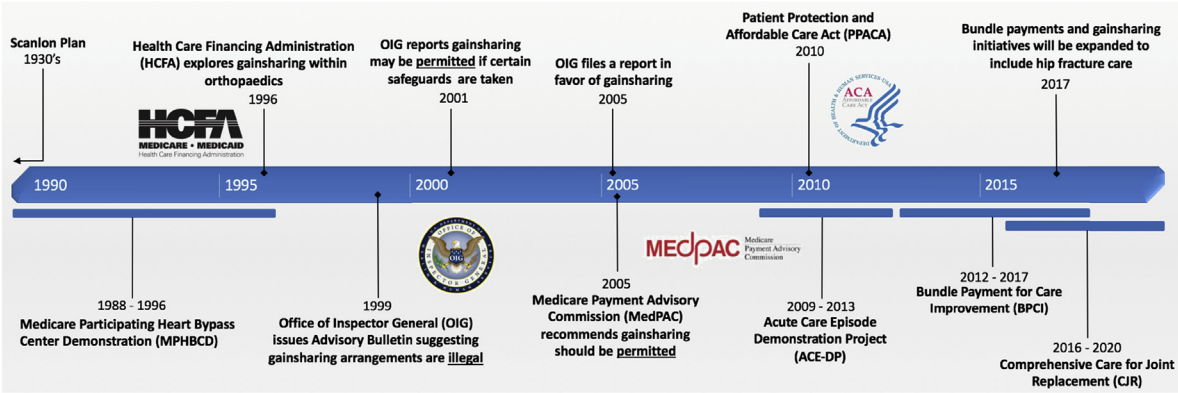

Fig. 1. History of gainsharing arrangements.