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# Healthcare Cost Containment

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## How a Hospital Quality and Efficiency Program Can Jumpstart Your CIN or ACO

By Dennis Butts Jr. and Vivek Gursahaney

*A hospital quality and efficiency program can help align physician performance to system goals and optimize cost-containment opportunities.*

Despite the rapid development of clinically integrated networks (CINs) and accountable care organizations (ACOs) over the past five years, many have failed to secure sufficient covered lives or generate meaningful improvements in care delivery transformation. Though many barriers have inhibited fledgling networks, two key challenges are lack of payer receptivity to create mutually beneficial, value-based contracts and insufficient physician engagement resulting from the absence of meaningful program initiatives and poorly designed incentive distribution models. A hospital quality and efficiency program can serve as an effective strategy for addressing these challenges while maximizing cost-containment opportunities in the short term.

### A Tool for Alignment

A hospital quality and efficiency program is a contractual agreement between a health system and a CIN or ACO to achieve quality improvements and cost reductions within the inpatient setting, self-insured employee population, or both. These initiatives typically fall under the following categories:

- Quality and safety outcomes (such as reduction in readmissions and hospital-acquired events)
- Resource utilization (such as reduction in implant or supply unit pricing)
- Operations (such as enhanced rounding and discharge planning processes)
- Employee population management (such as improved per member per month [PMPM] spend, avoidable utilization, and generic prescription rates)

### Governance and Operations

To optimize this partnership, a hospital quality and efficiency program should be jointly governed to ensure that it meets the objectives of both parties. Typically, a governance board is established to oversee the program and approve new initiatives. Beneath the governance level, a strong operating model should be in place to achieve the initiatives and provide timely and actionable data to the CIN or ACO. This model also will ensure that committees have been chartered with representation from the CIN or ACO, service line management, and care teams to deliver on the intended goals of the program.

Without this structure in place, finance leaders will have difficulty achieving the financial objectives of the program.

### Compensation Structure

To ensure that the hospital quality and efficiency program's compensation model meets regulatory standards, total compensation to the CIN or ACO should fall within fair market value (FMV) and commercially reasonable guidelines. There are three primary compensation models that can be built into the program's structure.

- *Gainsharing approach*: The CIN or ACO retains a fixed percentage of all generated savings from cost reduction efforts while maintaining the baseline level of quality. At least 50 percent of the savings should be retained by the health system to be consistent with national standards.
- *Metric approach*: The CIN or ACO is paid a specific amount for achieving predefined levels of performance (such as mortality rates and patient satisfaction), allowing for the inclusion of initiatives with non-financial benefits.
- *PMPM approach*: For hospital quality and efficiency programs over self-insured employee populations, the CIN or ACO is paid a fixed PMPM fee for managing outcomes and providing care coordination.

Regardless of the approach selected, the following advice can help finance leaders optimize the agreement's potential and ensure that the agreement achieves the key tenants of the Triple Aim (improved health and patient experience, and reduced costs).

*A large portion of the agreement should fall under a variable compensation structure.* Typically, 70 to 90 percent of the total compensation is at risk in a hospital quality and efficiency program. The contract should specify predefined initiatives with minimum and maximum performance and payment thresholds. This will allow the health system to reward actual, generated value rather than solely the activity of physicians.

*The agreement should include initiatives designed to increase quality, improve outcomes, and decrease waste.* Finance leaders should select opportunities based on historical data and national standards. Initiatives should be weighted based on the potential cost, quality, and efficiency opportunity vis-à-vis other initiatives. For example, implant pricing and other utilization opportunities often drive a large portion of the cost savings and should have a higher compensation potential versus smaller opportunities.

*A quality gate should be established to ensure the ACO or CIN only receives distributions from cost reduction if quality is maintained or improved.* Quality gate metrics should be consistent with national guidelines and programs (such as the Centers for Medicare & Medicaid Services' Value-Based Purchasing Program) and applicable to the selected initiatives.

*Initiatives should be reviewed each year.* This will ensure that the contract rewards continuous improvements in areas that provide meaningful value to patient care. The health system also should regularly monitor acuity, payer mix, referrals, and outcomes to verify that the hospital quality and efficiency program does not cause care rationing, cherry-picking of healthy patients, referral pattern changes, or premature discharges. This monitoring is often conducted by an independent, third party or by implementing a review process within the health system.

### Distribution Methodology

Once the total eligible compensation has been established, the ACO or CIN must develop a distribution methodology that can incentivize individual performance and care team collaboration while still sustaining the network's operations. The following lessons learned can

## Types of Hospital Quality and Efficiency Initiatives

| Initiative | Description |
|---|---|
| Readmissions | Reduce hospital's readmissions rate in key conditions (CHF, COPD) and frequent user patients. |
| Mortalities and Sepsis | Improve mortality observed-to-expected (O/E) scores and overall sepsis performance through increased bundle compliance. |
| Public Reporting Scores | Improve publicly reported scores (VBP, HAC) across quality, guidelines, and satisfaction. |
| Length of Stay | Establish effective rounding and decision making with care team to reduce delays in testing, treatment, and discharge. |
| Resource Utilization | Reduce internal medicine and family medicine CMI-adjusted cost per case to hospitalist levels. |
| Radiology Utilization | Elminate advanced imaging (MRI, CT, nuclear) ordered on last two days of inpatient stay. |

*Source:* Navigant.

Initiatives that drive quality and efficiency can take a variety of formats; however, they typically include the following categories: quality and safety outcomes, resource utilization, operations, and employee population management.

benefit organizations looking to create such a model.

*There is not a perfect distribution model.* Organizations should attempt to create a fair model that appropriately incentivizes individuals and groups across specialties. Building and communicating a transparent model to all providers is more critical than trying to solve for perfection.

*By structuring the contract between the health system and a Medicare Shared Savings Program (MSSP) participant, finance leaders can take advantage of ACO waivers to create additional regulatory protections.* The waivers provide more flexibility, allowing for direct incentives to individual providers for cost reduction. These direct incentives are not typically available within traditional hospital and physician alignment vehicles (such as co-management agreements).

*The distribution methodology for all initiatives should include separate pools of compensation, each of which has a select group of eligible physicians.* The organizations can create global pools to recognize the collaboration required by all members of the care team to drive results. However, physicians who directly influence quality, cost, and efficiency improvements in that specific area should retain the majority of funds. A value adjustment pool can be incorporated to reflect the potential negative impact of reduced utilization on certain specialties.

*The distribution methodology should comply with Stark, Anti-Kickback, and Civil Monetary Penalty statutes.* Differences in compensation can exist between providers, but the difference should not reflect the volume or value of referrals. Capping compensation to individual physicians is a useful way to prevent cost-reduction incentives from restricting necessary care.

*A portion of the compensation potential from each initiative should be carved out for program reinvestment.* This helps the CIN or ACO become more financially sustainable and reduces the level of subsidy that it may receive from its hospital partner. This also helps the network invest in the IT systems and personnel (such as data analysts and care managers) needed to truly manage the population.

## The Starting Line for Alignment

In as few as one to two years, a hospital quality and efficiency program can deliver significant results, including:

- Alignment between the CIN or ACO and health system to improve quality, safety, efficiency, and patient experience, including in publicly reported outcomes
- Increased physician engagement by enabling clinicians to receive rewards for driving meaningful performance improvement
- An ongoing funding mechanism to support the CIN's or ACO's infrastructure and operating costs
- A proven test case for use by the ACO or CIN in its discussions with payers and employers to secure new value-based contracts

As providers consider innovative structures to achieve the Triple Aim and migrate from a healthcare market that rewards the quantity of service to one that rewards value, the implementation of a hospital quality and efficiency program could be one thoughtful place to begin.

Dennis Butts, Jr. is a director in Navigant's strategic healthcare transformation practice, Chicago (dennis.butts@navigant.com).

Vivek Gursahaney is a managing consultant in Navigant's strategic healthcare transformation practice, Chicago (vivek.gursahaney@navigant.com).