applied | medical | software

White Paper to Maryland Health Services Cost Review Commission -

Gainsharing: Aligning Provider Incentives

Submitted by Applied Medical Software, Inc.

January 9, 2014

Executive Summary

This white paper focuses on "gainsharing", the direct payment of incentives by hospitals to physicians, based on performance. Legal, policy and operational issues are analyzed in the context of experience gained through the implementation of the Applied Medical Software Performance Based Incentive System® (AMS PBIS®) in successive Medicare projects and commercial patient population projects. To the best of our knowledge, the AMS PBIS® is the only broad based, comprehensive gainsharing methodology approved by Medicare to date. The objectives of the new population based approach set forth in the proposed Maryland waiver cannot be achieved without the active collaboration of Maryland's physician community. Based on our experience, we believe that gainsharing can provide the critical link between HSCRC's hospital-based authority and the physicians. Of course, gainsharing is only part of the puzzle; it provides the incentive framework through which to link both regulatory and waiver objectives, and connects these policies directly to operational initiatives. We discuss how the methodology can enable the Commission's new initiative to get off to a quick start, establish credibility within the physician community, energize internal hospital programs aimed at quality and efficiency, generate significant savings, and to link directly with other methodologies that may be required to support the Commission's expanded mandate.

We also discuss the organizational structure used in the NJ Model 1 Gainsharing Program approved by CMS. Central to the program is the role of "facilitator/convener". The role involves organizing the participants, administering the program (including application of the gainsharing methodology), and liaison with CMS. We understand that Maryland has submitted its waiver application under a separate provision, but the facilitator/convener role has proven particularly valuable to both CMS and to the participants in assuring the smooth implementation, operation and administration of a large scale gainsharing program. Such programs involve many moving parts including periodic data processing, an extensive reporting requirement to CMS and its various contractors, and direct engagement with the participating providers to insure effective implementation and to maximize the opportunity for success. The HSCRC may want to consider assuming this role, sharing responsibilities, or delegating it to a separate party such as the Maryland Hospital Association (MHA). As we discuss below, in New Jersey the hospital association acts as facilitator/convener, sharing program responsibilities by delegating most of the technical tasks to AMS. AMS will be pleased to participate in any way as directed by the Commission.

595 Haddon Avenue
Collingswood, NJ 08108
phone: 856.858.3822
fax: 856.858.3801
www.appliedmedicalsoftware.com

Introduction

Applied Medical Software (AMS) is pleased to respond to the request by the Maryland Health Services Cost Review Commission (HSCRC) for a white paper discussing physician alignment strategies in the context of all-payer rate-setting: specifically, the implementation of "gainsharing" within the framework of the Maryland waiver proposed and, it is our understanding, recently approved by CMS. Gainsharing here is defined as the direct payment of incentives by hospitals to physicians, based on performance. This paper discusses the Applied Medical Software Performance Based Incentive System® (AMS PBIS®), a large scale, comprehensive (all DRGs, all inpatient costs) gainsharing methodology. The AMS PBIS® has received 3 approvals from Medicare. Currently operational at approximately 40 hospitals in New Jersey and New York, it has been in continuous use at certain institutions since 2006. It currently is applied to both commercial (NY) and Medicare (NJ) inpatients.

The AMS principals were architects of the New Jersey Prospective Reimbursement System for Acute Care Hospitals Based on Patient Case-Mix (i.e. DRGs). Though no longer operational, the New Jersey model was an all-payer system, like Maryland. We recognize that State systems are unique and contain significant assets and strengths, including the opportunity to customize. For example, Maryland already utilizes severity adjusted All Patient Refined Diagnosis Related Groups (APR DRGs) and uses uniform charges rather than traditional cost finding methodologies. Discussed below, these features are part of the framework required to address *Stark* related issues. But they also help expand the opportunities to directly link gainsharing to quality. On the other hand, our New Jersey experience has made us well aware of the extra issues associated with federal waivers. Once these requirements are fully understood, gainsharing strategies can be customized within the all-payer framework to help the state meet the waiver tests.

We have reviewed the Maryland draft waiver application. We believe that gainsharing can effectively complement and support the Commission's forward-looking objectives under the new payment system. We note that under the new waiver the Commission's focus would shift from a per-admission evaluation to a global model – e.g., Total Patient Revenue and Global Budget Revenue. We also note that the Commission's authority is facility-based: Provider behavior, including physician behavior, can be influenced directly through revenue-based rewards or penalties at the institution level. Gainsharing can provide the crucial catalyst: It can help establish a bridge - a direct connection between the Commission's controls over a hospital's revenue and that institution's relationship to its physicians.

The AMS PBIS® methodology interfaces with other gainsharing methodologies developed for use in outpatient and non-hospital settings. Its features enable gainsharing to support the full universe of care encompassed by the new waiver, including the emphasis on population health.

Funding Gainsharing

Under the different variations of population based reimbursement, a hospital keeps the revenues associated with improved performance. This framework preserves the basic incentive structure that enables gainsharing to generate savings. The AMS PBIS® was designed to align the incentives of physicians and hospitals related to inpatient performance. Savings from improvements to inpatient performance can be used to complement and augment the revenue controls that the Commission is authorized to use. As part of the "interface" discussion, we will comment on features of the AMS PBIS® that can support payment incentives for Quality Based Reimbursement and enable the integration of new

Funding Gainsharing (Continued)

methodologies that could expand gainsharing beyond the inpatient setting. These discussions include the issues of Potentially Avoidable Volume and Attribution.

Performance Based Incentives

The AMS PBIS® has two components: a methodology for evaluating physician performance coupled with a system of incentives. (The details of these components are contained in the Physician Handbook for the NJ Medicare Model 1 Bundled Payments for Care Improvement Initiative under the Affordable Care Act, attached hereto.) This white paper discusses the evolution of these components over two decades - 5 years of initial development, followed by 10 years of operation. It shows how individual components reflect the responses to issues raised by 3 parties: the physicians, the hospitals and the regulators. The observations include important legal and policy considerations – preserving patient safety and promoting quality of care – as well as practical considerations – facilitating ease of implementation by minimizing barriers to provider participation.

As a starting point it may be helpful to keep in mind that the AMS PBIS® is a program, not a structure. A structure, like an ACO or Maryland's Health Enterprise Zones (HEZ), is a formal legal construct that is charged with meeting a set of goals – in the case of an ACO or HEZ, the healthcare goals of a defined population. AMS PBIS® is a program: It involves a set of rules designed to meet a specific objective, promoting physician inpatient performance related to cost and quality through financial incentives – the "Intel Inside" that enables a structure to meet its goals. The AMS PBIS® can be implemented on a stand-alone basis as a gainsharing program, or used as the inpatient gainsharing component within a suitable structure, such as an ACO.

A similar analogy applies to payment structures such as bundling: The AMS PBIS® does not involve the bundling of payments. In fact, the program was designed to avoid the barriers and pitfalls that often accompany bundled payment schemes: e.g., the need to implement and join formal structures, reassignment of payment rights, negotiating the distribution of a fixed pot of money between the hospital and diverse groups of physicians (reassignment that may or may not be based on performance), and so forth. Like its relationship to "structure", the AMS PBIS® can be utilized within a bundled arrangement. It provides an objective measure by which to evaluate physician performance and allocate incentive payments. But it was designed for implementation without the requirement of changing the form or process for payment, or other barriers that have hindered the widespread adoption of bundled payment initiatives.

Attention to practical issues is particularly important to success under the proposed Maryland waiver. Experience indicates that the AMS PBIS® can be implemented within 6 months. Once implemented, it will enable hospitals to make initial payments to physicians based on performance 9 months after implementing the program, and at 6 month intervals thereafter. (At least 6 months of data is required to make credible judgments regarding physician performance, and 3 months allowed to receive, correct, and process the data.) A quick start - establishing credibility, sending the right message, and getting traction with the physicians - is critical to program success, particularly given the rigorous terms of the waiver. The AMS PBIS® can provide the critical "first link" between hospital attending physicians and the institutions under the purview of the Commission.

Legal Support for AMS PBIS®

If approved by Medicare a gainsharing system can provide the bridge between the HSRSC's facility based authority and the physician community. We noted that the AMS PBIS® has been approved by Medicare 3 times, and it is our understanding that it is the only large scale, comprehensive inpatient gainsharing methodology currently operational. Set forth below are the concepts and features incorporated into the AMS PBIS® designed to respond directly to the legal and regulatory concerns raised under 3 laws - *Stark, Civil Monetary Penalties* and *Anti-Kickback.* These features provided support for the 3 waivers.

- The adjustment for severity of illness ("SOI") as reflected by the APR DRGs, is the cornerstone of the methodology. By adjusting the incentive structure to account for the correct amount of resources that may be required by a patient, given that patient's medical condition, SOI directly addresses important concerns raised by regulators: "cherry-picking", "quicker-sicker", "stinting" and "steering". Incentives to avoid difficult cases or to withhold medically necessary care are eliminated.

- As a further safeguard against any incentive to withhold medically necessary care, physicians are protected against the impact of difficult cases on incentive payments. Incentives are calculated on a case-by-case basis. A physician may receive no incentive for treating an extraordinarily difficult case; however, the case will not negatively affect his/her overall incentive amount over a period of time.

- On the other end of the payment spectrum, "best practice norms" ("BPNs"), are developed using local or regional data. BPNs are cost objectives set at the 25th percentile for each qualifying APR DRG. (See Physician Handbook Attachment A) No incentives are paid for surpassing these norms. Because these norms are derived from local or regional data, this rule discourages radical medical practice technique. Physicians are explicitly instructed in the Physician Handbook to use their best medical judgment and to provide each patient with all medically necessary care. The objective is to eliminate inefficiency; not to compromise patient care.

- Physician participation in a hospital program is voluntary and physicians may withdraw at any time.

- Regulators identified "phantom savings" as a potential source of abuse. "Customized savings methodologies" could be used as a vehicle to incent or attract high admitters, rather than as a tool to encourage improved performance. The current Maryland system provides the foundation for addressing this with its standard rate requirement. The AMS PBIS® adds the standardized methodology: Although there is room for both the Commission and the hospitals to customize the system to address their individual needs, the underlying methodology relates physician incentive payments directly to performance. The methodology is administered by AMS who serves as an independent, third party scorekeeper that is compensated on a flat fee basis.

Legal Support for AMS PBIS® (Continued)

- Under the current versions of the AMS PBIS®, volume requirements are included to help insure that the program will be used to improve quality and operational performance; not to encourage changes in referral patterns. These requirements include mandatory waiting periods for new admitters, as well as limits on new admissions from physicians currently on staff who have privileges at more than one hospital. We understand that the Maryland system will incorporate hospital level volume controls based on demographics, so we will leave the issue of physician level requirements as an open question.

- The projects include hospital and physician quality measures. These measures can be required to monitor quality at an institutional level such as those prescribed by Medicare. Under the current NJ Medicare demonstration these measures are reported to CMS periodically for monitoring purposes. In addition, the NJ demonstration provides for a "facilitator/convener". The New Jersey Hospital Association (and AMS) serve in this capacity and have also incorporated specific quality measures as a condition of participation. This would be similar if there were measures that HSCRC may require. In addition, individual hospitals are encouraged to include quality measures designed to address priority issues at their institutions. These include physician-specific quality measures that may be used to condition incentive payments and, depending on the measure, to govern physician participation. (See discussion of internal steering committee below.)

- The program is administered at each participating hospital by an internal steering committee composed of not less than 50% physicians. Suggested by Medicare as a component of the original AMS PBIS® waivered program, this committee provides leadership, governance and "hands on" administration of the program. It may add quality measures customized to meet the specific needs of the institution. Importantly, the committee may condition incentive payments based on these quality measures, and may terminate the participation of physicians that fail to comply with program rules.

- Each Medicare/Medicaid patient is notified of the program based on language approved by CMS.

Based on our experience, we believe that the above will satisfy Medicare regarding the application of gainsharing to Medicare/Medicaid patients. However, the HSCRC is seeking to continue its authority over all payers, including local commercial payers. AMS PBIS® has been implemented with the commercial patient population in New York. (See Department of Justice antitrust opinion, http://www.justice.gov/atr/public/busreview/291451.htm) However, it is our understanding that unlike New York, Maryland has a state version of the *Stark* law. To implement gainsharing, the HSCRC may wish to seek a clarification or formal exception as to its state *Stark* law. AMS is a consulting and software firm, we will be pleased to discuss our experience; however, we cannot provide legal advice or opinions.

Lessons Learned

Above we discussed the threshold distinctions between "structure vs program". Gainsharing is a program that evaluates and incents physician performance; it can be used within a legal structure, such as a Health Enterprise Zone or an ACO, or payment structure, such as bundling, or on a stand-alone basis. Below are various observations that we have made regarding development and design, implementation and operation. We start with the key perspective that gainsharing is fundamentally a "bottom up" strategy. That is, gainsharing is properly viewed as the tool to bring doctors and hospitals together at the table, and to enable the providers to respond to the pressures of health care reform. When this focus is lost,

Lessons Learned (Continued)

gainsharing functions sub-optimally. For example, when clinical objectives are prescribed by outside third parties, physicians often become suspicious. Much time is spent questioning the relevance of the items on the third party list. We have learned that the hospital, its administration, physicians and staff, are best positioned to identify and prioritize the issues that affect each institution, and to follow-through on implementation and enforcement. (See discussion of **Steering Committee** below.) Third parties have developed a valuable body of knowledge that can inform the debate. However, to function effectively, gainsharing must be seen primarily as an institutional strategy. Striking the right balance will be an important task for the Commission.

Design Strategy: Simplicity vs Complexity

During the period of the waiver, the HSCRC and its institutions will spend much time responding to issues. During the initial development period for the AMS PBIS®, interested parties – hospitals, physicians, government – raised many issues. Most legitimate issues were addressed through the lengthy period of design and development, and the years of operational experience that followed. But not all issues can be addressed without creating a system so complex that it will be unable to function in the real world, in real time. Healthcare reform is littered with complex failures. Resisting the natural impulse to resolve everyone's issues is important. So, for example, the AMS PBIS® relies on routinely collected data, avoids any changes to the form or process of claims payment, and requires no new structures. The tight focus that naturally results from these design decisions leaves certain issues unresolved. The benefit, however, is that gainsharing can be implemented in 6 months or less, the main physician decision-makers included, and payment can be made quickly and timely. Other systems can be developed over time to address other issues and, as we discuss below, the AMS PBIS® has been designed to interface with methodologies that relate to outpatient services, primary care, non-acute institutions, etc. Success "out of the box" is very important. Avoiding complexity helps to get started, to get results and, most importantly, to engage the physician community.

Important Methodological Features

Certain issues must be met head-on. Without resolving them before implementation, the system will lose credibility with part of its essential audience – regulators, physicians and/or hospitals – and fail.

- **Severity of Illness:** Physicians often believe that they treat the most difficult cases. While this is true only sometimes, it is an argument that must be dealt with up front in order to establish credibility within the physician community. We noted above that the same adjustment for SOI was critical to addressing the legitimate concerns about gainsharing raised by regulators over the years: steering, cherry-picking, quicker-sicker and stinting. Like other important issues discussed below, resolving the SOI issue responded to the concerns of multiple parties.

- **Local Data:** Physicians are often suspicious of data imported from elsewhere. Although such data may capture "best practices", there are many things, including local practices, local patient preferences and institution-specific obstacles that may present barriers to achievement. Reliance on local or regional data to establish "best practice norms" avoids this problem. Physicians recognize that the goals are realistic and attainable.

Important Methodological Features (Continued)

- **Patient Management:** Clinical issues, like the selection of clinical devices, often draw the early focus of gainsharing initiatives. But much of the healthcare system's inefficiency is locked up in poor patient management. While perhaps less exciting, the inclusion of an unnecessary day in the hospital is expensive and, from a quality perspective, could expose a patient to healthcare risks.

  Addressing this issue could involve anything from admission planning, to the use and scheduling of consultants, to the turnaround of OR and ancillary services, to discharge planning. It frequently implicates financial incentives related to practicing physicians that are inconsistent with efficient patient management. Three points: Much like the problem of trees and forest, it is important not to ignore the mundane issues of patient management; that's where the money is! Fixing bottlenecks may require a multi-disciplinary approach to unraveling multiple problems, some of which are subtle. Finally, nothing will work right without the cooperation of the physicians: In the case of the AMS PBIS®, this required practical solutions. For example, a specific component to the methodology compensates physicians for losses to professional income resulting from changes in practice that enable the institution to operate more efficiently.

- **Improvement vs Performance:** Early gainsharing programs aimed at improved performance. Focusing on medical devices, specific OR practices and so forth, these first generation programs were typically limited in duration. Also, they rewarded improvement indirectly, through physician membership in a group. Later programs, which widened the focus to include more industry related concerns, inevitably raised the issue about recognizing the performance of doctors that were already practicing efficiently. Beyond the issues of fairness and sustainability, implementing a program that recognized high performing physicians, as well as encouraging inefficient physicians to improve, provided steering committees with a valuable tool and enhanced the importance of individual accountability. Like conditioning payment (discussed below), it allowed each institution the flexibility to customize the gainsharing methodology to meet its unique needs and to get early buy-in from the medical staff.

Details of the gainsharing methodology, including specific examples of the incentive computation, are set forth in the Physician Handbook at Section IV and Attachment A.

Steps Important to Successful Implementation

Effective Recruitment and Early Payment: We noted that early payment is critical to traction and credibility with the physicians. But the process begins earlier with effective recruitment. Experience has taught that this involves 2 steps: developing accurate physician-specific data in a user friendly format (reference physician dashboard included in Physician Handbook p.4, attached), and face-to-face meetings with physician leadership and key admitters. An upfront investment in physician recruitment results in a robust initial sign-up, followed by a second wave once the first round of incentive payments are delivered.

Alignment vs Engagement: "Aligning provider incentives" is often put forward as the objective at the heart of healthcare reform. While alignment is essential, we have learned that it is only the beginning, not the end. Alignment is the first step in improving performance – i.e., reducing cost and improving quality – but it does not operate automatically: Success depends on engagement. Gainsharing, the purest form of alignment, establishes financial incentives based on objective measures, but it will yield benefits only if hospital administration uses it as a tool to actively engage physicians and bring them to the table. This is achieved by prioritizing institution-specific goals and communicating these goals through engagement and following-through. To support this, AMS couples its incentive payment reports with both institution-

Steps Important to Successful Implementation

Alignment vs Engagement (Continued)

specific "management reports" and physician-specific dashboard. (See Physician Handbook p.4 attached) We then follow up with each institution's steering committee to assist them in capitalizing on the features built into the methodology. AMS provides ongoing training sessions and learning sessions with participating hospitals. Materials are also provided to assist with physician recruitment and an Operations Manual is provided as ongoing program reference document.

Integration: Similar to the above, gainsharing must not be viewed in isolation. A hospital typically has many programs ongoing that are designed to improve institutional performance – both quality and cost. Discussed below under **Steering Committee**, gainsharing must be integrated into the hospital's overall strategy. The institution must avoid a "buffet approach" to setting objectives. But if priorities are clearly established, gainsharing can provide the economic incentive to propel the institution's priority objectives.

Structures that Made a Difference

Three structures have proven important to the success of the AMS PBIS®:

- **Steering Committee:** We have noted that gainsharing itself does not require the creation of a formal structure such as an ACO or a new physician organization. But as part of the process of securing the initial demonstration waiver, CMS required each participating hospital in New Jersey to empanel an internal steering committee composed of not less the 50% physicians. The purpose of the committee was to provide leadership, governance, and to administer the program. But along the way we found that this committee provided an even more essential function: a point of view. We have noted that the literature contains comprehensive laundry lists of issues, both clinical and non-clinical. But the issues that are important at any particular institution vary. These issues are usually well-known to the people that work there. By identifying and prioritizing the issues unique to each institution, this committee was able customize elements of the AMS PBIS®, and thereby multiply its effectiveness.

- **Facilitator/Convener:** For its Model 1 Initiatives, CMS identified the role of "facilitator/convener". The role involves organizing the participants, administering the program (including application of the gainsharing methodology), and liaison with CMS. We understand that Maryland has submitted its application under a separate provision, but the facilitator/convener role has proven particularly valuable to both CMS and to the participants in assuring the smooth implementation, operation and administration of a large scale gainsharing program. Such programs involve many moving parts, including periodic data processing and an extensive reporting requirement to CMS and its various contractors. Particularly critical is direct engagement with the providers to insure effective implementation and enable participating hospitals and their physicians to capitalize on the opportunity. The HSCRC may want to consider assuming this role, sharing responsibilities, or delegating it to a separate party such as the Maryland Hospital Association (MHA). In the New Jersey Model 1 gainsharing program, the hospital association acts as facilitator/convener and shares responsibilities, delegating most of the technical tasks to AMS. As we noted above, AMS will be pleased to participate in any way as may be directed by the Commission.

Structures that Made a Difference (Continued)

- **Independent Third Party "Scorekeeper":** One of the central concerns of *Stark* is payment for referrals. Hospitals may be tempted to use incentive payments to attract or reward high admitters. We noted that by capping hospital volumes and creating, for practical purposes, a fixed budget, the Maryland system provides the foundation for addressing this issue. (We believe this may still need to be reviewed to be sure there are no unintended consequences.) Administering a standardized methodology through a third party that is compensated on a flat fee basis insures uniform application and provides the balance of the solution. Hospitals and physicians clearly understand that gainsharing is utilized only to reward performance. But in addition to addressing CMS concerns, this approach also responds to the objectivity and "fairness" concerns often raised by the physicians, bridging decades of mistrust among traditional adversaries - hospitals and their medical staffs. Finally, it addresses antitrust concerns raised by the Department of Justice. (See DOJ letter to GNYHA, see http://www.justice.gov/atr/public/busreview/291451.htm.)

- **Division of Responsibility:** In NJ the overall demonstration project is administered through the New Jersey Hospital Association, the facilitator/convener. NJHA contracts with AMS to provide technical support, including preparation of the application for the gainsharing waiver for each of the approved Medicare projects. Hospital participation is voluntary. But for each hospital included in the application, once approved by CMS, the institution entered into an agreement with CMS. However, under the facilitator/convener structure, all CMS communication goes through NJHA and AMS, both serving as the liaison with CMS. In addition NJHA provides for statewide data collection, and determines project rules and terms of participation. AMS is responsible for the technical tasks including the application of the methodology, periodic reports and data submissions required by CMS, and ongoing liaison with each of the participating hospitals (including training and preparation of program materials such as the Physician Handbook and program Operating Manual). Each participating hospital is required to establish an internal steering committee and to appoint a program coordinator. The successful administration of the program is largely due to the facilitor/convenor role. If the HCSRC elects to take a similar role to NJHA, the responsibilities of all parties would need to be defined based on the environment in Maryland.

Integrating AMS PBIS® into a Global Model

AMS PBIS® can provide an important part of the foundation for the new waiver: Implementing the methodology will bring physicians directly into the process and begin the work of changing the terms of the provider relationship, from pay for volume to pay for performance. The system has been tested, approved by Medicare, and falls squarely within the authority of the Commission. Because of its practical design features, it can get the new system off to a quick start and enhance the likelihood of success. However, to fully encompass the vision of the new waiver, the Commission must build on this foundation: Inpatient gainsharing must be expanded to encompass new objectives and new settings. We noted above that the AMS PBIS® includes various interfaces that allow for this expansion. These features are discussed below, along with lessons learned that should be considered as the provider incentive structure is expanded to meet the mandate of the new waiver.

Payment Incentives for Quality Based Reimbursement: Above we discussed the various patient protections that have been built directly into the AMS PBIS® including the adjustment for severity of illness, limits on incentive payments, and so forth – "methodological protections" that neutralize incentives to withhold medically necessary care. Experience with our Medicare demonstrations and commercial projects have shown that a direct connection can be established between physician incentive

Integrating AMS PBIS® into a Global Model

Payment Incentives for Quality Based Reimbursement (Continued)

payments and initiatives to improve quality. Establishing this connection has three important components:

1) The first component is a suite of well-defined quality objectives. Here we note that both Medicare and the HSCRC have quality initiatives that need to be reported and monitored. In addition, participating hospitals are encouraged to incorporate physician-specific and other institution-specific quality measures and/ care re-design initiatives that address the priority issues unique to each hospital. It is important to capitalize on the body of knowledge at each institution, as well as the judgments of outside professionals, and to organize quality initiatives in a way that prioritizes the issues with the most significant impact. These initiatives may also change throughout the demonstration - a key role of the steering committee. (See below.)

2) The second quality component involved a direct link to gainsharing payments. Because incentives under AMS PBIS® are physician-specific, steering committees are able to condition payments based on satisfactory performance related to specific quality measures. To be effective, however, these requirements must be measurable, reasonable and practical to implement. Common mistakes involved the implementation of well-intentioned quality measures that are difficult to track, and the imposition of "all or nothing" payment penalties. This underscores the importance of the third component, the steering committee.

3) The steering committee provides a mechanism to prioritize initiatives, to provide "hands on" enforcement, and to adjust the program based on practical experience. Under both the Medicare demonstrations and the commercial projects, a steering committee composed of not less than 50% physicians, is explicitly given the authority to condition physician incentive payments based on quality. (See Physician Handbook section V.)

Potentially Avoidable Volume: The Global Model including strategies like Total Patient Revenue **(**TPR) and Global Budget Revenues provide natural incentives to avoid unnecessary admissions and visits on a global level. Other features of the Commission's strategy are aimed at Hospital Acquired Conditions and Admissions/Readmissions in which discrete clinical areas are identified and annual targets determined. Also, we note that the Commission has reserved the right to implement other population based reimbursement models that reward value rather than volume. (Waiver application at p.19.)

We noted that the AMS PBIS® incorporates interfaces that enable the Commission to integrate complementary methodologies. AMS cannot propose any specific approach, or set of strategies, until we fully understand the Commission's objectives. For example, we assume that the first step in implementing a program to avoid unnecessary admissions/visits would be to determine appropriate admission/visit rates related to specific clinical categories – e.g., UTIs, dehydration, pneumonia, COPD, diabetes, CHF, ESRD – conditions that, depending on their severity, should be cared for in a different setting. Once this is understood however, gainsharing can provide the vehicle for physician engagement. So, for example, assume that the Commission decides that pneumonia, severity level 1, should never be cared for in an acute care setting. The AMS PBIS® could be adjusted so that incentive payments are entirely eliminated from the appropriate APR DRG.

The example above suggests one straightforward approach. We understand that some clinical categories may require more complex strategies. There are at least 4 basic ways in which the reward or penalty

Integrating AMS PBIS® into a Global Model

Potentially Avoidable Volume (Continued)

associated with such strategies can be linked to inpatient gainsharing. The reward/penalty could be linked to:

- Specific APR DRGs, severity levels and outpatient clinical categories: This is the example noted immediately above. Because Maryland uses APR DRGs as the basis for its case-mix adjustment system, this approach is naturally compatible.

- If the Commission identifies broad clinical categories that should not be treated in a hospital setting, the overall pool of gainsharing funds could be reduced (or shifted to other settings.). Even if the admission rate is not zero for a given category, this strategy could be implemented on a weighted basis.

- Payment to specific physicians could be conditioned based on admission rates related to specific APR DRG and/or severity levels. This is currently done in both NY and NJ related to readmissions. (See discussion of internal steering committee above.). While beyond the scope of this white paper, steering committees can be particularly effective in changing physician behavior. These committees are uniquely aware of the institution's priority problems and the source of these problems – which often turn out to be individual physicians or small groups. The steering committees can be effective in prospectively identifying goals and clear standards, and coupling them with targeted, aggressive rewards and penalties, including program participation. If the Commission makes the system's overall goals clear, the internal steering committees at each institution can offer an effective vehicle for implementation and enforcement. For example, incentives can be conditioned based on physician performance related to the admission or readmission targets established by the hospital, effective use of discharge planning and other coordination of care initiatives, etc.

- Incentives/penalties could be linked to the departments or specialties that play a role in the clinical categories identified by the Commission. For example, the Emergency Room often plays a particularly important role in the admission process. Gainsharing incentives related to ER physicians could be targeted to specific clinical categories identified by the Commission. Under the gainsharing program, physicians work together to develop protocols which have helped to avoid admissions related to specific diagnoses. But when it is determined that the patient should be admitted, protocols have been established to determine the tests to be performed in the ER, as opposed to waiting until the patient is admitted. This has proven to be effective in reducing unnecessary testing which helps to control ancillary utilization in areas like radiology and lab.

- Length of Stay (LOS) specific objectives can be established utilizing payer specific data (i.e. Medicare) or total LOS to align with the Waiver tests. This is also key for hospitals to reduce costs under a fixed budget. LOS initiatives proved valuable under the Gainsharing Demonstrations in the CMS Spending Calculation and Budget Neutrality calculations – tests performed by CMS similar to the waiver tests. LOS reductions had an impact on Part B payments which proved favorable in the comparison of hospital results compared to expected Medicare payments.

Integrating AMS PBIS® into a Global Model

Potentially Avoidable Volume (Continued)

There are variations on each of these approaches, but the actual approach taken will likely depend on the availability of the data, its statistical strength, and the issue of responsibility, or "physician attribution". These issues are often related and may vary by clinical area. As to each new clinical area, the threshold question for the Commission is which available strategy will draw the parties closer to the goal of matching incentives with behavior. The next question involves complexity and expense: There is always an implementation challenge involved in going beyond data that is not routinely collected. This suggests a systematic process in which the clinical areas with the biggest payoff should be looked at first, followed by sequential implementation. Again we note that the process of selecting and customizing the particular linkages between quality and gainsharing begins with an understanding of the Commission's priorities and objectives.

Attribution: The effectiveness of gainsharing is enhanced with the ability to accurately target incentives to those individuals able to affect change. In the case of inpatient gainsharing, we are able to identify the "Responsible Physician" – that physician most responsible for inpatient resource utilization decisions – directly from the Uniform Bill. (See algorithm in Attachment A of Physician Handbook.) The UB lends itself to the physician-specific approach that maximizes the effectiveness of gainsharing. Relying on routinely collected data also enabled AMS to insure reliability: Because the UB is used for many purposes, it is less susceptible to manipulation. We were also able to enhance the cost/benefit ratio of implementing gainsharing. Collecting additional data often involves significant expense, delay and raises issues of reliability.

The UB can provide a foot hold for some of the non-inpatient gainsharing strategies that may be required to support Maryland's new, more comprehensive system. But some of the objectives, like eliminating potentially avoidable volume, may require a combination of the strategies noted above. Since the objective is preventing unnecessary events, the only readily available statistic may be an aggregate one – an institutional comparison from one year to the next. One may be able to target incentives to a specific department, APR DRG, severity level, or outpatient clinical category, but physician-specific attribution may not be realistic (except, perhaps, for the worst offenders). So, as to each clinical issue, the question is which available attribution strategy, or combination of strategies, will draw us closest to the goal of matching incentives with behavior. This again suggests a process in which the clinical areas with the biggest potential payoff and the richest available data should be looked at first.

Internal Consistency: At the beginning of this white paper we discussed the trade-offs between simplicity and complexity. Related to this is the challenge of internal consistency. New issues arise particularly as the Commission moves beyond the inpatient setting, which is relatively self-contained, into outpatient and other non-hospital settings that may overlap physicians' private practices, directly or indirectly. For example, above we noted the need to include a specific provision to offset the loss of professional income that may occur as physicians are asked to change practice patterns in order to support improvements in hospital efficiency. Although somewhat controversial, the decision proved to be both practical and effective. This is because individuals, including physicians, are not always willing to sacrifice income for the "greater good". Compensating physicians for a lost bedside visit in order to eliminate an unnecessary hospital bed day has a significant positive cost/benefit ratio. Other inconsistencies were uncovered closer to home. For example, long-standing arrangements between hospitals and hospital-based physicians – so called "legacy contracts" – sometimes contained inconsistent incentives (such as incentives to encourage testing), or payments for activities that would now be addressed under gainsharing – thus creating duplicate payments.

Integrating AMS PBIS® into a Global Model

Internal Consistency: (Continued)

The new waiver is an ambitious undertaking. Population based reimbursement takes the Commission into new areas which, for historic reasons, may include existing incentives that could compromise the system's overall objectives. Similarly, adding many new "moving parts" to the methodology creates opportunities for inconsistency. It also invites a level of complexity that may not be justified by the savings to be achieved; complexity that could undermine the overall effort. These are the same kinds of issues that AMS confronted when we had to find the proper balance between the demands of three parties – the physicians, the hospitals and the regulators – and the requirements of three laws – *Stark*, *CMP* and *Anti-Kickback*. The Commission's goals under the proposed waiver cannot be achieved without the active collaboration of the physicians.

Gainsharing can provide the bridge between the Commission's authority over institutions and the physicians. It brings the physicians and their institutions together at the table. The AMS PBIS® has established the standard for large scale gainsharing. We believe that our experience can help the Maryland health care community speed implementation and provide momentum, avoid pitfalls, inform the development of complementary methodologies, and enhance the likelihood for success.

CMS BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BPCI) INITIATIVE
MODEL 1/GAINSHARING PROGRAM

PHYSICIAN HANDBOOK

NEW JERSEY HOSPITAL ASSOCIATION
NJHA

ams
applied | medical | software

CMS Bundled Payments for Care Improvement Initiative Model 1 / Gainsharing Program

PHYSICIAN HANDBOOK

TABLE OF CONTENTS

NJHA/AMS invites your comments and suggestions. Please direct all correspondence to the New Jersey Hospital Association, Health Economics Department, 760 Alexander Road, P.O. Box 1, Princeton, New Jersey 08543-0001. By telephone 609-275-4024, by fax 609-452-9339, or by email @ shopkins@njha.com. or to Applied Medical Software, Inc., 595 Haddon Avenue, Collingswood, NJ 08108, phone (856) 858.3822, or by e-mail at info@appliedmedicalsoftware.com.

Version 2.4 – March 2013

I. INTRODUCTION

Our Hospital has been selected and approved by the Centers for Medicare and Medicaid Services (CMS) as an awardee in its Bundled Payments for Care Improvement (BPCI) Initiative for Model 1. The BPCI initiative is based on the Medicare Physician-Hospital Collaboration Demonstration (Demonstration) that successfully tested "gainsharing" at 12 New Jersey hospitals. The BPCI initiative builds on the Demonstration, strengthening the relationship between quality of care, care redesign and performance based incentives for physicians. Participation will enable us to enhance our current efforts to improve patient care and operational performance: It will provide the financial framework to align the economic interests of our institution with its medical staff – a tool essential for tolerating recent and proposed budget cuts, and for responding to the demands of health reform.

The BPCI initiative applies to Medicare fee-for-service inpatients. It has three components: 1. care redesign; 2. quality monitoring and maintenance, and; 3. gainsharing. Care Redesign (**Section II)**, is aimed at improving both quality of care and operational performance – initiatives that often go hand-in-hand. The system for quality monitoring and maintenance (**Section III**) protects patients by detecting any significant changes in medical practice that could affect patient care. Under the Program, the responsibility for these components resides with each institution and its physicians. Processes to improve quality and efficiency will be designed and implemented by the participants. The BPCI initiative will also include a revised version of the CARE Tool. The BPCI-Adapted Continuity Assessment Record and Evaluation (B-CARE) tool will be completed on all Medicare fee-for-service discharges during the period of performance. A Steering Committee composed of physicians and administration (**Section V**) will work with our medical staff and departments to establish the goals, develop implementation plans, and set the metrics to measure our progress. This will enable us to prioritize the issues unique to our institution and to customize our strategy.

The New Jersey Hospital Association (NJHA) serves as "Facilitator Convener" for the BPCI initiative. The Association's primary objective is to help us capitalize on the important opportunity presented by the Program. NJHA's commitment to quality begins with its statewide collaboratives, formal programs designed to improve patient safety across all institutions (**Section II**). Every participating institution has committed to participate in the NJHA collaboratives, or their equivalents, now part of the Hospital Engagement Network (HEN). In addition, tools developed under the BPCI initiative will be expanded and extended, including department and specialty-specific forums designed to share best practices.

NJHA is also responsible for administering the Program's third component, the gainsharing methodology. Under the Demonstration, participating physicians that used resources wisely and improved quality of care received incentive payments. But participation was limited to the "Responsible Physician". (See **Attachment A**.) Under the BPCI initiative, NJHA will work with us to expand the pool of eligible physicians and, as the Program generates measurable improvements, to potentially increase the amount of the incentives. (See **Section IV**.)

Similar to the Demonstration, during the BPCI initiative for Model 1, NJHA will employ Applied Medical Software, Inc. (AMS), to act as "independent scorekeeper". The methodological framework, the Applied Medical Software Performance Based Incentive System® (AMS PBIS®), (**Section IV** and **Attachment A**) provides flexibility for the Steering Committee to customize gainsharing to meet our unique needs. (**Section V**). The Committee, which is composed of at least 50% physicians, will work with the medical staff, the departments and administration to align provider interests and maximize the effectiveness of the gainsharing methodology. AMS will apply the methodology, incorporating the decisions made by our Steering Committee, to determine the amount of incentives earned by each physician who has met the Program's eligibility criteria (**Section VI**) and satisfied any quality and care redesign conditions that the Steering Committee may implement.

The cornerstone of the AMS PBIS® is a system for evaluating physician performance that accounts for case-mix and severity of illness (SOI). To be fair and equitable, a system that evaluates physician performance must first recognize that certain physicians may treat patients that are sicker. To insure that Best Practices are achievable, data for measuring performance are derived from local medical practice - New Jersey admissions. Best Practice Norms (BPNs) are established utilizing specific criteria designed to insure that standards incorporate the experience of NJ physicians that practice in the specialty.

I. INTRODUCTION (CONTINUED)

A system of economic incentives is linked to the methodology for evaluating performance. It includes components designed to balance two objectives: rewarding demonstrated levels of performance (Performance), and providing incentives to encourage change (Improvement). The balance between Performance and Improvement will be struck by our Hospital's Steering Committee. This is detailed in **Sections IV**, and in **Attachment A,** along with other features of the gainsharing methodology important to you. These include:

- There will be no change in the current process or form of payment. The Hospital and participating physicians will continue to receive payment from Medicare as we do currently.
- Upside bonus only; there is no risk or penalty involved in providing necessary care related to high cost cases.
- The Improvement incentive for medical admissions incorporates an adjustment for loss of income due to length-of-stay (LOS) reduction. This is to insure that physicians are not forced to sacrifice professional income to assist us in improving efficiency. Over time, the Steering Committee may merge the amounts allocated for the Improvement incentive into the Performance incentive.
- Incentives are continuous; not one time. Quality and efficiency will be rewarded during each and every time period of the Program.

The basic gainsharing methodology is fully discussed in **Section IV** and in **Attachment A**. A primary objective of the initiative is to find the balance between the interests of our physicians, our institution and Medicare that will make the Program sustainable, and enable us to make recognition of quality and efficiency a permanent part of our relationship with you.

As a member of our medical staff, your participation in the Program is strictly voluntary; you may withdraw at any time. If you participate, a portion of your incentives will depend on your individual performance with respect to certain quality indicators as identified by the Steering Committee **(Section III)**. Participating physicians will continue to be expected to use health care resources wisely and effectively, consistent with your professional judgment regarding the best interests of the patient. It is important that no Medicare beneficiary be denied medically necessary services as a result of participation in the Program.

Eligibility criteria are set forth in **Section VI**. This includes certain responsibilities specified by Medicare as a condition of participation in the Program. Please review the information in this Handbook. If you decide to participate, you must sign and return the Physician Election Form (**Section IX**). The incentive may be paid to you directly or, if you are a member of a group, to your group.

The BPCI initiative for Model 1 is scheduled to start April, 2013. Admissions on and after this date will be used to calculate your performance and/or improvement incentives, and you will be given "credit" for the eligible cases, as appropriate, if your acknowledgement is received on or before June 30, 2013.[1] Thereafter, credit will be given for admissions for each quarter during which you participate. Finally, the Program's success depends on the continuing support and commitment of all parties. Accordingly, like participating physicians, the Hospital and Medicare may elect to terminate participation (**Section VII**).

II. CARE REDESIGN

Redesigning Patient Management

The BPCI initiative creates both the opportunity and framework for effective provider collaboration. But the responsibility for care redesign is placed where it should be: squarely on us – the institution, its medical staff and administration. Allowing our Hospital to recognize efficient and high quality physician performance, and to encourage improvement with financial incentives, provides the tools that will enable us to build on our current efforts, and take them to a new level. This begins with our Steering Committee: A primary responsibility of the committee is to identify opportunities for improvement – both clinical and non-clinical (patient management) – and then to prioritize care redesign initiatives. (**Section V)** Experience under the Demonstration has identified numerous ways to improve quality of care and performance. For example, successful patient management strategies have included:

[1] If for any reason the implementation of the program is delayed, then acknowledgement must be received within 90 days of the implementation date to be eligible for the first quarter.

II. CARE REDESIGN

Redesigning Patient Management (Continued)

- **Improved admission planning:** Patient overcrowding can negatively affect hospital resources at all levels. Better planning with respect to elective admissions reduces unnecessary stress on inpatient resources. Steps like decreasing the time between admission and attending physician note can reduce the consumption of unnecessary resources at the beginning of the stay.

- **Efficient use of Emergency Department:** Admissions often occur through the ER. When an ED patient is admitted, time spent in the ER becomes part of the inpatient stay. Medical staff, department leadership and administration can collaborate to identify and resolve bottlenecks.

- **Tests and consultations:** Duplicative tests, and tests that are marginal but costly, can add unnecessary expense. Delay between order and result can prolong length of stay. Eliminating unnecessary tests and utilizing consultants efficiently improves care management.

- **OR scheduling and usage:** OR delays can lead to the use of additional resources, and an uncoordinated OR schedule can cause capacity issues. Late starts have a compounding effect. Successful strategies begin by determining the source of the problem: e.g., room unreadiness (hospital staff), delay by anesthesiologist, delay by physician. Also, the institution may have to consider standardizing and synchronizing the way in which data is acquired and shared in the process of preadmission testing and OR scheduling. Issues may relate to OR turnover and block time utilization, as well as OR/Cath lab utilization. Because of the complexity of the problem, effective solutions typically utilize an interdisciplinary group that includes surgeons, the anesthesiology department and hospital OR staff. Similar processes have been utilized to promote the cost effective use of critical care and telemetry units.

- **Discharge Planning:** A delay in placing an inpatient who is clinically ready for discharge to home, or into a post acute setting, results in the unnecessary use of inpatient resources, and may lead to complications. Reasons for discharge delays may include: no one at home to care for the patient; lack of transportation, or; lengthy admission process (or capacity issue) for the post-acute setting. Successful strategies typically involve engaging the social worker early in the process (even prior to admission in certain cases); expanding physician education regarding options/resources available concerning durable medical equipment, home and community-based health care and rehabilitation services; writing discharge orders early in the morning to facilitate discharges prior to noon, and; organizing resources, personnel and physicians to increase the proportion of weekend discharges.

There are many opportunities for care redesign: evidence-based selection and purchase of medical devices and hardware, reduction in pharmacy expense, avoiding duplication of services, etc. But, because the particular issues at each institution are unique, success will depend upon effective collaboration between our medical staff, administration, department leadership, and other stakeholders. The Steering Committee will identify opportunities, design and prioritize initiatives based on the needs of our institution, and may condition incentive payments based on the implementation of care redesign tasks.

To provide a starting point for individual doctors, each participating physician will be furnished with a report that ties the elements of the Program together - that links care redesign to incentive payments. The Physician Dashboard (see example on next page) will enable an individual physician to see the incentive payments that have been earned, incentive payments that could be earned, and to identify the areas where improvement can generate additional incentives. This will help individual physicians to identify changes to process that may require contributions from our institution, as well as steps that can be taken on your own – "low hanging fruit".

Redesigning Clinical Practice

Like patient management, issues related to clinical practice are unique to each institution. The Steering Committee will take the lead in identifying those areas that should receive priority attention, and in determining the care redesign initiatives that will result in the greatest improvement to quality and performance.

DASHBOARD
General Hospital
Prior - July 2010 through December 2010 and Current - January 2011 through June 2011; Medicare Only Claims
Non PAR - NPI Accuracy not Verified

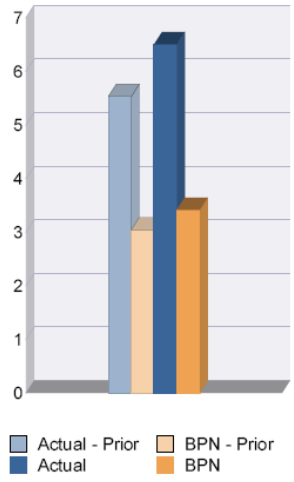
ams applied | medical | software
Analytics

Responsible Physician	0000000000	Specialty	Family Practice	
Physician's First Name		Physician's Last Name		

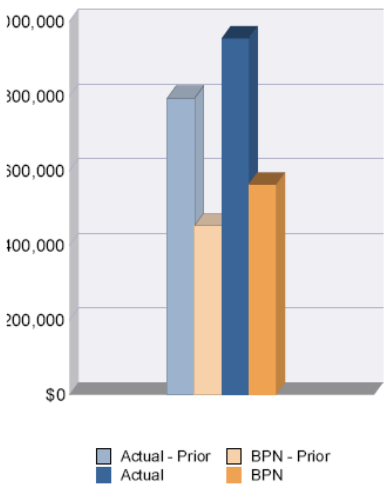
QUICK STATISTICS	Cost		Average LOS		INCENTIVE	Performance		Improvement		Total	
	Prior	Current	Prior	Current		Prior	Current	Prior	Current	Prior	Current
Your Information	$794,880	$954,577	5.53	6.50	Maximum Incentive	$10,615	$13,459	$21,559	$34,772	$32,174	$48,231
Best Practice Norm (BPN)	$452,531	$562,980	3.04	3.41	Your Incentive	$3,225	$4,878	$488	$11,427	$3,712	$16,304
Variance	$342,349	$391,596	2.50	3.09	Unearned Incentive	$7,390	$8,581	$21,072	$23,345	$28,462	$31,926

Admissions by Complexity Level (SOI)										
	Current	SOI 1:	3	SOI 2:	42	SOI 3:	47	SOI 4 :	17	Total: 109
	Prior	SOI 1:	9	SOI 2:	29	SOI 3:	57	SOI 4 :	8	Total: 103

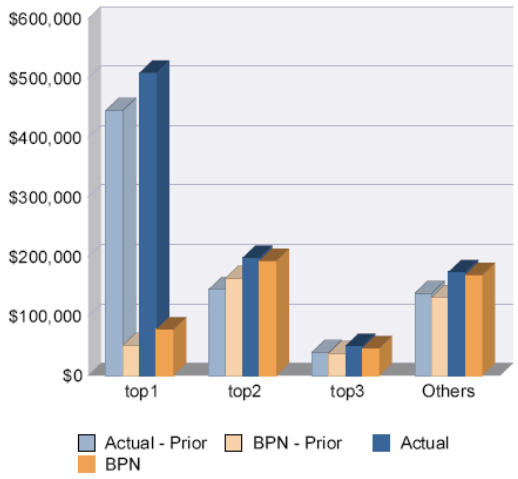
LOS Summary



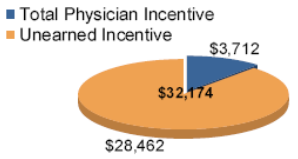
Cost Summary



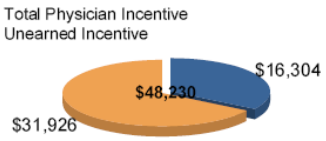
Top Cost Centers



Prior



Current



Cost Center Summary		Your Cost		BPN		Variance	
		Prior	Current	Prior	Current	Prior	Current
Top1	Intensive Care Units Cost	$446,377	$509,653	$50,987	$77,648	$395,391	$432,005
Top2	Adult-Peds Room Board Cost	$145,068	$198,232	$164,171	$192,962	$-19,103	$5,270
Top3	Laboratory Cost	$39,129	$50,227	$37,762	$45,796	$1,367	$4,430
Top4	Radiology Cost	$36,631	$44,232	$31,538	$36,848	$5,093	$7,385
Top5	Drugs Sold to Patients Cost	$32,752	$43,462	$31,930	$45,502	$822	$-2,040
Top6	Emergency Room Cost	$35,925	$36,475	$41,352	$46,162	$-5,427	$-9,688
Top7	Respiratory Therapy Cost	$15,462	$25,810	$7,504	$15,228	$7,958	$10,582
Top8	Med/Surg Supplies Sold Cost	$5,619	$8,754	$9,917	$13,439	$-4,297	$-4,686
Top9	Blood Cost	$4,602	$8,285	$5,224	$6,858	$-623	$1,426
Top10	Physical Therapy Cost	$7,631	$7,340	$4,391	$5,098	$3,240	$2,241

II. CARE REDESIGN

Redesigning Clinical Practice (Continued)

(Since the savings to make physician incentive payments are generated through efficient internal hospital performance, the Steering Committee may condition incentive payments on the successful implementation of specific care redesign initiatives – both clinical and non-clinical. See Sections IV and V.) However, the commitment to improving the quality of patient care under the Program is extensive. Although our Steering Committee will be the primary focus, the NJHA, in its role as Facilitator Convener, will be supporting participants with programs and tools designed to present fundamental care redesign initiatives that can be implemented across all institutions. Our institution has committed to participate in all NJHA Collaboratives, or their equivalents, through our participation in the Hospital Engagement Network (HEN). Other tools include specialty and department-specific forums and subcommittees, hosted by NJHA, that will enable the BPCI initiative participants to share "best practices".

Our Hospital care redesign plan, as finalized by the Steering Committee, will be shared with all physician participants in the BPCI initiative.

III. QUALITY MONITORING AND MAINTENANCE

Safeguards Built into Gainsharing Methodology

Quality of patient care remains our priority while we strive to operate more efficiently. Various safeguards have been incorporated into the Program to protect patients and insure that care redesign results only in improvements to quality of care. This begins with safeguards built directly into the gainsharing methodology:

Methodological Safeguards

- **Physician Performance Measured Using a Methodology That Adjusts for SOI.** This adjustment insures that there is no penalty to participating physicians for utilizing the appropriate resources to treat sicker and more difficult patients.

- **Best Practice Norms Determined using Local Practice Data and Minimum Case Volume Standards.** Minimum case volume insures that the practice standard is determined with data from practitioners across the State who treat a substantial number of patients in the same specialty, and not from physicians who treat particular types of patients only occasionally, or from other regions of the country.

- **Evaluation Based on Overall Performance, Not Any Individual Case.** An individual patient's needs may vary, even within an All Patient Refined Diagnosis Related Group (APR DRG[2].), severity-adjusted DRG. You should always use your best medical judgment to determine the best course of care for each patient. Under the Program, evaluation is based on overall performance over the course of a 6 month period. (Incentive payments are made semi-annually.) Also, exceptionally difficult-to-treat cases are reclassified as "outliers" so as not to affect your overall evaluation. Finally, because incentives are computed case by case, using intensive resources in an individual case will not compromise the overall average.

- **Payment Limits.** Medicare has incorporated upper-limits into the BPCI initiative to insure that payments are reasonable and will not improperly influence physician practice decisions. This is set at a percentage of Part B payments (see **Attachment A**).

- **No Additional Incentive Payments for Performance Surpassing the Best Practice Norm.** Physicians who have already established efficient patterns of practice will be rewarded under this methodology. You are encouraged to provide cost-effective care while meeting the quality goals established under the Program. As an added safety mechanism to discourage new and untried practices and prevent aggressive cost-cutting behavior that might jeopardize the quality of care, no additional financial incentives will be paid for exceeding the Best Practice Norm.

[2] APR DRG System is a proprietary product of 3M-HIS

III. QUALITY MONITORING AND MAINTENANCE (CONTINUED)

Quality Monitoring Program

The BPCI initiative's highest priority is the well-being of the patients. This includes our Hospital, our participating physicians, and Medicare. In addition to the safeguards built directly into the gainsharing methodology, our Hospital will implement a quality monitoring program. The Steering Committee is charged with developing, implementing and administering the quality monitoring program. It will include the following:

A. Hospital-Level Quality Measures

An important element of the program is to monitor hospital quality on a broad basis. The purpose of such monitoring is twofold: to seek new means to measure and improve quality of care, and to insure early detection of any quality issues that could compromise the overall objectives of the Program. The Hospital will:

1. Continue to comply with all of The Joint Commission's accreditation standards;

2. Monitor our performance on CMS' Hospital Inpatient Quality Reporting (IQR) Program.

3. Submit data related to Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

4. Review readmission and mortality rates and other nationally recognized quality indicators. If there is an adverse change in indicators, the Program will be reviewed in greater depth to determine if the Program has had an impact on quality. The Program will be modified, or may be terminated, if a reduction in quality resulting from the Program is identified.

5. Monitor and track patient complaints to determine if there is an impact on patient satisfaction as a result of the Program. An increase in complaints linked to premature discharge would trigger an in-depth review of the Program.

As part of our participation in this BPCI initiative with Medicare, we are also required to implement a subset of the Continuity Assessment Record and Evaluation (CARE) tool, which will be referred to as the BPCI Adapted Continuity Assessment Record and Evaluation Tool or the B-CARE Tool, to evaluate beneficiary condition on day of discharge.

B. Physician Quality Measures

Physician-specific quality components of the Program, as determined by the Steering Committee, will be distributed to all physicians participating in the Program. We will follow the guidelines below to insure quality of care standards are met:

- Our Steering Committee will develop and implement the Quality Components of the Program. This will include minimum quality thresholds.

- Incentive payments, in part or whole, will not be made to physicians who fail to meet the Quality Components of the Program. Our Chief Medical Officer will oversee implementation of the quality components.

- The Hospital may amend the Quality Components of the Program from time to time.

Our Steering Committee will be continuously evaluating new measures to better understand and assess functional status improvement, reductions in rates of avoidable hospital readmissions, rates of discharge to the community, rates of admission to an ER after a hospitalization, incidence of health-care acquired infections and patient perception, among other things. All participants in the Pilot are committed to working with CMS and its contractors on monitoring and evaluation including responding to data requests, site visits, surveys and interviews.

IV. GAINSHARING METHODOLOGY

The Applied Medical Software Performance Based Incentive System® (AMS PBIS®) is the gainsharing methodology utilized in the previous Gainsharing Demonstration and in this BPCI initiative. The basic elements are reviewed in **Section I** and in this section. A detailed discussion appears in **Attachment A.** The AMS PBIS® has two components: a system for evaluating physician performance linked to a system of economic incentives. Noted in **Section I Introduction,**

IV. GAINSHARING METHODOLOGY (CONTINUED)

the cornerstone of both components of the methodology is the adjustment for severity of illness: APR DRGs are utilized to insure that the system for measuring physician performance is fair and equitable, and that there are no penalties to participating physicians for using appropriate resources to treat difficult cases. The incentive payments apply to Medicare inpatient fee-for-service patients.

The system of economic incentives incorporates payments for Performance and Improvement. Performance is your inpatient resource utilization compared to your peers', adjusted for case-mix and severity of illness. The Performance incentive is designed to financially recognize efficient levels of performance that have been achieved and are currently in place. Improvement is your current performance compared to your prior year performance, adjusted for case mix and severity of illness. The Improvement incentive is designed to encourage new efficiencies. These concepts were developed to strike a balance between rewarding efficient performance and encouraging improvement. Our Steering Committee will monitor the allocation of payments and determine this balance.

Incentive Payments: Examples of Performance and Improvement

Examples of incentive payments to four Surgeons and four Physicians with differing levels of performance are shown on the following pages:

- Surgeon A/Physician A already performs efficiently.
- Surgeon B/Physician B shows relatively efficient performance, but makes improvements in response to the incentives.
- Surgeon C/Physician C shows relatively inefficient performance, but makes significant improvements in response to the incentives.
- Surgeon D/Physician D shows inefficient performance, but elects not to change.

For purposes of this example, two-thirds of the Year One incentive is dedicated to Improvement (i.e., Maximum Improvement Incentive), and one-third to Performance (i.e., Maximum Performance Incentive). This is done initially to emphasize the reward for improvement. Because of this, the highest total incentives were paid to Surgeon C and Physician C because of their improved performance. However, because of the efficient levels of performance they have already achieved, Surgeon A and Physician A both received a significant incentive payment. (We noted that our Steering Committee is free to alter this balance from time to time to respond to changes at the institution.) Overall, a non-linear distribution is used to assure that the relationship among physicians to the Best Practice Norm is fair and proportionate.

The incentive examples above and the sample payment report included on the following pages are provided for illustration purposes. The algorithms to compute Performance and Improvement are set forth in detail in **Attachment A.**

Sample Payment Report

Following the examples is a sample of the incentive payment report that will be furnished semi-annually to the Steering Committee and to you. In this example:

- Compensation for Improvement is included in total and by level of severity in the shaded portion. (Improvement payments for non-surgical cases is computed to compensate for loss of professional income (LOI)).
- Compensation for Performance is shown in the unshaded portion through a comparison of your performance (actual cost) to the Best Practice Norm by case, by level of severity, and in total.
- The final 3 columns show, by case, the potential savings opportunity (cost opportunity), the Performance incentive related to the APR DRG, and the Performance incentive earned as a result of your actual performance.

In this sample report (as in the examples above), 2/3 of the Total Available Incentive is allocated to Improvement, and 1/3 to Performance. As noted, the actual allocation will be determined by our Steering Committee, and may be changed from time to time (See **Section V**).

The methodology currently incents only the "Responsible Physician", the physician most responsible

EXAMPLE 1—SURGICAL INCENTIVE[3]

APR_DRG 165—Coronary Bypass with Cardiac Cath or Percutaneous Cardiac Procedure (SOI Level 3)

Surgical Improvement Incentive

Assume:	90th Percentile	=	$40,962
	Best Practice Norm	=	$21,077
	Maximum Physician Incentive	=	$1,000

		Prior Year Cost	Current Year Cost
Surgeon A	=	$21,077	$21,077
Surgeon B	=	$29,031	$25,054
Surgeon C	=	$38,914	$26,048
Surgeon D	=	$40,962	$40,962

Surgeon							Impr $
A	($21,077 - $21,077) / ($40,962 - $21,077)	=	$0 / $19,885	X	$1,000	=	$0
B	($29,031 - $25,054) / ($40,962 - $21,077)	=	$3,977 / $19,885	X	$1,000	=	$200
C	($38,914 - $26,048) / ($40,962 - $21,077)	=	$12,866 / $19,885	X	$1,000	=	$647
D	($40,962 - $40,962) / ($40,962 - $21,077)	=	$0 / $19,885	X	$1,000	=	$0

Surgical Performance Incentive

Assume:	90th Percentile	=	$40,962
	Best Practice Norm	=	$21,077
	Maximum Physician Incentive	=	$500
	Surgeon A Current Year Cost	=	$21,077
	Surgeon B Current Year Cost	=	$25,054
	Surgeon C Current Year Cost	=	$26,048
	Surgeon D Current Year Cost	=	$40,962

Surgeon							Perf $
A	($40,962 - $21,077) / ($40,962 - $21,077)	=	$19,885 / $19,885	X	$500	=	$500
B	($40,962 - $25,054) / ($40,962 - $21,077)	=	$15,908 / $19,885	X	$500	=	$400
C	($40,962 - $26,048) / ($40,962 - $21,077)	=	$14,914 / $19,885	X	$500	=	$375
D	($40,962 - $40,962) / ($40,962 - $21,077)	=	$0 / $19,885	X	$500	=	$0

Total Surgical Incentive

Physician		Impr $		Perf $		Total $
A	=	$0	+	$500	=	$500
B	=	$200	+	$400	=	$600
C	=	$647	+	$375	=	$1,022
D	=	$0	+	$0	=	$0

[3] This example is for illustration purposes only. Actual computations utilize a non-linear distribution formula to assure that the relationship to the Best Practice Norm is both fair and proportionate. This example also assumes Year One: Improvement Incentive = 2/3; Performance Incentive = 1/3.

EXAMPLE 2—MEDICAL INCENTIVE[4]

APR DRG 343—Musculoskeletal Malignancy & Pathological Fracture D/T Musculoskeletal Malignancy (SOI Level 3)

Medical Improvement Incentive

Assume:	Maximum Physician Incentive per day	=	$96
	Best Practice Length of Stay	=	4

	Prior Year LOS	Current Year LOS
Physician A =	4	4
Physician B =	7	5
Physician C =	12	8
Physician D =	15	15

Physician									Impr $
A	4	-	4	=	0	X	$96	=	$0
B	7	-	5	=	2	X	$96	=	$192
C	12	-	8	=	4	X	$96	=	$384
D	15	-	15	=	0	X	$96	=	$0

Medical Performance Incentive

Assume:	90th Percentile	= $19,802
	Best Practice Norm	= $5,818
	Maximum Physician Incentive	= $202
	Physician A Current Year Cost	= $5,818
	Physician B Current Year Cost	= $8,615
	Physician C Current Year Cost	= $9,314
	Physician D Current Year Cost	= $19,802

Physician								Perf $
A	$19,802 - $5,818 / $19,802 - $5,818	=	$13,984 / $13,984	X	$202	=	$202	$202
B	$19,802 - $8,615 / $19,802 - $5,818	=	$11,187 / $13,984	X	$202	=	$162	$162
C	$19,802 - $9,314 / $19,802 - $5,818	=	$10,488 / $13,984	X	$202	=	$152	$152
D	$19,802 - $19,802 / $19,802 - $5,818	=	$0 / $13,984	X	$202	=	$0	$0

Total Medical Incentive

Physician		Impr $		Perf $		Total $
A	=	$0	+	$202	=	$202
B	=	$192	+	$162	=	$354
C	=	$384	+	$152	=	$536
D	=	$0	+	$0	=	$0

[4] This example is for illustration purposes only. Actual computations utilize a non-linear distribution formula to assure that the relationship to the Best Practice Norm is both fair and proportionate. This example also assumes Year One: Improvement Incentive = 2/3; Performance Incentive = 1/3.

Performance Based Incentives
Physician Report 1 (All to BPN Simulation)
January 2010 through December 2010; Medicare Only Claims

Provider Number	0000001	**Provider Name**	General Hospital
Responsible Physician	1000000	**Specialty**	Surgery/Thoracic/Vascular
Physician's First Name		**Physician's Last Name**	

Medical Improvement Incentive (LOI)	$968
LOI Breakdown by Severity of Illness	1: $0 2: $968 3: $0 4: $0
Surgical Improvement Incentive	$14,118.59
Performance Incentive	$7,711.24
Total Physician Incentive	$22,797.54
Total Unearned Incentive	$0.00
Maximum Performance Incentive	$7,711.19
Maximum Improvement Incentive	$15,086.30

Total Eligible Cases 40 out of 47 cases

Patient	APR / SOI	Case Type	Actual LOS	Simulated LOS	Actual Cost	Simulated Cost	BP LOS	BP Cost	LOS Opport	Cost Reductions Opport	Max Perf Inc 1st Year	Actual Perf Inc
000000762	1732	Surgical	1	1	$11,790.75	$8,652.79	1.00	$8,652.79	0	$0	$175.58	$175.58
000000764	2203	Surgical	9	7	$27,381.51	$13,350.98	7.00	$13,350.98	0	$0	$229.92	$229.92
000000766	0044	Surgical	39	26	$125,939.36	$71,598.56	26.00	$71,598.56	0	$0	$1,000.00	$1,000.00
000000767	1693	Surgical	8	6	$27,243.09	$14,865.74	6.00	$14,865.74	0	$0	$301.65	$301.65
000000767	3173	Surgical	4	4	$11,344.06	$8,179.64	5.00	$8,179.64	0	$0	$99.52	$99.52
000000768	1711	Surgical	1	1	$8,026.95	$8,026.95	1.00	$9,967.48	0	$0	$146.25	$146.25
000000768	5113	Surgical	5	5	$12,146.87	$11,581.50	5.00	$11,581.50	0	$0	$143.89	$143.89
000000768	1203	Surgical	5	5	$15,835.42	$13,502.44	6.50	$13,502.44	0	$0	$264.91	$264.91
000000770	1203	Surgical	8	7	$22,189.66	$13,502.44	6.50	$13,502.44	0	$0	$264.91	$264.91
000000770	1733	Surgical	13	4	$27,845.76	$13,405.73	4.00	$13,405.73	0	$0	$272.02	$272.02
000000771	1712	Surgical	5	2	$15,356.47	$11,599.37	2.00	$11,599.37	0	$0	$170.19	$170.19
000000771	1213	Surgical	2	2	$9,460.10	$9,460.10	6.00	$11,418.66	0	$0	$224.03	$224.03
000000773	2203	Surgical	9	7	$26,553.11	$13,350.98	7.00	$13,350.98	0	$0	$229.92	$229.92
000000773	1211	Surgical	4	1	$12,360.38	$4,875.02	1.00	$4,875.02	0	$0	$95.65	$95.65
000000773	2201	Surgical	5	2	$17,683.81	$6,450.98	2.00	$6,450.98	0	$0	$111.09	$111.09
000000775	1731	Surgical	1	1	$19,318.94	$7,319.67	1.00	$7,319.67	0	$0	$148.53	$148.53
000000775	2203	Surgical	6	6	$20,147.99	$13,350.98	7.00	$13,350.98	0	$0	$229.92	$229.92
000000776	1202	Surgical	5	4	$17,032.80	$8,297.23	4.00	$8,297.23	0	$0	$162.79	$162.79

IV. GAINSHARING METHODOLOGY

Sample Payment Report (Continued)

for inpatient resource utilization. (See **Attachment A** for the algorithm that determines the Responsible Physician.) NJHA will be working with the BPCI initiative for Model 1 Hospital awardees to expand the Program to include consultants and hospital-based physicians. During the first year, NJHA will work with Program participants to develop incentive models designed to encourage new levels of improvement based on the inclusion of certain ancillary physicians and consultants in the Program. Implementation of this feature is optional and will be based on the decision of each Steering Committee. The expansion is scheduled to begin in Year 2 of the BPCI initiative and, based on the models developed (and approved by CMS), may be customized by our Steering Committee to meet our institution's needs.

Model 1/Gainsharing Program Integrity Safeguards

The Program is designed to be completely self-sustaining: funding for physician incentive payments, as well as for the discounts required from Medicare, comes from the participating hospitals. As a condition of participation in the BPCI initiative for Model 1, Medicare requires a discount of ½% in the second 6 months of Year 1, 1% in Year 2, and 2% in Year 3 on hospital payments. The objective of Program Integrity is to properly balance the interests of participating physicians, Hospitals and Medicare, so that the Program is sustainable; so that we can make the recognition of quality and efficiency a permanent part of the relationship with our medical staff. To accomplish this, our institution must realize sufficient improvement in performance to enable it to make these payments and, at the same time, strengthen its institutional health. The BPCI initiative includes 4 safeguards in the methodology designed to achieve sustainability:

- Beginning in Year 2, the formula for determining the Improvement incentive will be determined by comparing performance year over year, rather than to the Program base year. The Performance incentive will continue to reward individual physicians for maintaining achieved efficiencies.

- It is important to insure that the institution is financially able to accept the discounts to Medicare. Beginning in year 2, the Program will identify the overall savings achieved by each institution, as a whole. At a minimum, savings must be sufficient for the institution to pay the discount to Medicare, before incentives are paid to physicians. At its option, the Steering Committee may prospectively condition the payment of incentives on achieving a minimum economic threshold based on the specific needs of our institution.

- For reasons similar to the payment threshold described above, increases to the overall level of allowable physician incentive payments will be linked to new savings realized at each institution. Beginning in Year 2, each Steering Committee may have the option to raise the Maximum Physician Incentive proportionately based on measurable new savings achieved, as determined by the methodology developed by NJHA and approved by CMS.

- Finally, to insure that the opportunity to participate in the Program remains voluntary to both physicians and hospitals, participating hospitals will have the opportunity to withdraw from the BPCI initiative upon 60 days notice to Medicare, with 60 days notice to participating physicians.

V. STEERING COMMITTEE

We shall establish and maintain a Steering Committee comprised of representatives from our Hospital (including our Program Coordinator and Chief Medical Officer) and participating physicians. At least half of the Steering Committee will be physicians. The Steering Committee will be responsible for Program leadership, governance and administration. It will provide the internal framework for preparing, implementing and administering the Program. This includes preserving the integrity of the Program, and insuring that all Program responsibilities are met. Its primary objective is to make this important opportunity work for us and for our patients.

The Steering Committee will provide a forum for sharing ideas, identifying problems and developing solutions. The committee will identify and prioritize care redesign initiatives (**Section II**) - tasks designed to enhance quality of care and improve operational performance - to respond to the unique needs of our institution. The committee may prospectively condition

V. STEERING COMMITTEE (CONTINUED)

the payment of incentives on the accomplishment of specific tasks related to care redesign and quality of care. Other Steering Committee responsibilities include assisting and overseeing the roll-out of the Program and providing input to the Chief Medical Officer regarding the Quality Components of the Program. The Committee will oversee the operation of the Program, including changes to the incentive compensation formula noted in **Attachment A**, and implementation of the new features mentioned in **Section IV.** This includes determining the balance between Performance and Improvement, and implementing Program Integrity safeguards that will enable us to sustain the Program and maximize its benefits.

Patient safety and protection is the highest priority. Among other things, the Hospital and participating physicians, in aggregate, will report to CMS on the measures reported through the Hospital IQR, Hospital Outpatient Quality Data Reporting Program (HOP QDRP) and the Physician Quality Reporting System (PQRS). The Steering Committee must insure the care redesign initiatives only enhance, and do not compromise, quality of care. The committee is responsible for providing oversight and implementing the Quality Components of the Program including developing and revising the Quality Components as indicated. Before paying incentives, the Steering Committee will review compliance with the Quality Components of the Program, and assess any other issues related to the Program or variation in practice patterns that impact our quality of care. The Steering Committee shall advise our Chief Medical Officer whether any of the participating physicians failed to meet Program Quality Components in a payment period. The Chief Medical officer will send each physician who failed quality goals written notification that includes the details of components that were not achieved, and whether the physician is ineligible for payment in whole or part for such period.

Finally, the Steering Committee shall address the continued participation of any physician who has compromised, or may compromise, patient safety or quality of care, or who has otherwise failed to comply with the Program requirements. If the issues identified are not promptly corrected, the Steering Committee may exclude such physicians from further participation in the Program. Similarly, the Steering Committee will continuously monitor overall quality and will make any adjustments to the Program that may be required and which are approved by CMS.

VI. PHYSICIAN ELIGIBILITY

Participation in the Program is voluntary. Participating physicians, referred to in the Bundled Payments for Care Improvement Model 1 Innovation agreement ("BPCI Agreement") as "Enrolled Physicians", must be in compliance with all Medicare enrollment requirements, including having a valid and active NPI. Participating physicians agree to comply with all relevant terms of the BPCI Agreement, the BPCI Request for Application and the Application submitted by our Hospital. These documents are available for your inspection. The relevant terms, detailed throughout this Handbook, relate primarily to the maintenance and improvement of quality (Hospital IQR, HCAPS, PQRS and B-CARE) – that all necessary care is provided to Medicare beneficiaries; to the maintenance of and access by CMS to records, information and data for monitoring and reporting; and, to cooperation with CMS on the evaluation of the Program's effectiveness.

In addition:

A. As of the date you elect to participate, you must have active admitting privileges at the BPCI initiative for Model 1 participating Hospital for at least a year; maintain active admitting privileges in accordance with the Hospital's bylaws and all applicable credentialing and peer review standards, and; must have at least 10 cases at the Hospital during the 12 month period immediately preceding your election to participate. If you meet these criteria prior to April 1, 2013, you are eligible to participate at any time, subject to paragraphs B. and C. If you do not meet the eligibility criteria as of April 1, 2013, you may, after meeting the criteria in this section, participate in the BPCI initiative for Model 1 at the beginning of the next Program Year – i.e., April 1, 2014 or 2015 – provided that you had and maintained active admitting privileges at the participating Hospital for at least a year.

B. You must participate in the Quality Components of the BPCI initiative for Model 1 set forth in this Physician Handbook, as amended from time to time by the Steering Committee.

VI. PHYSICIAN ELIGIBILITY (CONTINUED)

C. To participate, you must sign the Election Form in **Section IX** of this Physician Handbook and submit it to the Hospital. (Credit will be given for admissions on or after April 1, 2013, if acknowledgement is received on or before June 30, 2013. Thereafter, credit will be given for admissions for the quarter after the date the acknowledgement is received).

Finally, if you otherwise meet the eligibility criteria in this section, but also maintain active admitting privileges at another hospital, you shall be subject to the following:

D. The number of admissions eligible for physician incentive payments during your first year of eligibility under the Program shall be capped at the number of your Medicare fee-for-service admissions to the Hospital during the 12-month period immediately preceding your date of enrollment to participate in the Program. During your second and third year, admissions eligible for physician incentive payments shall be capped at your Medicare fee-for-service admissions to the Hospital during the 12-month period immediately preceding the applicable year. So, if you were eligible for the Program on 04/01/13, then your admissions for the time period 04/01/15 to 03/31/16 (Program Year 3) shall be capped at your admissions during the 12-month period from 04/01/14 to 03/31/15 (Program Year 2).

VII. DURATION OF PROGRAM

The BPCI initiative for Model 1 is scheduled for a 3 year term, beginning April 1, 2013. We hope that the continued effectiveness of the BPCI initiative will be evident therefore, although your participation is voluntary, it is important to the Program's success. As noted, the Hospital may terminate participation in the Program upon 60 days notice to Medicare, with 60 days notice to participating physicians. Likewise, NJHA may terminate the Program at the end of any Program Year upon 60-days notice to the Hospital. Medicare may terminate the Program at any time. Physicians may end their participation at any time. Incentive payments will be made on a pro-rata basis if you choose to leave the Program.

VIII. PAYMENT AUTHORIZATION

Physician participation in the Program is voluntary. If you do wish to participate, you must return the Election Form to the Hospital Program Coordinator to be eligible for payment. As indicated, credit will be given for qualifying admissions on and after April 1, 2013, if the acknowledgment is received on or before June 30, 2013.[5] Thereafter, credit will be given for qualifying admissions for the quarter after the date the acknowledgment is received.

IX. PHYSICIAN ELECTION FORM

A sample form follows.

[5] If for any reason the implementation of the program is delayed, then acknowledgement must be received within 90 days of the implementation date to be eligible for the first quarter.

SAMPLE FORM

Insert Hospital Name/Logo

Physician Election Form and Participation Agreement

I have received and reviewed the Physician Handbook, and I wish to participate in the Incentive Program.

_____ _____

Name *(please print)* Date

See the Physician Handbook, which is incorporated by reference for the terms and conditions governing your participation in the program. To comply with Section II of the Physician Handbook, please indicate whether you admit patients to:

- ❑ This Hospital Only
- ❑ This Hospital and Other Hospital(s). Please list Hospital names:

_____

_____

_____

***** THE FOLLOWING INFORMATION IS NEEDED TO MAKE INCENTIVE PAYMENTS TO YOU, IF YOU ARE ELIGIBLE FOR SUCH PAYMENTS. PLEASE INDICATE TO WHOM ANY EARNED INCENTIVE PAYMENTS SHALL BE MADE PAYABLE, AND WHERE SUCH PAYMENTS SHOULD BE SENT.*****

I WOULD LIKE MY INCENTIVE PAYMENT TO BE MADE PAYABLE TO:
(*Please note—PAYEE and Tax ID# MUST match)

- ❒ **MYSELF—TAX ID # (SOCIAL SECURITY #): _ _____**
- ❒ **MY GROUP—TAX ID # (GROUP): _ _____**

I WOULD LIKE MY INCENTIVE PAYMENT TO BE SENT TO THIS ADDRESS:

_____

_____

_____

Physician Signature: _____

Please return completed Enrollment form to: _____

_____

_____

_____

_____

_____

Hospital Name Representative Date

ATTACHMENT A
GAINSHARING / INCENTIVE METHODOLOGY

AMS PERFORMANCE BASED INCENTIVE SYSTEM® ("AMS PBIS®")[1]

DATA PREPARATION

1. Obtain and Edit Data

AMS will obtain inpatient discharge data from NJHA that covers all admissions in the State of New Jersey, excluding psychiatry, normal deliveries and newborns. The charge data on each patient record will be converted from charges to costs utilizing cost center–specific ratios of costs to charges (RCCs) developed from the Hospital's cost report. This data set will enable AMS to group patients by APR DRG, by physician, and by hospital. AMS employs a proprietary set of edits to insure the integrity of the data for purposes of the gainsharing methodology. These edits will identify data problems that may require updates or corrections to the data.

2. Classify Patients

Admissions will be classified into APR DRGs,[2] a system of patient classification that adjust for the patients' severity of illness (SOI). Cost outliers, defined as the mean plus three standard deviations, will be excluded.

3. Determine Best Practice Norms

Best Practice Norms will be determined, adjusting for wage and teaching differentials, using the following algorithm to insure that the standards are realistic and attainable:

- At least ten (10) patients required per physician within a product line;
- At least five (5) qualifying physicians required within a product line;
- At least three (3) qualifying admissions required within an APR DRG. (This adjusts for case-mix and SOI).

If the above criteria are met, the Best Practice Norm is set as the cost at the 25th percentile of cases across New Jersey, ranked from lower to higher by cost.

4. Group Patients by Hospital

Once Best Practice Norms are determined, patients are grouped by hospital.

5. Group Patients by Physician

Once Best Practice Norms are determined, patients are grouped by physician utilizing the National Provider Identification (NPI).

6. Identify Opportunities for Implementing Performance-Based Compensation

Based on the results of paragraphs 4, and 5, patients grouped by hospital and by physician are compared to the Best Practice Norm (see paragraph 3. above) and adjusted for case-mix and SOI. AMS will generate reports summarizing these results for the physicians and the Hospital.

7. Correct, modify and refine baseline reports

First draft reports commonly contain problems related to the inputs, formatting, etc. NJHA will work with the Hospital and its participating physicians to identify and correct any errors or deficiencies. This will help insure the integrity of future reports. The baseline reports will then be reissued as necessary. These reports will not be shared with any other hospital. The physician-specific reports will only be shared with the Hospital, its Program designees, and the individual participating physician.

DETERMINING PHYSICIAN PAYMENTS FOR IMPROVEMENT AND PERFORMANCE

1. Determine Total Available Incentive

The opportunity for savings (Best Practice Variance) is determined by computing the difference between the Best Practice Norm and the actual costs for each admission. The total available incentive (Total Available Incentive) is computed by taking a

[1] The AMS Performance Based Incentive System ® and AMS PBIS ® are registered trademarks of Applied Medical Software, Inc. and may not be used without the prior written consent of Applied Medical Software, Inc. The AMS PBIS® is patent protected (US Patents: 7,546,245; 7,640,173; 7,640,174, and 7,716,067).

[2] APR DRG System is a proprietary product of 3M-HIS.

DETERMINING PHYSICIAN PAYMENTS FOR IMPROVEMENT AND PERFORMANCE

1. Determine Total Available Incentive (Cont'd)
percentage (e.g. 10%) of the Best Practice Variance across all hospitals in New Jersey for each APR DRG (and for each severity level within the APR DRG) for which a Best Practice Norm is established. The resulting amount by APR DRG is the maximum physician incentive (Maximum Physician Incentive or MPI). The Hospital may elect to have these amounts adjusted so that the MPI is never less than $100 per case or more than $3,000 per case. This and certain other payment decisions will be independently established by the Hospital, subject to the overall constraints of the Program.

2. Apportioning the Maximum Physician Incentive Between Performance and Improvement

Performance is defined as each physician's cost per case, adjusted for case mix and SOI, compared to the Best Practice Norm. Improvement is defined as each physician's Prior Year performance compared to his or her actual performance during the relevant Program Year (i.e., the Current Year) adjusted for case-mix and SOI. For medical admissions, the improvement computation also includes a component for loss of income. During the first Year, the Maximum Physician Incentive is apportioned as one-third for Performance and two-thirds for Improvement. This is done initially to reward improvement. Over time, the Steering Committee may change the allocation of the Maximum Physician Incentive dedicated to Improvement and Performance to respond to conditions at the Hospital. The Steering Committee may also impose other conditions to balance the objectives of the Program in light of unique circumstances at the Hospital.

3. Identifying the Responsible Physician

A responsible physician (the RP) is defined as the physician most responsible for resource utilization while the patient is hospitalized. The identity of the RP is determined from the two physician fields on the Uniform Bill:

Attending Physician	UB-04 Form Locator 76
Operating Physician	UB-04 Form Locator 77
Other Physician	UB-04 Form Locator 78 and 79

The determination of the RP is as follows:

1. If the admissions cannot be grouped into an APR DRG, there is no RP assigned;

2. If the APR DRG is surgical, the RP is the entry in the operating physician location. If the operating physician location is empty, the attending physician is used;

3. If neither of the above apply, the RP is the attending physician; and

4. If the attending physician is empty, then no RP is assigned.

4. Performance Incentive Formula

The Performance Incentive is designed to recognize achieved levels of efficient performance: RPs will receive incentive payments in proportion to the relationship between their individual performance and the Best Practice Norm. A non-linear distribution formula is used to assure that the relationship to the Best Practice Norm among physicians is both fair and proportionate. This computation is the same for surgical and medical admissions. An equation illustrating the computation of Performance Incentives for individual RPs is as follows:

$$\left\{ \frac{\text{90th Percentile Cost - Physician's Actual Cost}}{\text{90th Percentile Cost - Best Practice Cost}} \right\}$$

X

Maximum Performance Incentive

This computation is performed at the case level for each admission. Payment for the Performance Incentive is made to all physicians except the 10% of physicians with the highest cost.

DETERMINING PHYSICIAN PAYMENTS FOR IMPROVEMENT AND PERFORMANCE (CONT'D)

5. Improvement Incentive Formula

The Improvement Incentive is intended to encourage change in practice patterns that results in more efficient performance, while improving the quality of care delivered. For surgery and medicine, Improvement incentive payments are made unless an individual physician does not demonstrate measurable improvement in operational performance. However, because physicians who admit medical cases may be forced to sacrifice professional income to achieve Program objectives, different methodologies are used to compute the Improvement incentive.

The Improvement incentive formulae for medical and surgical RPs are as follows:

For Medical RPs:

The per diem may vary by severity level. Accordingly, for each severity level:

{ Prior Year Case-Mix Adjusted ALOS—Current Year Case-Mix Adjusted ALOS[3] }

X

Per Diem

X

Current Year Admissions

For Surgical RPs:

{ Prior Year Case-Mix Adjusted Cost—Current Year Case-Mix Adjusted Cost }

{ X^{th} Percentile Base Year Cost[4]—Best Practice Cost }

X

Case Mix Adjusted Maximum Improvement Incentive

X

Current Year Admissions

[3] Because an individual physician or surgeon is unlikely to treat patients with the identical case-mix and levels of severity in the Prior Year and in the Current Year, the adjustment made to facilitate the comparison are a physician-specific case-mix/SOI index for the Prior Year and the Current Year.

[4] Percentile will be set to eliminate the outlier effect caused by high-utilizing physicians.

NEW JERSEY HOSPITAL ASSOCIATION
NJHA
760 Alexander Road
Princeton, NJ 08543
609.275.4000
www.njha.com

ams
applied | medical | software
595 Haddon Avenue
Collingswood, NJ 08108
856.858.3822
www.amspbis.com