Gainsharing: providing care in a more economical way

By David Harlow

As more and more competing demands are placed on the health-care dollar, and as Massachusetts physicians continue to contend with the economics of practice in a state with high costs, many physicians have embarked on a path of entrepreneurship, often competing directly with the hospitals in their communities.

Why is this so? Many physicians believe that they are better able to manage the business of health care than the hospitals, and they want to share in the facility fees that are being paid directly to hospitals by third party payors.

Historically, hospitals were loath to share revenue with physicians at all, and some physicians responded creatively by developing their own facilities or accommodating a broader range of procedures in their offices or other outpatient facilities. Many hospitals now regret their earlier stance, since "half a loaf is better than none" – and, as one hospital executive recently observed: the horse is out of the barn and several miles down the road.

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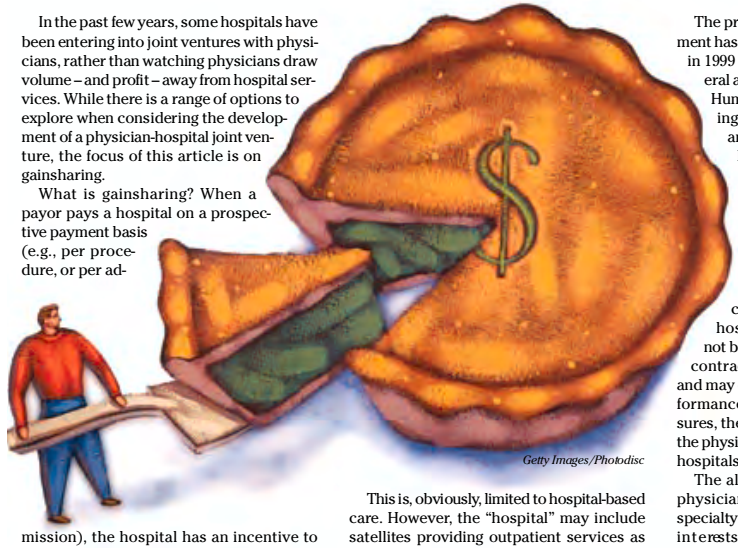
In the past few years, some hospitals have been entering into joint ventures with physicians, rather than watching physicians draw volume – and profit – away from hospital services. While there is a range of options to explore when considering the development of a physician-hospital joint venture, the focus of this article is on gainsharing.

What is gainsharing? When a payor pays a hospital on a prospective payment basis (e.g., per procedure, or per admission), the hospital has an incentive to provide services for that episode of care as economically as possible.



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Since the physician providing professional services and managing the entire episode of care is generally paid a separate professional fee, she does not share the hospital's incentive (even though she is the individual most capable of managing that encounter efficiently).

Gainsharing refers to the gain in hospital operating margin achieved by providing care more economically, and shared with the physician managing the care.

This is, obviously, limited to hospital-based care. However, the "hospital" may include satellites providing outpatient services as well. Furthermore, as reimbursement trends make certain non-hospital care settings less attractive economically to physicians (consider the recent elimination – barring post-election-season legislative changes – of the Medicare reimbursement advantage enjoyed by ambulatory surgerycenters and diagnostic imaging centers, which took effect on January 1, 2007 under the Deficit Reduction Act of 2005), it will be in physicians' financial interest to become more interested in exploring gainsharing arrangements with hospitals rather than competing head-to-head.

The proverbial fly in the gainsharing ointment has been the Special Fraud Alert issued in 1999 by the Office of the Inspector General at the U.S. Department of Health and Human Services, describing gainsharing arrangements between hospitals and physicians as violating the anti-kickback statute, as well as the civil monetary penalties (CMP) rule under which fines may be assessed for limiting care reimbursed by Medicare.

That alert noted that fixed-fee fair market value personal services contracts under which physicians could be involved in managing hospital care more efficiently would not be barred by the statute. While these contractual arrangements may be legal, and may even be augmented with some performance incentives tied to process measures, they are not particularly attractive to the physicians interested in gainsharing with hospitals.

The alert also made special mention of physician-hospital joint ventures such as specialty hospitals, noting that if investment interests in such hospitals were marketed only to physicians in a position to refer to the hospital then, even if a deal otherwise fit within the anti-kickback law's "whole hospital" exception, the arrangement could constitute an inducement to limit care by physician participation in profits generated by savings in clinical expenses.

The OIG has come to peace with both gainsharing and specialty hospital arrangements. In August 2006, the moratorium on new specialty hospitals was lifted and a report was issued focusing on disclosure and

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enforcement of existing rules, rather than limiting the ability of physicians to establish new specialty hospitals. (Massachusetts physicians are only partial beneficiaries of the moratorium lifting; some hospital specialties, such as certain cardiac surgery, are regulated by the Commonwealth under the Determination of Need program and no new projects may be approved under current guidelines.)

And in a series of advisory rulings – one issued in 2001, six in early 2005, and one in late 2006 – the OIG has been sketching out the parameters of permissible gainsharing arrangements between physician specialists and their hospitals, while standing by the continued applicability of the 1999 Special Fraud Alert.

The 2005 and 2006 rulings were issued to cardiologists, cardiac surgeons and hospitals working with an outside consultant who had collected sufficient data concerning care provided within these specialties to be able to serve as an arbiter of appropriateness. The providers determined to minimize waste and standardize care, but not to reduce the quality or appropriateness of services provided.

For example, certain supplies ("cell saver" kits for use in case of excessive bleeding) were routinely unwrapped and laid out for potential use in the course of a surgery. The data showed that the kits were needed only 30 percent of the time. The providers agreed that they would only be opened as needed, and certified to the OIG that the time it would take to open the packaging would not have an impact on care if they were needed. The hospital agreed to split with the physicians the savings attributable to the reduction in use of this particular item, so long as the physicians were not to be rewarded financially for reducing utilization below 30 per cent.

Other examples include using less-expensive catheters (appropriate in 90 per cent of cases), and establishment of a more limited "formulary" of implantable devices (with exceptions permitted where medically necessary) yielding savings due both to unit cost and standardization of procedures.

The physicians agreed that the severity of the cases they admitted to the hospital would be monitored, and if they varied downward significantly from the base year's figures, they would forfeit the gainsharing payments. This safeguard was intended to ensure that the physicians would not seek to admit more severe cases to other hospitals, thus skewing the gainsharing calculations in their favor.

The OIG was convinced that there was no inducement to the physicians to inappropriately limit care or services through these arrangements and, in fact, cited the risk (to the physicians) of departure from a standard of care (even if it is a standard of defensive medicine) among the grounds for approving the gainsharing payment, suggesting that taking such a departure would be self-limiting.

These concepts clearly are not limited to cardiology and cardiac surgery. They are equally applicable to orthopedics, other surgical specialties, oncology and, in fact, any specialty where physicians control use of hospital resources in management of a patient's care, and where the potential savings through standardization are great.

The guidelines espoused by the OIG through this succession of advisory rulings come as a breath of fresh air in an atmosphere of heavy-handed regulatoryoversight. After all, it makes sense for physicians and hospitals to collaborate rather than compete, for a variety of reasons.

From a systems perspective, a medical arms race between competitors leads only to greater capacity without higher volume, leading to higher unit costs. This may represent a diversion of resources from more needed basic services. For physicians, it makes sense to try to collaborate with hospitals, because the truth is that even in this era of ever-increasing ambulatory care, certain services still need to be provided in general hospitals.

Since hospitals are now coming to the realization that they need to share the pie with physicians, these emerging guidelines mean that certain types of arrangements may be accomplished without complicated for-profit-not-for-profit joint ventures, which can require physicians to cede more control (so as not to jeopardize a hospital's tax-exempt status).

There has been some discussion of Congressional action that would permit gainsharing across the board. However, thus far, Congress has seen fit to authorize gainsharing demonstration projects under the DRA, and the Centers for Medicare and Medicaid Services (CMS) has also used its discretionary authority to issue a call for gainsharing project proposals using its broad demonstration project authority under the Medicare Modernization Act of 2003 (MMA).

The medical device manufacturers' trade association has been vocal in its opposition to the expansion of gainsharing, citing concerns about limiting innovation and denying access to the latest and greatest implantable devices; the industry sought to block the DRA demonstration project language from being enacted in the first place. Between the DRA demonstration projects (six hospitals) and the MMA demonstrations (up to 72 hospitals), CMS will start to see a wealth of data to consider once the projects are approved and kicked off over the course of this year.

As these three-year demonstration projects wind up, CMS and Congress may be ready to authorize a broader approach to gainsharing, perhaps involving statutory changes.

The demonstration projects will offer complete regulatorypeace of mind – no exposure to liability under the CMP or anti-kickback statutes or the Stark law – to the providers participating in them, and perhaps future legislative changes will broaden such protections to all providers engaged in gainsharing within the confines of permissible activity as defined by the OIG.

Until the government raises a "big tent" of gainsharing, there is still the issue of whether gainsharing is permissible under the Stark law. There are arguments to be made that some gainsharing activity falls within Stark exceptions; furthermore, while there are significant risks to acting without an "all-clear" in this area, it seems unlikely that the government would exercise its prosecutorial discretion to undertake enforcement actions against providers under Stark for participating in a gainsharing arrangement that fits within the advisory rulings' guidelines.

Finally, the new CMS Stark advisory ruling process is open to providers that may wish to seek Stark advisories to gain the same sort of clarity available under the OIG advisory ruling process.

Hospitals around the country are slowly beginning to reach out to their physicians on gainsharing. The range of gainsharing programs extends from simple efforts to appropriately reduce average length of stay to more involved programs seeking to change standards of practice involving the drugs, devices and equipment used in the operating room and throughout hospital stays without compromising the standard of care.

Physicians can take the initiative in designing programs tailored to their specialties and patterns of practice, and promoting their use to the hospitals they are affiliated with. The keys to successful design and implementation of any such program are data, the shared belief that there is always room for improvement and, most importantly at the start of any such undertaking, an atmosphere of mutual trust conducive to physician-hospital collaboration.

Technically, any hospital-physician partnership seeking to implement a gainsharing program should first seek an advisory ruling from the OIG, and perhaps a Stark advisory ruling from CMS. While this would be the most conservative approach, any program that comes within the four corners of OIG advisories already issued is unlikely to attract the unwanted attention of the regulators. However, for a program of significant scope, providers would be well-advised to invest the time and expense necessary to obtain advisory rulings in advance of implementation. **MMLR**