BACK TO BASICS

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Hospital-Physician Gainsharing

Hospitals are reconsidering gainsharing arrangements with physicians after the Office of the Inspector General (OIG) issued several formal advisory opinions last year indicating that specific gainsharing practices would not violate federal law if properly administered.

In order to strengthen physician relations, improve loyalty and reduce costs, hospitals are making a proactive effort to align their own economic and financial interests with those of their medical staffs. Aligning these financial interests improves communication and trust between the two groups, who historically have tended to operate from an "us versus them" perspective.

Over the years, hospitals have shared savings with physicians by investing a portion of those savings in equipment purchases or continuing education seminars, or funding educational programs for nursing staff. While this may encourage physicians' support of the hospital, it is not gainsharing because the physicians do not receive a direct financial benefit from such programs.

What is Gainsharing?

The OIG defines gainsharing as an arrangement by which hospitals and other health care organizations promote standardization and more efficient use of expensive supplies in order to cut costs; a percentage of the resulting cost savings is then distributed among the physicians who helped generate those savings.

From the supply chain perspective, reduced use of supplies—combined with the transition to standardized, less expensive, clinically equivalent devices—can save organizations a significant amount of money. Such changes are typically described as "quick wins" because of the immediate and favorable effect the adjustments can have on an organization's bottom line.

While hospitals are constantly looking for ways to reduce costs, especially supply costs (where, for instance, cardiac devices can cost thousands of dollars), physicians in the typical business model have no reason to choose less expensive devices. Physicians are paid on a fee schedule, whereas hospitals receive a fixed amount from Medicare and sometimes other payers for each patient regardless of the actual cost of treating that patient.

The ability to link financial reward to a more conscientious use of supplies translates into a mutually beneficial situation: hospitals save money, while physicians, responsible for those savings, reap a reward for their commitment to cost reduction. As Lewis Morris, chief counsel to the Inspector General in the U.S. Department of Health & Human Services stated in his testimony to the House Committee on Ways and Means last October, "By giving the physician a share of any reduction in the hospital's costs attributable to his or her efforts, hospitals anticipate that the physician will practice more effective medicine."

Why is there a Renewed Focus on Gainsharing?

In February last year, the OIG issued six advisory opinions addressing specific hospital-physician gainsharing arrangements. These opinions—targeting cardiology and cardiovascular services at four hospitals—made it possible for the hospitals to reward physicians financially for helping the organizations achieve cost reductions.

With respect to these six opinions, the OIG declared it would not impose administrative sanctions because of safeguards that were incorporated into the arrangements. The safeguards address concerns regarding gainsharing's potentially adverse impact on quality of patient care and potential payments to induce referrals.

Yet, the OIG had previously expressed significant concerns about the risks posed by gainsharing. In 1999, it issued a special advisory bulletin on gainsharing, warning that it violated the Civil Monetary Penalties statute prohibiting hospitals from offering payments to physicians that either directly or indirectly encouraged them to reduce or limit care for Medicaid/Medicare patients. This development summarily halted all gainsharing practices for the following two years.

By 2001, however, the OIG softened its position through its advisory opinion permitting a limited gainsharing

arrangement under the Civil Monetary Penalties law and the antikickback law.

In its most recent advisory opinions, the OIG indicated that properly structured arrangements under which cost savings are shared can serve legitimate business and medical purposes. Lewis Morris' testimony indicated that the OIG remains concerned that such arrangements could: limit patient care; lead to "cherry picking" healthy patients and steering sicker, more expensive patients to other hospitals; result in payments in exchange for patient referrals; or lead to unfair competition among hospitals based on their gainsharing programs.

Still, the ruling is significant for not-for-profit hospitals as they have historically been limited by regulations governing fraud and physician self-referrals to hospitals, in addition to issues involving their non-for-profit status.

All six gainsharing arrangements approved by the OIG apply to acute care hospitals and to one or more physician groups (either cardiologists or cardiac surgeons). In each gainsharing arrangement, the participation of an outside independent "program administrator" to collect data and develop the one-year-long gainsharing programs was a feature that contributed to the success of the arrangement and helped address the OIG's concerns.

Under these arrangements, physicians can earn up to 50 percent of the cost savings achieved in a single year. To preclude any conflict of interest, the program administrator, who also monitors the program, is paid a fixed monthly fee not tied to any cost savings attributable to the program.

OIG-Approved Gainsharing Safeguards

1. Programs will be transparent, with clearly identified cost-saving actions and resulting savings that allow for public scrutiny and individual physician accountability.

2. The physicians will offer credible medical support for the position that the cost-saving recommendations would not adversely affect patient care.

3. Payments will be based on all procedures, regardless of payer, and savings that result from procedures related to federal health care programs are subject to a cap.

4. Procedures to which the cost-saving program applies will not be performed disproportionately on federal health care program beneficiaries or a generally healthier mix of patients.

5. Each cost-saving mechanism will be tracked separately to preclude shifting cost savings.

6. Objective historical and clinical measures will be used as benchmarks to protect against inappropriate service reductions.

7. After the arrangement is implemented, individual physicians will have discretionary judgment to select cardiac devices to use for specific patients.

8. The program is of a limited, one-year duration. (It is unclear as to whether the OIG will approve multiyear programs. In a footnote to the advisory opinions, the OIG indicated that "any renewal or extension of the Proposed Arrangement should incorporate updated base year costs.")

9. The hospital and the physician groups involved in the gainsharing program will provide written disclosures of their participation in the cost saving measures about arrangements for patients whose care may be affected.

10. Financial incentives will be limited to a reasonable duration and monetary amount.

11. Participating physician groups will distribute their profits on a per capita basis, thus restricting the incentive for individual physicians to generate disproportionate cost savings through these programs.

Successful Physician-Hospital Relationships

Traditionally, the challenge to find the "right" relationship between hospitals and physicians has been a constant struggle.

But when physicians have an economic interest, it is easier to get their attention, according to Jon Soderholm, president of Avera Heart Hospital, Sioux Falls, S.D. "There is a significant difference when physicians have 'skin in the game,'" he says. "In most [hospital] relationships, the physician isn't an equal partner. When a physician is an equal partner and has equal input into decisions being made, it is very powerful. In many hospitals, you only hear 'I need' from physicians; however, when the decision-making and influence are shared, then you begin to hear 'We need.'"

The 1999 report by the Institute of Medicine, *To Err Is Human,* as well as countless other research studies, point to standardization as the critical element in improving quality of care and cost reduction. Soderholm predicts, "The institutions that are going to be successful in the future are the institutions that are going to take the most variance out of the system. When you take variation out of the system, you drive your quality up and drive your costs down."

One way of eliminating variation in the system is to ensure that the hospital's interests and the physician's interests are aligned; gainsharing offers this opportunity.

Gainsharing Safeguards

However, the OIG has given only cautionary approval for specific gainsharing arrangements that it believes provide sufficient protection from abuse. (See "OIG-Approved Gainsharing Safeguards" on the left-hand side of this page.)

In the absence of such safeguards, the OIG has found that nearly all gainsharing cases violate the Civil Monetary Penalties statute and improperly induce physicians to reduce or limit items or services furnished to their Medicare and Medicaid patients. However, the proposed gainsharing arrangements in the advisory opinions contained sufficient safeguards to prevent the imposition of sanctions. "The most important thing to take from

these new advisory opinions is that legal and effective gainsharing programs can be structured," says Tom Dutton, a partner with the international law firm Jones Day. "The key is to structure the program in a manner that tracks the safeguards that the OIG has described in the advisory opinions."

Gainsharing Practices

All of the 2005 OIG advisory opinions addressed arrangements to manage patient care and related costs between hospitals and either cardiac surgeons (with respect to cardiac surgery programs) or cardiologists (with respect to cardiac catheterization laboratory services). The cost-saving measures in the OIG-approved arrangements included:

1. Opening packaged items (e.g., surgical trays) only as needed during a procedure

2. Performing blood cross-matching only as needed

3. Substituting less costly items, such as a knee-high sequential compression device for items currently being used, such as a thigh-high sequential compression device, which provides the same level of effectiveness.

4. Product standardization of certain cardiac devices where medically appropriate (e.g., stents)

5. Limiting the use of certain vascular closure devices to an "as needed" basis.

Any gainsharing arrangement considered by the hospital should be reviewed by outside legal counsel. Additionally, the hospital should obtain an advisory opinion from the OIG before implementing a gainsharing program, since one court opinion has held that any gainsharing program will violate the Civil Monetary Penalties statute unless it has been approved by the OIG through the advisory opinion process. Larry Ellis, senior vice president for cardiovascular services for Sisters of Charity Providence Hospital, Columbia, S.C., says, "We would never have considered moving forward with a gainsharing program without first making sure we were in compliance with all state and federal laws and without the advisory letter from the OIG, which basically gave us approval to proceed."

Gainsharing Features to Avoid

Board members should also be aware that there are aspects of gainsharing programs to avoid. For instance, it is inappropriate to pay incentive rewards in the following cases:

- Where there is no direct, demonstrable connection between individual actions and any reduction in a hospital's out-of-pocket costs
- If individual actions would result in unspecified savings
- If there are insufficient safeguards against the risk that other actions, such as increases in patient volume or premature hospital discharges, might actually account for any savings
- If quality of care indicators are of questionable validity and statistical significance
- When there is no independent verification of cost savings, quality of care indicators or other essential aspects of the arrangement.

The Future of Gainsharing

Although gainsharing agreements between physicians and hospitals are no longer strictly prohibited by the OIG, boards must nevertheless continue to approach the subject with caution. And while recent opinions indicate that the gainsharing door is opening, trustees should not assume that implementing a gainsharing program will be easy.

According to Dutton, "To date, there has been a lot of talk and very little action surrounding gainsharing programs." He says this is because, notwithstanding the recent OIG opinions, hospitals remain concerned about: potentially significant consulting, information systems and legal

The Board's Role in Developing a Gainsharing Program

The board's role in the process of developing a gainsharing program is to act as steward of the hospital, to ask the right questions and hold management responsible for implementing a solid gainsharing plan. Some of the questions a board member should ask include:

- **What are the specific objectives for proceeding with this program? What are the clinical goals (e.g., to reduce length of stay, increase formulary compliance or product standardization)? What are the cost-savings goals?**
- **What other models are there for aligning hospital and physician interests? What are the pros and cons of each?**
- **What other hospitals or health systems have implemented gainsharing programs, and has someone from our organization talked to them about their experiences?**
- **Is there adequate physician representation and involvement in the process? Have all physicians signed a conflict-of-interest statement? Is there a process in place to update the conflict-of-interest statement annually?**
- **Is there an implementation plan in place with clearly defined action steps, accountabilities, costs and time frames? Does the hospital have clear expectations of the physicians? What is the estimated cost of implementing a program?**
- **Who is providing legal counsel? (Make sure that approval by the OIG is also included in the timeline, recognizing that sometimes OIG review can take up to a year and a half.)**
- **Will the hospital use a consultant to help with the process? (Hospitals often find it helpful to seek outside help to walk them through the process.)**
- **Who will provide the software to track costs? (Again, hospitals may find that it is easier to contract with an outside vendor to ensure complete objectivity and data integrity. This is also a way to gain physicians' confidence.)**

While board members have a lot on their plates, they should expect to receive at least quarterly updates on the gainsharing program's development. Once the program is implemented, quarterly updates should be provided on its cost savings and the progress made in reaching the goals.

implementation costs; the uncertainty regarding re-basing cost targets in the second year, which could limit the hospital's anticipated cost reductions; and the long delay that the OIG advisory opinion process likely represents.

Even if the path is cleared, gainsharing still may not be the best solution for every organization. Says Ellis: "I think it is different for all facilities, and I don't know if gainsharing is going to work for every hospital." He adds, "Providence is more of a specialty cardiovascular facility. We have the largest open-heart program in South Carolina. Based on our volumes, gainsharing makes a lot of sense. But gainsharing may not make sense in a university setting, in a hospital where the physicians are employees, or in smaller facilities."

Boards are urged to stay informed for continued developments in gainsharing. Experience is very limited, since the OIG has only issued the six recent advisories and one previous advisory opinion in 2001; however, that number may rise as hospitals and physicians continue to seek options to align their interests for the future. When structured properly, gainsharing arrangements have the potential to decrease hospital and system supply costs and increase efficiency and quality.

Despite the obvious work involved and the long-term commitment hospitals must make to receive OIG approval, gainsharing does offer a unique set of rewards for hospitals and physicians willing to work together.

Dutton believes that possible pending legislation could have a significant effect on gainsharing. "Congress has recently become more aware of the merits of gainsharing from the Medicare Payment Advisory Commission (MEDPAC) report in March 2005.

"If Congress approves gainsharing," says Dutton, "then administratively it will become simpler to implement because you would not have to receive an advisory opinion from the OIG. And, it will become clearer what you can and cannot do with these programs. If this happens, gainsharing could really take off."

Case Study for Success: Sisters of Charity Providence Health System

The Sisters of Charity Providence Hospital (SCPH), part of the Sisters of Charity of St. Augustine Health System (CSA), is a 322-bed acute care hospital in Columbia, S.C. The hospital is one of only four to have received the Office of Inspector General's (OIG) approval last year for its two gainsharing programs, one for cardiovascular surgery and one for cardiology.

SCPH was already successful in working with its medical staff on cost reductions. The organization had been benchmarking its performance against that of its peers and sharing this information with the board and medical staff. In the late 1980s and early 1990s, its physicians had worked closely with the hospital on numerous issues that had an impact on cost and quality, such as utilization and product selection. At the time, the hospital was struggling with new technology, such as cardiac stents, which allowed physicians to provide clinical innovation, but at a premium price. During the mid-1990s, as these demands continued to grow, SCPH began to talk with consultants about ways to move forward, but because of the legal ramifications of the Stark amendments, it was impossible to proceed. In addition, there was the question of how quality would be affected.

According to Larry Ellis, senior vice president for SCPH's cardiovascular services, in 2002 the hospital began working with Joane Goodroe, president and CEO of Goodroe Healthcare Solutions LLC, Atlanta. Goodroe had worked with St. Joseph's Hospital in Atlanta to help the organization achieve the first gainsharing approval from the OIG in 2001. SCPH's management knew this model had worked and looked to St. Joseph's for advice. The board received regular updates, and the executive committee was deeply involved in several of the discussions. When the time came to make a decision, management and the board reviewed a list of pros and cons. The board knew the health care industry was struggling with the escalating cost of supplies and new technology. At the same time, it was important to make technology available to patients, strengthen quality of care and achieve desired outcomes. One of the safeguards favorably looked upon by the OIG is a system to monitor clinical outcomes for surgery. This software allowed SCPH to track a supply item from a patient, to a physician, and to an outcome. For example, if a cardiac catheter was substituted for one offered by a different manufacturer and was deemed therapeutically equivalent by the medical staff, then physicians could see the cost and efficacy data related to that change.

The gainsharing program began last year, involving 57 cardiologists on staff and has already achieved several million dollars of savings. "What's important for boards to realize," says Ellis, "is that any time you can align a hospital and its physicians in the right direction, you are in a win-win situation. In our organization, we were able to lower our costs, and the patients, physicians and the hospital benefited from the effort." While Ellis concedes the organization may re-evaluate the program in the next several years as the health care marketplace changes, he says, "I'm very excited about what we are doing."

For Additional Reading

1. OIG Advisory Opinions Nos. 05-01-05-06. http://oig.hhs.gov/fraud/advisory-opinions/opinions.html
2. Testimony of Lewis Morris, Chief Counsel to the Inspector General, U.S. Department of Health & Human Services; House Committee on Ways and Means; Subcommittee on Health; Hearing Oct. 7, 2005. http://oig.hhs.gov/testimony/docs/2005/ Gainsharing10-07-05.pdf
3. ABA Health eSource, November 2005, "The New Gainsharing—Has Anything Really Changed?" www.abanet.org/health/esource/vol2no3/dean.html
4. BNA's Health Care Fraud Report, June 8, 2005, "Gainsharing: Regulatory Breakthrough, but Challenges Remain." **T**

Created from original content in *Trustee Magazine* March 2006 Vol. 59 No. 3