Legal Concerns Hinder Adoption of Gainsharing

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Hospitals are reluctant to offer physicians a portion of the savings generated by reducing clinical costs—a concept known as gainsharing—because of legal fears, D. McCarty Thornton, said during an audioconference on gainsharing sponsored by the Integrated Healthcare Association.

"It's clear, I think, that gainsharing is not on the fast track," said Mr. Thornton of the law firm of Sonnenschein, Nath, and Rosenthal LLP, based in Washington.

In the long run, gainsharing approaches that can save money without impacting patient care are likely to take hold, he said, but first hospitals need clarification from Congress, the Health and Human Services secretary, and the Office of Inspector General about what arrangements are allowed.

In 1999, the HHS Office of Inspector General issued a special advisory bulletin saying that the civil monetary penalty provision of the Social Security Act prohibits most gainsharing arrangements. Under that provision, hospitals are prohibited from making payments to physicians to reduce or limit services to Medicare and Medicaid beneficiaries.

The advisory bulletin said that these types of arrangements could also trigger the antikickback provisions of the Social Security Act, which prohibits arrangements used to influence the referral of patients in federal health care programs.

"Historically, the office has been somewhat leery of gainsharing arrangements," said Catherine A. Martin, OIG senior counsel.

Since the 1999 bulletin, the OIG has issued a number of advisory opinions which outline gainsharing arrangements that would be allowable. In general, in order to give the green light to a gainsharing arrangement, the OIG looks for transparency and accountability, quality of care controls, and safeguards against kickbacks, she said.

In order to be transparent, any actions taken to save costs need to be clearly and separately identified and fully disclosed to patients. Hospitals must also put in place controls to ensure that cost savings do not result in the inappropriate reduction of services. OIG officials also want to see ongoing monitoring of quality by the hospital and an independent outside reviewer, Ms. Martin said.

But OIG is not the only regulator that hospitals and physicians need to consider when embarking on gainsharing arrangements, Ms. Martin said. Hospitals and physicians must also keep from running afoul of the Stark self-referral prohibitions, which fall under the purview of the Centers for Medicare and Medicaid Services. Gainsharing arrangements must also meet Internal Revenue Service rules, and hospitals are at risk for private lawsuits, she said.

But the industry is keeping an eye on two demonstration projects that test the gainsharing concept in the Medicare fee-for-service program. Both projects are set to begin this year.

The first project, which is required under the Deficit Reduction Act of 2005, will involve six hospitals and will focus on quality and efficiency in inpatient episodes and during the 30-day postdischarge period. The DRA provision waives civil monetary penalty restrictions that would otherwise prohibit gainsharing.

The second project will focus on physician groups and integrated delivery systems and their affiliated hospitals. The demonstration will include inpatient episodes, as well as the pre- and posthospital care over the duration of the project. This demonstration was mandated the Medicare Modernization Act of 2003.

Participants in both demonstrations will be required to standardize quality and efficiency improvement initiatives, internal cost savings measurement, and physician payment methodology, said Lisa R. Waters, a project officer with the division of payment policy demonstrations at CMS.

But CMS officials are looking to test various gainsharing models so participants will have flexibility in how they choose to target savings from reducing the time to diagnosis and treatment to improving discharge planning and care coordination.

There are some alternatives and variations on gainsharing that are occurring in the marketplace, Mr. Thornton said. For example, hospitals can move forward with nonmonetary gainsharing, in which the savings are earmarked to improve physicians' work lives by upgrading surgical suites or through better scheduling. ■