Legal Fears Are Slowing Gainsharing Arrangements

BY MARY ELLEN SCHNEIDER
New York Bureau

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, a partner with 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 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, Ms. Martin said.

Before it approves a gainsharing arrangement, the OIG looks for transparency and accountability, quality of care controls, and safeguards against kickbacks.

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 6 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.

Another option is to proceed with standard gainsharing but to carve out Medicare and Medicaid patients, who fall under federal statutes. However, the OIG has been skeptical of carve-out scenarios, Mr. Thornton said. ■

Tablet PC Can Enhance the Visit for Physician and Patient

BY BRUCE K. DIXON
Chicago Bureau

For Dr. Rod Tanchanko's patients, his tablet PC has become as emblematic of the internist as the traditional stethoscope.

That ever-present computer is the locus of a complete electronic medical records (EMR) and practice management system, according to Dr. Tanchanko, who is in solo practice in Middletown, Del.

Tablet PCs are equipped with a sensitive screen designed to interact with a complementary stylus. Because the user is interacting directly with the screen, rather than through a mouse and keyboard, the PC is more portable and easier to use than laptops and can even be used while standing.

Each morning, Dr. Tanchanko starts the EMR program and opens his Internet browser. Wireless access provides immediate access to patient records and other information.

"I have a folder for my most commonly used patient education materials, and there's another folder for vaccine information sheets, and another for screening forms for various conditions. We're virtually paperless. Charts, lab data, patient records … everything is right there at my fingertips, most often in PDF format," he said in an interview.

Dr. Tanchanko prints documents and patient education materials directly off the Web, from sources such as the American Academy of Family Physicians (www.familydoctor.org) and Medscape (www.medscape.com).

"Medscape even has animations, which are a wonderful teaching tool for conditions such as disk herniation. For evidence-based and medication information, I access the American College of Physicians' Physician Information and Education Resource, or PIER, and Epocrates, which serves as backup to my EMR's e-prescribing feature," he explained.

Efficiency is further enhanced with central printing, so that all printed materials, including controlled prescriptions, are ready by the end of the patient's visit, Dr. Tanchanko said.

Why carry a tablet PC instead of installing computer stations? "The tablet PC allows better face-to-face contact with the patient, it's portable, and I don't have the expense of buying and installing desktop computers," he explained.

"This system significantly reduces clutter, keeps materials up to date, boosts efficiency, and, best of all, the information is almost free. It has enhanced the visit experience for both myself and for patients, who generally feel that I have done a little extra for them," he added.

Dr. Tanchanko is author of "An EMR Journey," an e-Book available at www.anemrjourney.com that recounts his experiences with adopting an EMR system into his practice. The e-book offers practical and real-world advice on EMR implementation. ■

Paperless Direct Admission Form Increases Efficiency

BY BRUCE K. DIXON
Chicago Bureau

If you're tired of filling out hospital admission forms by hand, Dr. Arnold Jay Simon offers a suggestion: Switch to a paperless direct admission form.

"My hospital created a paperless direct admission form for me using the Microsoft Word form field, and the form was sanctioned by the hospital executive committee," said Dr. Simon, a solo-practice internist specializing in geriatrics in Palm Springs, Fla.

A simple Word form saves the physician from the 'dreaded' task of copying out by hand a long list of medications.

"The form fits perfectly into my routine and eliminates the inefficient process of hand-copying data from computer screen onto little boxes on the old paper form, which I hated," he said in an interview. Dr. Simon opens the form at the end of an office visit when he feels a patient needs to be admitted to the hospital.

"I can easily navigate through the form fields using the tab key to add, delete, or change small amounts of patient data," Dr. Simon said. Larger entries, such as office notes and patient medications, can be pasted into the form. "This simple Word form has saved me the dreaded task of having to copy a long list of medications by hand onto the admission form. Using the tab keys and the cut-and-paste feature saves me a lot of time and reduces errors," he explained.

Hospital personnel and patients are happier because the information is easier to read and hospitalizations are expedited. "The nursing staff appreciates having neatly typed admit forms faxed to them," Dr. Simon added. ■

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