

THE CURRENT STATE OF GAINSHARING

JOHN L. GREEN, ESQ. & PETER L. JENKINS, ESQ.

BACKGROUND. With the ever-rising cost of health care, health care organizations are always looking for ways to reduce spending and become more efficient. One way to do this is commonly known as “gainsharing.” While there is no single definition of gainsharing, such arrangements generally involve financial incentives given by hospitals to physicians in order to induce the physicians to reduce costs. In a typical gainsharing arrangement, the incentive would equal a percentage of any cost savings achieved that could be directly traced to the efforts of the physician. An example of a cost savings method that might be a part of a gainsharing relationship includes the substitution of less costly items with similar characteristics to those items currently in use in an operating room.

Essentially, gainsharing aligns the interests of physicians with the interests of the hospital by providing a financial incentive for the physician to find a less costly method of providing the same level of medical care to his or her patients. While aligning the interests of the hospital and its physicians may sound like a reasonable way for a hospital to reduce overhead expense, such arrangements have historically been viewed by the government as a violation of Federal law. Specifically, the federal government has taken the position that gainsharing arrangements violate Sections 1128A(b)(1) and (2) of the Social Security Act (the “Act”), the anti-kickback statute, and other statutes and regulations.

Social Security Act. In July of 1999, the Office of the Inspector General for the Department of Health and Human Services (“OIG”) released a Special Advisory Bulletin (the “Bulletin”) discussing the OIG’s perspective on gainsharing. In the Bulletin, the OIG stated that absent legislative relief, the civil money penalty in Section 1128A(b)(1) of the Act prohibited any gainsharing arrangement which involved payments by or on behalf of a hospital to physicians for the purpose of inducing a reduction or limitation of services to Medicare or Medicaid patients. The purpose for this broad prohibition was to prevent the creation of a conflict of interest that would limit the ability of physicians to exercise their professional judgment in a manner that was in the best interests of their patients.

Anti-Kickback Statute. The purpose of the anti-kickback statute is to prevent the payment of any remuneration in exchange for referrals, the result of which would be reimbursement by a federal health care program. Gainsharing arrangements can violate the anti-kickback statute if one purpose

of the cost savings payments is to influence physicians to make such referrals. This can be the case when a gainsharing arrangement is set up in order to induce a physician to send healthier (and therefore less costly) patients to an institution that offers gainsharing payments, while sending sicker (and more costly) patients to hospitals

which are not making such payments. The anti-kickback statute would also be implicated if a hospital is offering gainsharing payments in order to attract referrals from new physicians or a greater number of referrals from physicians already on the medical staff.

Stark. The purpose of the Stark law is to prevent physicians from referring patients for the provision of designated health services (“DHS”) to entities with which the physician has a financial relationship. While enforcement of the Stark law falls to the Centers for Medicare & Medicaid Services (“CMS”), the OIG has commented that gainsharing arrangements may also be a violation of Stark. This is because a gainsharing arrangement is considered a financial relationship, and the services involved are almost always DHS. Therefore, in order for a gainsharing arrangement to comply with Stark, it must be structured so as to fall within one of several enumerated exceptions to the law. There is no current specific exception for gainsharing plans.

OIG’S CURRENT APPROACH. In early 2005, the OIG signaled a shift in its thinking with regard to gainsharing arrangements. In a series of six advisory opinions issued in February of this year, the OIG concluded that while the gainsharing arrangements did violate the CMP and anti-kickback statutes, because various measures were taken to reduce the risk of fraud or abuse, sanctions would not be imposed.

In reaction to these opinions, many individuals commented that the OIG had “opened the door” for the proliferation of gainsharing. However, a careful reading of the OIG’s opinions reveals that the OIG has not simply given the green light for gainsharing in any form. As stated above, in each instance in which the OIG decided not to impose sanctions, the gainsharing arrangement contained safeguards to prevent hospitals and physicians from using the gainsharing arrangement for improper purposes.

On October 7, 2005, in testimony before the House Ways and Means Committee, Lewis Morris, Chief Counsel to the Inspector General, discussed the OIG’s views on gainsharing and offered additional perspective on the recent gainsharing advisory opinions. Mr. Morris informed the committee that:

“Properly structured, gainsharing arrangements may offer opportunities for hospitals to reduce costs without causing inappropriate reductions in medical

services or rewarding referrals for Federal health care program patients. In a number of specific cases, OIG has concluded that the arrangement presents a low risk of abuse and, therefore, exercised its prosecutorial discretion not to impose sanctions. However, absent a change in law, it's not currently possible for gainsharing arrangements to be structured without implicating the fraud and abuse laws."

With regard to the recently issued advisory opinions, Mr. Morris acknowledged the favorable nature of the rulings, but unequivocally stated that those opinions were limited to the specific facts and circumstances of the parties requesting the advisory opinion. He did, however, recognize that factors identified in the opinions are also relevant when assessing the viability of other gainsharing arrangements as well. These factors include, but are not limited to, whether a gainsharing program has the necessary accountability, quality controls, and safeguards against the payment for referrals built into the arrangement. Concerning such factors:

Accountability. OIG believes that accountability in a gainsharing arrangement is achieved through the creation of a transparent arrangement, "that clearly and separately identifies the actions that will result in the cost-savings..." This will allow those individuals administering the program to conduct an objective assessment of the effect that the gainsharing arrangement has on patient care. According to Mr. Morris, transparent gainsharing arrangements should also include (i) full disclosure to each patient that his or her physician is participating in the gainsharing program, and (ii) methods which allow the scrutiny of each physician act attributable to the gainsharing arrangement so that the medical malpractice liability system can act as an additional safeguard against inappropriate care.

Quality Controls. Quality controls were also important to the OIG when determining whether a gainsharing arrangement would be detrimental to patients. When evaluating a gainsharing arrangement, the OIG will determine whether there are adequate measures in place to protect the quality of care that patients receive. "For example, the OIG believes it is important to have a qualified, outside, independent party perform a medical expert review of each cost-savings measure to assess the potential impact on patient care." Such monitoring would not, however, cease at the inception of the gainsharing program. "The arrangements OIG approved also include ongoing monitoring of quality of care and compliance with the gainsharing program." These types of precautions will help to eliminate the risk that a physician will make medical decisions based upon fiscal incentive rather than what is medically appropriate.

Safeguards Against Payment for Referrals. When determining whether a gainsharing arrangement is really a method by which a hospital is attempting to procure referrals, the OIG has focused on how the gainsharing payments are calculated and distributed to participating physicians. Examples of appropriate safeguards include: "calculating savings

based on the hospital's actual acquisition costs; limiting participation to physicians already on the hospital's medical staff (to prevent enticing other physicians to change referral patterns); limiting the amount, duration and scope of the payments (there is less incentive for a physician to switch referral patterns for short-term dollars); and distributing the gainsharing profits on a per capita basis."

CONCLUSION. While the above factors are those that have been used by the OIG to determine whether to impose sanctions on parties engaged in gainsharing in the past, it is important to remember that the OIG approaches, at least initially, each gainsharing arrangement as an automatic violation of the CMP and anti-kickback statute. Therefore, each gainsharing arrangement is going to be evaluated on a case-by-case basis, and improperly structured arrangements still pose a substantial risk. In addition, each gainsharing arrangement must also comply with the Stark regulations which are enforced by CMS rather than the OIG. Therefore, while the OIG has signaled that not all gainsharing arrangements will be subject to sanctions and/or penalties under the CMP or anti-kickback statutes, other regulatory hurdles to gainsharing exist. Accordingly, physicians and hospitals should consult with qualified advisors before entering into any type of gainsharing arrangement.