

## Is There A Future for Hospital/Physician Gainsharing?

by Mark Stadler

**F**aced with ever dwindling third party payments, hospitals continue to seek opportunities to control costs and promote efficiency while maintaining or enhancing the quality of care. Physician behavior is a critical component of this endeavor. In an effort to persuade physicians to become partners with them working to control costs and promote efficiency, many hospitals have implemented (or are considering) gainsharing programs. On July 8, 1999, the Office of Inspector General ("OIG") attempted to derail these programs by issuing an advisory opinion stating that federal law clearly prohibits gainsharing arrangements. This article will explore gainsharing programs in general, the impact of this OIG advisory opinion and the future prospects for gainsharing.

### What Is Gainsharing?

Gainsharing is a process through which physicians share in the cost savings hospitals realize as a result of strategies jointly implemented to lower costs, improve efficiency and enhance medical care. It provides economic incentives for physicians to act more cost consciously and efficiently in providing quality medical care in the hospital setting.

### How Does Gainsharing Work?

Most gainsharing programs follow a common set of principles:

1. Physicians within a given specialty work with the hospital to identify potential cost savings and develop strategies to realize those

savings while maintaining or enhancing the quality of care. For example, a group of anesthesiologists might help develop a program for greater efficiency in using hospital-employed department personnel; a group of surgeons might assist through more effective scheduling of surgeries or by agreeing to a single supplier of surgical supplies; a group of practitioners (such as cardiologists) might help standardize care and eliminate or reduce often unnecessary tests or other procedures by developing recommended care plans or treatment protocols for particular medical conditions.

2. A hospital (typically in consultation with the involved physicians) develops ways to measure the cost savings realized. Most often, this is done by comparing costs in a given year to a predetermined base year. Other alternatives include comparing actual costs to a projected budget or determining average cost savings for particular DRGs.

3. The physicians are compensated for participating. This can be fixed fee compensation (i.e., a predetermined fee or per-hour charge for time devoted to the program), but is most often shared cost savings. Typically, the physicians receive a share (usually 50% or less) of the savings realized.



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4. Safeguards ensure that no payments are made when no savings are realized, patient satisfaction declines or the quality of care decreases.

### The Advisory Opinion

The OIG advisory opinion concludes that gainsharing initiatives are inconsistent with a federal statute which prohibits a hospital from making payments to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. While recognizing gainsharing's value in containing costs, the OIG laments that it cannot provide any regulatory relief in this area (such as rulings) absent an amendment to the statute. The OIG also advises hospitals to immediately undo existing gainsharing arrangements. If they do, the OIG suggests that it may ignore the fact that the terminated programs were illegal.

This opinion, especially its bluntness in concluding that gainsharing programs are clearly prohibited by federal statute, was largely unexpected. However, it may not be a total knock out punch to gainsharing. It remains to be seen whether federal authorities will vigorously challenge gainsharing arrangements based on the federal law underlying the OIG's opinion. Most agree that healthcare cost containment initiatives should be encouraged. In an era of shrinking Medicare dollars, it would be bad policy to hamstring hospital cost containment efforts. Also, the opinion

itself notes that certain fixed fee arrangements can work. Finally, the federal law underlying this opinion applies only to Medicare and Medicaid beneficiaries. Gainsharing programs which do not encompass these beneficiaries are not affected.

### Other Legal Risks?

Gainsharing programs also pose other regulatory/liability risks.

#### 1. Tax Exemption

Among the concerns here are:

- Will the program jeopardize the hospital's tax-exempt status?
- Will the program expose the physicians to substantial excise taxes through the intermediary sanction rules?
- Will the tax-exempt nature of an outstanding hospital bond financing be jeopardized?

Historically, the IRS has looked favorably upon hospital incentive compensation plans so long as it could be demonstrated that the plans (a) were consistent with the organization's exempt status, (b) were reasonably designed to accomplish its exempt purposes and (c) ensured payment of no more than reasonable compensation. Most recently, the IRS issued two unpublished private letter rulings holding that gainsharing programs would not adversely affect tax exemptions.

Although gainsharing programs must be carefully designed with these issues in mind, current law indicates that effective programs can be adopted and implemented without raising unresolvable tax exemption issues.

#### 2. Anti-Kickback Law

It is extremely difficult to fashion a gainsharing program (especially one which shares cost savings on a percentage basis) which will fall neatly within a safe harbor. However, this does not render those programs illegal or clearly suspect. Payments flowing to the physicians should be consistent with the fair market value of the services rendered. Also, remember that the anti-kickback rule is intended to punish overutilization of services, and an effective gainsharing program can be justified as being consistent with this. Nonetheless, gainsharing

programs cannot be used as a subterfuge to compensate physicians for patient referrals or admissions.

#### 3. Stark II

Virtually all gainsharing programs will qualify as "compensation arrangements" between the involved physicians and hospitals under Stark II. In addition, under most circumstances the involved physician services will fall within the categories of "designated health services" subject to Stark II. Unless and until certain proposed Stark II regulations are more fully developed and adopted, it is unlikely that most gainsharing programs will be able to fit neatly within one of the Stark II exceptions. A technical application of Stark II would preclude physicians participating in a gainsharing program from referring patients to the involved hospital.

#### 4. Liability Concerns

Hospitals and physicians who participate in gainsharing programs should recognize that their malpractice liability exposure may be adversely affected. Plaintiffs' counsel who become aware of such programs will try to characterize them as attempts to marginalize patient care for the sake of cost savings. Incorporating adequate safeguards to ensure that patient care is not compromised can minimize such an argument's impact.

#### Practical Considerations

Given the fact that gainsharing programs are relatively new to the hospital industry, it is difficult to statistically validate what is reasonable compensation for a physician's participation. Avoiding many of the above legal issues requires adequate documentation of reasonable compensation. If these programs are allowed to continue, the data that will become available will help determine what that compensation should be.

As with many hospital/physician initiatives, a key to developing an effective gainsharing program is the extent to which a group of otherwise unaffiliated physicians cooperate. A gainsharing program will be much more defensible if it encompasses a broad group of physicians and payments are made to the group as a

whole rather than to individual physicians. Of course, the group has to be able to function effectively in ascertaining eligibility to participate and the distribution of incentive payments. Your physician/hospital organization may be a highly effective vehicle for addressing these issues.

Hospital based physician groups (radiology, anesthesiology, pathology, etc.) often present the best opportunity to implement gainsharing programs. An organized group is already in place and has a contract negotiated with the hospital. With amendments to the contract, appropriate incentives can control department costs while maintaining quality care. A portion of the savings can be shared with the physician group.

#### Conclusion

By creating a joint venture between the hospital and physicians to control costs, gainsharing programs can provide significant benefits for both. However, significant problems arise within the existing regulatory framework. In light of the recent OIG advisory opinion, currently the most cautious approach would be to immediately undo all existing gainsharing deals and await further federal guidance before venturing back into these waters. This additional guidance is likely to arrive fairly quickly. Some forms of meaningful gainsharing will probably be permitted. Under all circumstances, a facility continuing with an existing program or creating a new one must pay careful attention to the applicable legal concerns and recognize that significant risks are inherent in virtually all gainsharing programs. If you decide to proceed with gainsharing, you must develop a well-thought out and well-structured plan which acknowledges the regulatory risks and affirmatively seeks to minimize them as much as possible.

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