For the first time, the government has issued a favorable ruling on a spinal-fusion surgery gainsharing arrangement between a hospital and physicians. In the ruling, issued July 31, the Health and Human Services Office of Inspector General (OIG) explains why it won’t impose sanctions for the arrangement, which could potentially violate the law. The ruling was the 11th on gainsharing for Goodroe Healthcare Solutions, a unit of VHA, Inc. The other opinions have been in cardiovascular and anesthesia services.

Gainsharing is a structured plan in which a hospital and physicians agree to share savings while demonstrating they are not “cherry picking” healthier patients, inducing referrals, or stinting on patient care.

In the project, the Goodroe group studied the surgeons’ historic practice patterns and identified 36 cost-saving opportunities. The hospital and surgeons then decided which changes to adopt. The opportunities were in 2 major categories:

• Limiting use of bone morphogenic protein (BMP) to an as-needed basis, following clinical indicators. Before the project, BMP was used in 15% of cases. The physicians determined usage could be reduced to 11% without an adverse effect on patient care.

• Standardizing spinal fusion devices and supplies where medically appropriate. To pass muster with the OIG, the hospital had to make available the same selection of devices and supplies as before. Savings had to come, not from limiting devices and supplies, but from decisions about “clinical and fiscal value.” Data were monitored to ensure savings came solely from the project, and patients had to be informed about the project.

Direction set by MDs

It’s critical that direction for the project is set by the physicians, Joane Goodroe, founder of Goodroe Healthcare Solutions and VHA senior vice president of innovation, told OR Manager.

“It’s not about getting down to certain vendors,” she says. Instead, the project focuses on examining how the surgeons perform the procedures, assembling the data, and having the surgeons compare notes on their practice.

“It’s amazing how many different products they use, and no two surgeons are using the same thing,” she says.

“The data piece is probably the most underappreciated part,” Goodroe adds, because the analysis involves more than looking at the cost of individual items. The project might, for example, focus on a 2-level fusion, gather data about how the surgeons perform that procedure, determine the costs, show the data to the surgeons, and have them discuss their practice patterns. The savings stem from their discussions.

One of the biggest learning curves for the physicians is how much effort the project involves, Goodroe notes. Some decide they want to spend the time, while others do not.

She estimates administrative costs of a project are about 10% of the total savings.

Does every gainsharing project require an OIG opinion?

That’s up to the lawyers, Goodroe responds. Some legal teams believe they
have enough guidance from previous opinions and don’t need an opinion, whereas others still feel they do.

Each project the Goodroe group has done follows the same model, she notes. She says VHA has over 30 such projects underway.

**What difference does gainsharing make?**

A new study examines the effects of 13 gainsharing programs in coronary stent patients using the Goodroe model. Compared to other hospitals, gainsharing hospitals reduced costs by 7.4% per patient. Most of the savings, 91%, came from lower prices on drug-eluting stents, with 9% from reducing utilization of stents and other products. The average payout to physicians was $17,000.

The findings indicated gainsharing didn’t change physician referral patterns nor did it seem to limit patients’ access to stents. Gainsharing also seemed to improve physicians’ compliance with evidence-based practice, such as use of anti-thrombolytic therapy. The study by Ketcham and Furukawa is in the May-June 2008 *Health Affairs*.

**Catching on?**

Is gainsharing catching on?

The government is looking at creating an exception in the physician self-referral law to allow incentive payments and “shared-savings programs.” The Centers for Medicare and Medicaid Services (CMS) asked for comments on the idea in the physician payment rule published in July. But the government has been considering gainsharing for more than 10 years, and it’s not clear whether there will be action this time.

The American Hospital Association (AHA) supports the exception but says the CMS proposal is too complex and costly. Instead, AHA says CMS should allow hospitals and physicians to use protocols and evidence-based practices already developed as part of gainsharing.

Whatever the specifics, Goodroe says health care must make headway on eliminating waste and variability. With predictions that Medicare will be out of funds by 2018, “we’ve got to get waste out of the system. Waste isn’t bringing benefit to patient care.” She says the model her group has developed is one that has been shown to work.

*OIG Advisory Opinion No. 08-09 is at www.oig.hhs.gov/fraud/advisoryopinions.html.*