New rulings on sharing savings with MDs

New government rulings are creating a buzz about the potential to share cost savings with physicians for high-cost items like cardiac devices and orthopedic implants.

The Health and Human Services Office of Inspector General (OIG) issued 6 favorable opinions in February on “gainsharing” projects in which hospitals would share cost savings directly with physician groups. All were developed by Goodroe Healthcare Solutions (www.goodroe.com), an Atlanta-based consulting firm.

Observers say the rulings may open doors for aligning incentives with physicians to help control costs for physician-preference products, one of ORs’ biggest cost challenges.

The news caused some Wall Street analysts to upgrade prospects for stocks of for-profit hospital companies and lower ratings for orthopedic vendors.

A ‘game changer’?

The OIG opinions represent “a real game changer,” wrote analysts for investment bankers Leerink Swan & Co. If the projects take hold, they said orthopedic companies might not be able to sustain the 4% to 5% annual price increases they have been seeing.

Following suit, HCA, the nation’s largest hospital chain, said in February it plans to buy hip and knee prostheses only from the 3 largest manufacturers, down from about 6 now, the Nashville Tennessean reported. HCA also said it would ask the OIG for a ruling on sharing cost savings with physicians.

“It seems like there is some wind in the sails” for gainsharing, says George Martin, MD, senior director of clinical process improvement for VHA Inc, co-author of the first gainsharing proposal reviewed by the OIG in the late 1990s.

The rulings could be a “lever to bring hospitals and physicians together,” he notes, saying tens or even hundreds of facilities might be moving in that direction by the end of the year.

Carefully designed safeguards

The OIG made clear the arrangements passed muster only because they were designed to prevent abuse (sidebar, p 8). Officially, an OIG opinion applies only to one set of facts and should not be construed to apply to other situations. But observers thought the opinions might signal a shift in the OIG’s approach to anti-fraud statutes.

Joane Goodroe, president of Goodroe Healthcare Solutions, has refined her gainsharing model for several years. Two of the hospitals involved are PinnacleHealth, Harrisburg, Pa, and Sisters of Charity Providence Hospital, Columbus, SC. Goodroe did not disclose names of the others.

Typically, the OIG has not allowed hospitals to share cost savings with physicians because such projects could sway physicians’ judgment and potentially undermine care for Medicare and Medicaid patients. For example, physicians might deny patients more expensive devices or shift more costly patients to other hospitals. These types of arrangements generally are illegal and could lead to big fines.

In fact, the OIG found most aspects of the arrangements it ruled on were potential violations but said the government would not impose sanctions because of the way the projects were designed.

Good data key

A major key to designing gainsharing projects properly is good data systems.

“We have developed software to measure cost, quality, and utilization both before and after the target opportunities,” Goodroe told OR Manager. Her firm
claims to have data on more than 1 million cath lab and open-heart procedures for comparison.

The OIG noted that for each cost-saving recommendation, there was a way of measuring historical practice patterns and comparing them to practice after the project began so savings could be clearly identified and quality monitored.

For example, assume surgeons at your hospital use aprotinin in 80% of coronary artery bypass cases to help reduce the need for blood transfusion. Some use it all the time, others not at all. The literature might support using aprotinin on 10% of cases with certain indications. If you found only about 10% of your cases met criteria for aprotinin, your hospital might decide it could reduce utilization from 80% to 15% without risk. If you had access to benchmarking data, you could compare your practice with others for further guidance.

Goodroe maintains having an “outside party,” such as her firm, do the data analysis and monitoring is another safeguard. The firm is paid a monthly set fee not tied to cost savings.

No guarantee

Hospitals need to be clear about what these projects entail, observes Karen Barrow, RN, vice president of the group-purchasing organization Amerinet. “It takes a lot of time, and there is no guarantee” the plan will get past the OIG, she says.

Even with the new rulings, hospitals that want to emulate the projects would need to seek an OIG opinion or at least close scrutiny by their attorneys.

Also, the project has to be fully disclosed to patients before admission. The arrangement also could negatively affect clinical research or consulting arrangements physicians have with vendors. When physicians learn this, Barrow finds they often hesitate, especially in orthopedics.

As an alternative, she finds they often are interested in projects with indirect rewards. For example, the hospital might agree that, if physicians help save money on implants, half of the savings will go to purchasing equipment such as power drills for orthopedics to help shorten turnover time. 

—Pat Patterson

The opinions (05-01, 05-02, 05-03, 05-04, 05-06, and 05-07) are at http://oig.hhs.gov. Look under Fraud Prevention and Detection, then Advisory Opinions.

Highlights of gainsharing opinions

These are highlights of the advisory opinions from the Health and Human Services Office of Inspector General.

Proposed arrangement

A hospital would share with a physician group a percentage of the hospital’s cost savings that come directly from specific changes in the physicians’ practices. For example, the surgeons agree to use some less costly items during surgery and agree to standardize on some products.

The hospital would pay the surgeon group 50% of the cost savings for implementing a set of recommendations over a 1-year period. At the end of the year, the saving would be calculated for each of the recommendations by subtracting the actual cost from the baseline. The surgeon group would distribute profits to its members on a per capita basis.

Questions for the OIG

1. Would this arrangement be subject to civil money penalties because it could induce a physician to reduce or limit services to Medicare or Medicaid patients?

2. Would the arrangement be subject to civil money penalties under the anti-kickback statute, which prohibits inducing physician referrals?
What the OIG said

Though the proposed arrangement would be improper and could potentially generate payments to physicians prohibited by the anti-kickback statute, the OIG would not impose sanctions.

Features of arrangement

In OIG opinion 05-01, for example, a consultant studied historical practices in a hospital’s cardiac surgery department and identified 24 specific cost-saving opportunities in 4 categories:

1. Opening packaged items, such as surgical trays, only as needed during the procedure. One example is disposables for the cell saver. The items would be readily available if needed.
2. Performing blood cross-matching only as needed. All patients would be typed and screened before the procedure, with the cross-match performed only when the patient requires a transfusion. The hospital does not outsource its blood supply. The delay in blood readiness should be minimal when a cross-match is necessary and would not adversely affect patient care.
3. Substituting less costly items for the items currently being used by the surgeons.
4. Standardizing certain cardiac devices where medically appropriate. The surgeons would work with the hospital to clinically review the vendors and products.

Safeguards

The arrangement had these safeguards to protect against inappropriately reducing service to patients:

• For the cell saver, blood cross-matching, and product substitution, objective historical and clinical measures would be used to establish a “floor.” If the measure fell below the floor, surgeons would not receive a share of the savings. For example, the cell saver is set up for 100% of the cases but is used on about 30% of cardiac procedures. The surgeon group would not receive a share of any savings that reduced cell saver use below the 30% floor.
• For product substitution, historical usage was analyzed and thresholds established. Surgeons would not receive cost savings for savings beyond that threshold. For example, data indicated that certain less-expensive catheters could be used in 90% of cases without adversely affecting care. Thus, any savings from using less expensive catheters in more than 90% of cases would not be credited to the surgeon group.
• The surgeons would make a patient-by-patient decision on the most appropriate cardiac device to use. Individual surgeons would still have the same selection of devices as they did before the project began.

Other safeguards

• The volume of services would be monitored, and physicians would not share in cost savings for additional procedures performed over the volume in the base year.
• Patient demographics and severity of illness would be monitored to make sure physicians were not shifting more costly patients to other hospitals.
• Patients would be informed about the cost-saving project in writing.

Why OIG would not impose sanctions

These are reasons the OIG said it would not impose sanctions on these arrangements:

• Cost savings for each separate recommendation were clearly identified.
• There was medical input to ensure the savings did not adversely affect care.
• Payments to MDs would be based on all surgery regardless of the patient’s insurance coverage.
• The hospital and surgeon group would provide written disclosures to patients whose care might be affected by the arrangement.
• The financial incentives would be reasonably limited in duration and amount.
• Because the surgeon groups’ profits are distributed on a per capita basis, any incentive to an individual surgeon to generate a disproportionate share of cost savings is mitigated.
• There are safeguards to reduce the likelihood that the project would be used to attract physicians or attract referrals from existing physicians, which would violate the anti-kickback statute.