PUBLICATION

Gainsharing Update

August 11, 2008

Background

In July 1999, the Department of Health and Human Services, Office of Inspector General (OIG) issued a Special Advisory Bulletin addressing the prohibition on gainsharing arrangements. While the OIG recognized the significant benefits that such arrangements could have if there was no adverse impact on quality of care, it advised that Section 1128A(b)(1) of the Social Security Act prohibited gainsharing arrangements since hospital payments may directly or indirectly induce a physician to limit or reduce medically necessary services. The OIG submitted that regulatory relief from the Civil Money Penalties (CMP) provision would require statutory authorization.

Commencing in 2001, the OIG issued a series of advisory opinions agreeing not to prosecute gainsharing arrangements under specific fact scenarios that posed minimal risk of program abuse. In addition, Congress authorized a series of gainsharing demonstration projects. Pursuant to its authority under Section 5007 of the Deficit Reduction Act (DRA) of 2005, in September 2006 the DHHS Centers for Medicare & Medicaid Services (CMS) announced a three-year demonstration project, the Medicare Hospital Gainsharing Demonstration, to operate six projects, each consisting of one hospital. Two projects were to be rural. The Medicare Health Care Quality (MHCQ) Demonstration Programs under Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Action of 2003 (MMA) authorized a five-year program to examine health care delivery factors that encourage delivery of improved care. Pursuant to this authorization, CMS announced in September 2006 the Physician Hospital Collaboration, a gainsharing demonstration to examine the effects of gainsharing to improve quality of care while increasing efficiency across an entire health care system.

In April 2008, in the 2009 Hospital Inpatient Prospective Payment System Proposed Rule, CMS solicited comments regarding whether there should be a gainsharing exception under the Stark law.

Proposed Exception to the 2009 Physician Fee Schedule Proposed Rule

CMS now proposes an exception in the 2009 Physician Fee Schedule Proposed Rule, published on July 7, 2008. The purpose of the new exception is to offer broad flexibility for innovative programs of gainsharing, value-based purchasing and pay-for-performance which foster high-quality, cost-effective care. Comments on this proposed exception are due on or before August 29, 2008.

The exception closely resembles the safeguards blessed in the Advisory Opinions. The exception applies to hospitals only for hospital-based programs. It requires participation of pools of at least five physicians for each particular incentive payment program, shared savings program or particular performance measure or measures. A qualified physician organization will qualify as a pool if it has at least five participating physicians. All physicians must participate on a per capita basis. The physicians must be on the hospital medical staff when the gainsharing arrangement starts and new medical staff members may not be added once the program begins. CMS is soliciting comments on whether and if other physicians who join the medical staff can be added to the pools. The arrangement must be in writing; include term, remuneration, details of the program to permit independent review and monitoring of the program and details regarding baseline measures, target levels and performance measures; and include other program requirements and objectives.

Quality measures must: 1) be listed in the CMS/JCAHO Specification Manual for National Hospital Quality Measures; and 2) be supported by an objective methodology that is verifiable, supported by independent credible medical evidence and tracked individually.

To qualify for the exception, the arrangement cannot limit a physician's discretion in making medically appropriate decisions for his/her patients or limit physician access to items, supplies and devices the hospital made available prior to the physician's participation in the incentive payment or shared savings program. CMS also proposes that the hospital not limit availability of new approved technologies.

CMS proposes that the remuneration to the physician be limited in duration. Protected programs could be no shorter than one and no longer than three years.

Proposed Remuneration Limits

CMS also proposes two types of limits on the amount of remuneration. The first would limit remuneration expressed as a percentage of cost savings for changes in clinical or administrative practices. The second limits would address the risk that physicians would continue to receive payments for already achieved results. As to the first type of limit on remuneration, CMS is seeking comments on whether to impose a flat 50% limit on the sharing of cost savings and whether to require rebasing for prior cost savings payments. CMS is also seeking comments on whether a cap is appropriate and how to limit payments in multiple years, as well as whether a scaled limit approach should be adopted, decreasing payments over the course of the program. CMS also proposes calculating actual cost-saving payments by comparing the hospital's acquisition cost to the hospital's baseline costs for the items, supplies or costs of delivering the services that are the subject of the incentive or shared savings program during the one-year period immediately preceding the program.

In considering limits on the amount, CMS is seeking comments on whether to limit payments to address the risk that physicians will continue to receive financial rewards for performance measures already achieved prior to the program or clinical or administrative practices already implemented. CMS also proposes "rebasing" under this second payment limit to take into account payments already made for performance measures already achieved. However, CMS is seeking comments on whether to rebase at all.

CMS proposes an independent medical reviewer to monitor each program's impact on quality of care and to protect against inappropriate reductions or limitations on services. Written notice to patients would be required prior to implementing the program. Lastly, CMS proposes other limitations related to physician ownership and investment and fraud and abuse.

Baker Donelson Senior Public Policy Advisor Nancy Johnson, former Connecticut Senator and recognized authority on health policy, adds:

With this rule, CMS is seeking input on important issues for now and for the future of health care reform. I believe that it is through this kind of approach that we will find our way out of the silo payment system that fails to foster collaboration and coordination of care. Equally important is building a system that isn't static, that encourages continual improvement. This rule is a thoughtful effort but needs a lot of practical advice to be workable and enable small as well as large providers to participate. I would encourage anyone with an interest in fostering collaboration and coordination of care to comment on this proposal.