Establishing a Shared Savings Arrangement with Physicians

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By Mary C. Reed and Scott A. Edelstein

A suggested approach to establishing a shared savings program—that conforms with OIG requirements.

Until recently, hospitals and health systems have been hesitant to pursue gainsharing, or shared savings, programs with physicians given the Office of Inspector General's (OIG's) past position on these initiatives. However, the tides are changing.

Shared savings programs are being incorporated into various demonstration projects as healthcare reform legislation rolls out. When correctly established, shared savings programs can align incentives and encourage hospital-physician collaboration towards improving efficiency, encouraging appropriate utilization/standardization of resources, and improving the quality of care.

Health systems and physicians considering the feasibility of a shared savings program need to understand the regulatory environment, the safeguards that must be in place, the resources required, the time frame to establish the program, and the financial implications.

A Short History

Gainsharing was first tested in the healthcare industry in the 1990s when a small, select number of hospitals and cooperating physicians experimented with payments to physicians for achieving targeted cost savings. However, in 1999, the OIG issued a Special Advisory Bulletin that said these hospital-physician arrangements violated civil money penalty law of the Social Security Act, which prohibits any hospital or critical access hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's care. In addition, the OIG noted that gainsharing arrangements may trigger the federal Antikickback Statute and the federal physician self-referral prohibitions of the Act.

Over the last decade, however, gainsharing has gained federal favor through the course of various demonstration projects and private initiatives that received favorable OIG opinions (15 to date). With the emergence of healthcare reform, gainsharing has evolved into shared saving initiatives, which are currently part of CMS' Acute Care Episode global pricing demonstration projects and the focus of the Medicare Hospital Gainsharing Demonstration Project announced in September 2009. Furthermore, as part of the healthcare reform act the government has set forth a Medicare shared savings program where there would be an incentive for providers to reduce costs and provide services more efficiently.

Shared shavings arrangements are also increasingly included as a component of clinical service line comanagement arrangements, where physicians are contractually engaged to provide management services in concert with a hospital for certain programs or services. The management services provided are typically at a level substantially more robust than conventional medical director agreements. These agreements have performance incentives based on predefined quality, satisfaction, and/or efficiency metrics.

In the last several years, clinical service line comanagement ventures between hospitals and physicians have received increasing notice, in large part because of recent revisions to the federal physician self-referral law greatly limiting the ability of hospitals and physicians to enter into joint ventures. And, with the focus on clinical integration, comanagement is viewed as a tool to foster clinical integration. The majority of these arrangements, built on incentivizing the participating physicians to achieve performance targets, have not included cost-saving initiatives. Comanagement arrangements are natural structures through which shared savings could be pursued.

OIG Safeguards

Whether a shared savings arrangement is part of a comanagement venture or a stand-alone initiative, the OIG looks for certain safeguards to be in place. The following list is based on our analysis of OIG opinions of existing gainsharing arrangements:

Transparency. The specific cost-saving actions and resulting savings should be clearly and separately identified. The hospitals and participating physicians should disclose the arrangement to patients.

No adverse impact on patient care. The parties should be able to provide credible medical support for the position that implementation of the cost-saving recommendations does not adversely affect patient care.

No disproportionate impact on Medicare patients or Medicare program. The amounts paid under the arrangement should be based on all procedures regardless of a patient's insurance coverage and should ensure that a disproportionate amount of such procedures are not performed on Medicare patients. If a participating physician's volume of procedures performed on Medicare patients in the current year exceeds the volume of like procedures performed on Medicare patients in the base year, there should be no sharing of cost savings for the additional procedures.

Protections against inappropriate reductions in services. The arrangement should use objective historical and clinical measures to establish baseline thresholds beyond which no savings accrue to the participating physicians.

Product standardization without limiting selection. Participating physicians should still have available the same selection of devices and supplies after implementation of the arrangement as before. The arrangement should be designed to produce savings through inherent clinical and fiscal value, not from restricting the availability of devices and supplies or interfering with a physician's medical judgment. The outcomes of standardization are to improve efficiency while maintaining quality.

Compensation cap and per capita distribution. A cap on total compensation to the participating physicians should be established based on projected cost savings, and the compensation should be distributed by the participating physician groups to their members on a per capita basis.

Participation limited to physicians on staff. Participation in the arrangement should be limited to physicians already on the hospital's medical staff. Also, the arrangement should be limited to specific specialties (i.e., cardiology, orthopedics) so no other surgeons or physicians who refer patients to the participating physician groups can be rewarded through the arrangement.

Minimize incentive to steer costly patients to other hospitals. Case severity, ages, and payers of the patient population treated under the arrangement should be monitored by an independent third party and a committee of hospital personnel and participating physicians. If significant changes from historical measures indicate a physician has altered his/her referral patterns to steer sicker, costlier patients away from the hospital, the physician can be terminated from the arrangement.

In addition to addressing Civil Monetary Penalty issues, the arrangement should also be structured to conform to the federal physicians' self-referral law, the federal Antikickback Statute and, as applicable, laws for tax-exempt organizations.

Key Steps to Shared Savings

Below is a suggested approach to establishing a hospital-physician shared savings program, which would be in line with OIG safeguards.

- Initiate discussions with physicians to establish their interest, as well as to educate them on the regulatory environment, necessary safeguards, and timeframe. It will be important to establish a shared understanding of the risks, requirements, timeframe, and outcomes.
- Engage a third-party to act as the program administrator and who as an objective third-party will be able to verify the opportunities, value each opportunity, and conduct audits during and after each shared savings initiative to verify: accomplishments, achieved savings, clinical outcomes are maintained, and patient profiles not compromised.
- Conduct an analysis to measure costs, quality, utilization, and demographics by service. An essential component of this analysis is to develop a profile by physician and by patient acuity level. As you evaluate your opportunities and the overall program, there is a need to identify clearly what saving opportunities are directly influenced by physicians and establish the acuity and profile of patients served to assure there is no cherry-picking going forward.
- Based on the analysis, identify and quantify shared savings opportunities. Differentiate between opportunities that require direct physician involvement and those that can be achieved through the organization's own efforts.
- Establish the necessary structure and agreements with physicians who will participate in the shared savings program. If there is a comanagement structure in place, consider incorporating the program into the structure, if that structure has the required physician participation and if the terms of existing agreements can be modified to meet regulatory requirements. Agreements should be in writing, have a term of at least one year with payment terms consistent with fair market value.
- Establish the shared savings program, reflecting the safeguards in the OIG opinions, to include:
    - Policies and processes through which the shared savings program will be managed to include:
        - Transparency, including patient notification of the existence of the shared savings program
        - A system to allow for standardization, while assuring access to a selection of devices and supplies based on patient need
        - Physician participation criteria
        - Methodology and mechanism for payment of savings
        - Performance baselines and benchmarks to provide protection against inappropriate reductions in services or steerage of costly patients to other hospitals
        - Specific work plans for each opportunity
        - Provision of quarterly performance reviews

- Work with legal counsel to review the program and determine whether you need to submit a request to the OIG for an advisory opinion.

Long-Term Benefits

With healthcare reform a reality, gainsharing represents a significant opportunity—but one that should be pursued with due diligence. While the financial rewards can be significant, the collaborative structures and working relationships that are developed can result in significant long-term benefits to the health system, the physicians, and the community.

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