Legal Corner

Can Hospitals Share Cost Savings With Their Oncologists?

By Paul F. Danello

The U.S. Department of Health and Human Services Office of Inspector General (OIG) has recently issued a remarkable series of six inter-related advisory opinions that give more favorable treatment to gainsharing arrangements between physicians and hospitals. In health care, gainsharing is an arrangement by which a hospital gives physicians a share of any reduction in the hospital's costs for patient care attributable in part to the physician's efforts. A gainsharing program typically involves a sharing of the cost savings achieved by the hospital through some combination of a percentage payment, an hourly fee, or a fixed fee to the physician, together with features to safeguard quality of care and control malpractice liability exposure.

The new gainsharing opinions represent a significant change in tone, if not position, by the OIG. For the first time, they open the door for hospitals to influence the cost of medical devices and, by extension, drugs, where equivalent clinical safety and effectiveness is maintained and proper disclosure is made to the patients affected.

Historically, the OIG has been extremely suspicious of gainsharing arrangements. Federal law prohibits hospitals from inducing doctors to reduce or limit services and items to Medicare and Medicaid beneficiaries and imposes civil monetary penalties. As recently as 1999, the OIG issued a Special Advisory Bulletin concluding that gainsharing arrangements involving payments to physicians to induce a reduction or limitation of services to Medicare or Medicaid patients were "flatly prohibited." Since then, hospitals and physicians have generally avoided such arrangements.

In 2004 the Centers for Medicaid & Medicare Services (CMS) approved a "Hospital Performance-Based Incentives Demonstration," a 3-year gainsharing demonstration project developed by the New Jersey Hospital Association, which was to begin early that year. However, the demonstration project was barely underway before legal problems arose. A federal court issued a permanent injunction against the demonstration project. The court found that the demonstration project violated the law, because the physicians stood to earn a financial bonus for reducing costs (and, therefore, services, in the court's view) to Medicare patients.

All of the new advisory opinions involve arrangements between hospitals and cardiac surgeon groups or cardiologists in which the hospitals would pay the physician groups 50% of any cost savings achieved through specific cost-savings measures during a 1-year period. Each of the hospitals used

"practice-pattern reports" to identify areas in which their cardiac surgeons or cardiology departments could reduce costs. Some of the recommendations in each of the proposed gainsharing arrangements revolved around product standardization, in which the hospital and the physician groups would evaluate the devices and agree to use, when medically appropriate, those selected largely for their cost efficiency. Devices at issue include guidewires and catheters, vascular closure devices, diagnostic devices, pacemakers, cardiac heart valves, and defibrillators.

The key to the OIG's approval of the product-standardization elements of the gainsharing arrangements were the safeguards against patient harm, the opinions stated. None of the proposed arrangements would pay cost-saving bonuses beyond the first year, and in all cases the payout would go to the group practice rather than individual physicians. Another important limitation in the proposals was a provision that hospitals would continue to stock a full range of devices, not merely those that had been agreed upon as the standard products. There must also be written disclosure to patients of the arrangement.

The OIG's permission for product standardization and substitution provisions presents the possibility that hospitals can give oncologists financial incentives to choose the most cost-efficient chemotherapeutic agents and other items that are clinically equivalent and medically appropriate.

Any such program would need to be set forth in writing and subject to safeguards to protect against inappropriate reductions in services. The oncology group and a hospital would agree to use only certain preselected brands or types of chemotherapeutic agents or to substitute less costly drugs or other items for those currently being used. The product-standardization or -substitution decisions would be based on credible medical support proving the actions would not affect patient care adversely and would be subject to continuing periodic reviews, typically including an independent third-party reviewer. The oncologists would be required to work in conjunction with the hospital to evaluate and clinically review vendors and products. The oncology group would also agree to use the standardized or substituted products where medically appropriate, which may require additional training or changes in clinical practice.

Since there is still legal uncertainty surrounding gainsharing arrangements, and hospitals and oncologists considering such a program should evaluate the possible need for an OIG advisory opinion.

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