PUBLICATION

OIG Permits Gainsharing under Co-management Agreement [Ober|Kaler]

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In Advisory Opinion 12-22, the OIG permitted a hospital to make payments to a cardiology group as part of a co-management agreement that for all intent and purpose are gainsharing payments. The extent to which this represents further loosening of restrictions on gainsharing payments is not entirely clear because of some of the unique circumstances of the arrangement. However, fundamental changes are underway in the health care industry that will pressure the government to allow arrangements "designed to align incentives by offering physicians compensation in exchange for implementing strategies to meet quality, service, and cost savings targets."

A large, rural acute care hospital in a medically underserved area operates four cardiac catheterization labs. The cath labs are located on the hospital's main campus and are provider-based departments of the hospital. The hospital bills and collects for all non-professional services provided in the cath labs. The hospital has entered into a three-year co-management agreement for the cath labs with a cardiology group. The cardiology group consists of general cardiologists, interventional cardiologists, and electrophysiologists. The cardiologists in the group are the only cardiologists on the hospital's medical staff and are the only physicians performing procedures in the cath labs. The cardiology group bills and collects for all professional services performed in the cath labs.

Under the co-management agreement, the cardiology group provides management and medical direction services. The agreement includes a detailed list of services. In exchange, the hospital pays a fixed fee and a potential performance-based payment subject to a maximum amount. The fixed fee and an estimated performance fee are paid quarterly with an annual reconciliation. The performance fee consists of the following components:

5% − Employee satisfaction
5% − Patient satisfaction
30% − Quality
60% − Cost savings

To receive a payment under each component, a baseline achievement level must be met which represents status quo performance for that component. The payments are then paid in tiers of 50 percent, 75 percent, and 100 percent depending on the achievement level. The advisory opinion goes into some detail about the various components of the performance fee.

The OIG begins its analysis by referencing the benefit of incentive compensation arrangements designed to align incentives between physicians and hospitals. The OIG also recognizes that properly structured arrangements that compensate physicians for achieving hospital cost savings can serve legitimate business and medical purposes, including increasing efficiency and reducing waste. Nevertheless, the OIG cautions that "unscrupulous parties" might misuse such payments to induce limitations or reductions in care or to disguise kickbacks. The OIG expressed concern about (i) stinting on patient care, (ii) "cherry picking" healthy patients and steering sicker, more costly patients to hospitals that do not offer payments, (iii) payments to induce patient referrals, and (iv) unfair competition among hospitals offering such payments.

The OIG then analyzed the arrangement under both the CMP against inducements to reduce or limit services (42 USC § 1320a-7b(b)(1)–(2)) and the antikickback statute (42 USC § 1320a-7b(b)).

Under the CMP analysis, the OIG concluded that the only aspect of the compensation under the co-management agreement that implicated the CMP was the cost-savings component. The OIG expressed concern that the standardization provisions might induce physicians to alter their current medical practice to reduce or limit services. However, the OIG found sufficient safeguards so that it would not impose sanctions. First, the OIG noted that the hospital certified that the arrangement would not adversely affect patient care. The OIG then detailed the internal and external resources the hospital employs to ensure that patient care is not affected. Second, the OIG found a low risk that the arrangement would lead the physicians to apply specific cost-savings methods. The OIG noted that physicians have access to any device or supply. The OIG stated that the arrangement "is designed to produce savings through inherent clinical and fiscal value and not from restricting the availability of devices and supplies." The tiered payments permit payments based on aggregate performance, not specific standards for particular patients.

Third, the OIG asserted that the financial incentives were reasonably limited in duration and amount as they are subject to a maximum annual cap and a three-year term. Fourth, the contract conditions payment on the group not (1) stinting on care, (2) increasing referrals to the hospital, (3) cherry-picking healthy patients or those with desirable insurance, or (4) accelerating patient discharges. The OIG recognized that such a contractual provision by itself was not sufficient protection, but it was a factor to consider.

Under the antikickback analysis, the OIG noted that the personal services and management contracts safe harbor (42 CFR 1001.953(d)) was potentially applicable but could not be satisfied because the aggregate payments under the arrangement were not set in advance. The OIG then discussed several reasons for not imposing sanctions. First, the OIG noted that the compensation was fair market value and that there are substantial services provided under the management agreement. Second, the OIG noted that compensation does not vary with the number of patients treated, so an increase in referrals does not result in additional compensation. Third, the OIG concluded that the compensation is unlikely an incentive to shift referrals because the hospital has the only cath labs for 50 miles and the group only performs such procedures at the hospital's cath labs. Fourth, the OIG found that the specificity of the measures helps ensure that their purpose is to improve quality and not to reward referrals. Finally, the OIG noted that there was a written agreement with a three-year term.

Comments

The overall tenor of Advisory Opinion 12-22 suggests that the OIG may be becoming increasingly open to gainsharing payments, particularly in the context of co-management agreements. The OIG expressly extolls the virtues of incentive payments between hospitals and physicians. Nevertheless, the fact-specific nature of the advisory opinion process and some of the unique aspects of the co-management agreement in Advisory Opinion 12-22 raise questions about just how far the analysis might extend in permitting further expansion of gainsharing payments.

The OIG noted at the outset that the arrangement is not exclusive, and that the hospital would consider including additional cardiologists in the future. However, the current reality is that the arrangement is essentially exclusive. The hospital has the only cath labs for 50 miles. The cardiology group has the only cardiologists on the hospital's medical staff and the only physicians in the area that provide cardiac cath services. In addition, the cardiology group does not provide cardiac cath services anywhere other than in the hospital's cath labs. The lack of competition turns out to be one of five factors the OIG cites in refusing to

impose sanctions under the antikickback statute. We are left to wonder whether similar payments in a crowded market (either competing cath labs or competing cardiology groups) would be approved by the OIG.

Another factor the OIG cites approvingly in its antikickback analysis is that the arrangement is limited in duration – only three years. The OIG recognizes that the arrangement has an automatic renewal provision. The OIG specifically expresses no opinion with respect to any future extension of the arrangement. However, the OIG warns that quality improvement and cost savings measures should be adjusted over time to avoid payment for improvements already achieved in prior years. Such limits on the length of gainsharing payments are consistent with the prior OIG guidance. As a practical reality, it may be difficult to sustain gainsharing payments even in the context of a co-management arrangement as processes are improved and cost savings and quality improvement opportunities are squeezed from the system.