Gainsharing, Shared Savings Examined

***Karen Minich-Pourshadi, for HealthLeaders Media* , August 28, 2012**

This article appears in the August 2012 issue of **HealthLeaders** *magazine.*

Whereas gainsharing is still viewed with apprehension by many in healthcare, shared savings programs are being embraced by hospitals nationwide. The two models pursue the same goal—to reduce costs without negatively impacting the quality of care—but there are unique legal and structural challenges that come with each approach; however, for hospitals and health systems willing to overcome some hurdles, both gainsharing and shared savings can add millions in sustainable savings to the bottom line.

Gainsharing tends to target device and supply usage within a specific service line, such as cardiology or orthopedics, whereas shared savings programs take a broad-spectrum look at cost reduction by targeting specific patient populations, such as diabetics.

"We're all trying to partner effectively with our medical staff to find savings. We've done a lot of initiatives, joint ventures, employment agreements and service line management agreements," says Robert Glenning, executive vice president and CFO at the 775-licensed-bed Hackensack (N.J.) University Medical Center. "Gainsharing and shared savings have been missing in our approach until recently. We recently added shared savings to our oncology service line."

HUMC's decision in the first quarter to pursue shared savings was based on the organization's strategic goal to reduce overall costs; but why not choose gainsharing?

"Gainsharing has been difficult to implement because of the process of obtaining an opinion from the Office of Inspector General, and it tends to work for a subset of physicians, like orthopedists or cardiac surgeons, but not all physicians. Though the OIG has granted waivers, it is complex to get those waivers; at least it was in the past. I think people are still uncomfortable with the waivers, which is
why gainsharing has struggled," explains Glenning.

The Centers for Medicare & Medi-caid Services has no fixed definition of gainsharing, but says the term generally refers to an arrangement in which "a hospital gives physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts." These agreements were initially found to violate the Civil Monetary Penalties Law, the Stark Law, and the anti-kickback statute, though they did demonstrate promise in cost saving when
structured correctly.

Though the OIG can grant waivers to allow these arrangements to take place, the potential to violate several key statutes deterred most healthcare organizations from attempting the use of these agreements and cast a negative cloud around them, explains Addison, Texas–based healthcare attorney Cynthia Marcotte Stamer.

There is a key legal distinction between an accountable care organization shared savings arrangement and a gainsharing one, notes Marcotte Stamer. New shared savings rules outline detailed requirements pursuant to which ACOs can reward providers by providing shared savings. In contrast, if the ACO does not meet the ACO shared savings rules or the party other than an ACO offers gainsharing, "the gainsharing arrangement is presumptively against the law and participating parties are subject to enforcement, unless the parties seek and obtain an advisory opinion in which HHS agrees not to enforce the Stark, Fraud & Abuse, and CMP laws without revoking the ruling based on the gainsharing arrangement and the parties receiving that ruling in fact comply with the assumptions of the advisory opinion so as to qualify to rely upon that agreement not to enforce," she explains.

Moreover, each advisory opinion on gainsharing participation is directed specifically to that organization. "The ability to rely upon the [advisory opinion] remains limited to the requesting parties. The fact that a party has obtained an advisory opinion based on its application does not allow a different party to rely upon or claim any protection against prosecution for its gainsharing arrangement even if the facts are similar or even identical," says Marcotte Stamer.

Some of the elements that the OIG requires of those wishing to obtain the commitment not to enforce are defined, Marcotte Stamer says. In 2005, the Deficit Reduction Act renewed interest in gainsharing agreements, and the OIG has agreed not to prosecute organizations that pursue gainsharing arrangements if following criteria are applied: (1) measures that promote

accountability and transparency, (2) adequate quality controls, and (3) controls on payment related to referrals, she explains.

The initial DRA exemptions to gainsharing were intended to allow Medicare to create pilot programs for cost savings in its fee-for-service population. However, with the passage of the Patient Protection and Affordable Care Act, gainsharing evolved into shared saving as part of the accountable care organizations program.

However, Marcotte Stamer notes that the regulations surrounding the Medicare ACO model shouldn't be deemed less complex. "These rules are just coming out and … there's tremendous cost involved and liability risk. You're building a very complex organization and asking providers to sign on and consent to rules that could change." Moreover, as with gainsharing, organizations that participate in the Medicare ACO program will need to demonstrate not only cost savings, but also steady or improved patient outcomes.

For those organizations that are willing to work within the OIG's guidelines and pursue gainsharing, there are bottom-line rewards. At the 864-licensed-bed St. Luke's Health System, based in Boise, Idaho, gainsharing was a choice the organization made to encourage greater supply-chain savings in its cardio, spine implant, and total joint implant service lines while maintaining or improving the quality of products and care to the patient. The system, which reaches southwest Idaho, northeast Nevada, and southeast Oregon, began looking into gainsharing in 2009 after doing a cost analysis, explains Cam Marlowe, St. Luke's system director of contracting and sourcing for supply chain management. The analysis showed that St. Luke's combined spend for cardiology, spine implants, and total joint implants totaled $39 million.

"We had a sense that our three largest spend areas had contract prices that were average at best, and perhaps below average given our size," says Marlowe. "We need to reduce our costs and wanted to get the doctors involved to help us determine how we could lower our cost while maintaining or improving quality. The gainsharing program was the best way to jump-start that collaboration."

Also wary of the OIG guidelines, the organization worked with Goodroe Healthcare Solutions, a subsidiary of VHA, to guide it through the legal logistics and help it get its data gathering processes in place.

St. Luke's gainsharing agreements took effect in two of its hospitals in 2009, but year one was filled with trial and error and limited returns, Marlowe says. By 2010, however, the organization had cleared a path to reap financial savings, reducing the cardio, joint implant, and spine implant spend by $1.3 million for the two participating hospitals, and garnering another $450,000 in rebates from implant device vendors. In 2011 St. Luke's saved another $7.1 million, and it anticipates estimated savings of an additional $3.7 million in 2012, he says.

By year two Marlowe says the organization invested in a benchmarking service that provided data on vendors by tracking hundreds of hospitals supply prices. The information helped with vendor contract negotiations. And, to encourage collaboration between the hospital and the physicians and help measure progress and define the financial goals for the gainsharing model, clinical department administrators and directors together with supply chain leaders shared data on individual performance with the physicians. They held regular group meetings with the cardio, orthopedic, and spine implant physicians and reviewed physician usage data and discussed optimal implant product choices and pricing.

To help physicians gauge their performance, individual physician data was compared to that of their peers and to the group average to allow for easy comparison and discussion. The gainsharing company provided quality and competitive cost data for key devices. In addition, St. Luke's tracked and reported patient outcomes to ensure these remained constant, or improved.

Implementation of the savings program did not adversely affect clinical care in any of the specialties included in the gainsharing program, Marlowe says. "The physicians did not alter the demographic makeup of the patient populations they treated. Indicators such as outcomes, case severity, age, and payer are monitored throughout the program to assure no significant changes from historical measures," he adds.

Marlowe says that ultimately the greatest challenge in setting up a gainsharing program proved not to be working with the OIG guidelines, but gathering the data and learning to communicate better with physicians. "Establishing gainsharing is challenging; it isn't a cake walk, but it's been very successful for us. Although we had a gainsharing partner, they didn't do all the work; we still have to engage the physicians and work with them to make this a continual success," says Marlowe. "Through this process I have learned that physicians are eager to work with the hospital to accomplish shared goals."

Getting physician buy-in and collaboration has proved a similar challenge for those organizations that do opt to pursue a shared savings program, notes Mark Shields, MD, MBA, senior medical director for Advocate Physician Partners and vice president of medical management for Advocate Health Care, an Oak Brook, Ill.–based system that includes 10 hospitals, 2 integrated children's hospitals, and more than 3,222 beds.

"On the surface it can look like a gainsharing program might be a quicker and easier path to cost reductions because it's typically limited to one to two service lines or handful of DRGs," says Shields. "But we felt it really wasn't easier due to the administrative and legal complexities, and the organizational hurdles to get the physicians working together."

Advocate Physician Partners entered into a care management and managed care contracting joint venture between the Advocate Health Care System and 3,900 physicians on the medical staff of the Advocate hospitals to create one of the first commercial ACOs and shared savings programs. The system created a clinical integration program in which physicians collaborate to address the quality and cost associated with an entire episode of care, explains Shields.

"If an organization hasn't strategically committed to wanting to be a population health management company, then shared savings isn't going to fit for them; gainsharing may be a better approach," he says.

Physicians work directly with patients to reduce the physical and financial effects of disease and illness by designing treatment plans that include medical intervention and lifestyle changes. The program came about during a contract renewal with BlueCross BlueShield of Illinois in late 2010. With just four months left in the year to establish the program, the payer and Advocate agreed to set provider incentives in the contract based on meeting specific quality, safety, efficiency, and patient satisfaction metrics. Dubbed AdvocateCare, the accountable care and shared savings project started in January 2011.

In the case of Advocate Health Care, population health management was a key strategic goal, so the opportunity to work with BCBS of Illinois aligned with that goal. The organization hired 60 full-time nurses to act as outpatient care managers and work closely with the sickest 3% of the patient population, and it added software to enable costs and outcomes to be monitored and measured against core metrics.

Data is essential for the program to succeed, Shields says, as it allows the team to dig into the numbers by physician, group practice, disease type, etc., and to provide all participants quarterly feedback on progress. Although it tracks nearly 160 metrics, Shields says "a handful are high-priority areas and help maintain the focus for our physicians and our hospital."

In April, Advocate released its 2012 Value Report based on the organization's 2011 results for the first full year of the program, and the cost savings for its shared savings, population health management-based approach are promising.

The Value Report notes Advocate set a generic prescribing target rate of 73% or better for its physicians and it reached 74%, resulting in savings of $12.4 million. Its asthma outcomes initiative resulted in a control rate for its patients of 59%, some 17 percentage points above the national average, saving $8.9 million annually in both direct and indirect medical costs. Additionally, its diabetes care initiative calculated savings of $4.3 million just for making improvements to poor HbA1c levels.

Both gainsharing and shared savings programs can reduce costs by millions of dollars, and while the two approaches differ in their implementation structure, the cost savings goal is consistent and the cornerstone for both rests on physician collaboration.

"We'd been on a clinical integration road for a decade, so we had a lot of relationships with physicians and infrastructure already built," says Shields. "But I think for people who are particularly new to clinical integration, gainsharing can offer a good beginning. Whichever path is chosen, it needs to fit with the larger organizational strategy."

This article appears in the August 2012 issue of **HealthLeaders** *magazine.*

Reprint HLR0812-7

Karen Minich-Pourshadi is a Senior Editor with HealthLeaders Media.

Back