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OIG Bulletin Hightlights Schizophrenic Attitude in Cost-Saving Measures: Gainsharing Arrangements--Thier History, Use, and Future

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COMMENT

OIG Bulletin Highlights Schizophrenic Attitude in Cost-Saving Measures: Gainsharing Arrangements—Their History, Use, and Future

In 1985 the Office of the Inspector General of the Department of Health and Human Services (OIG) investigated Paracelsus Healthcare Corporation, a health care chain, to determine the legality of the gainsharing arrangement[1] implemented by Paracelsus.[2] Paracelsus implemented the gainsharing arrangement following Medicare's implementation of diagnostic related groups (DRGs)[3] and the prospective payment system (PPS).[4] Under the arrangement, which was reportedly established to align the physicians' economic incentives with those of the hospital,[5] physicians were individually

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1. Throughout this Comment the term "gainsharing arrangements" will be used. On occasion, this Comment also refers to incentive programs in the same context as gainsharing arrangements. Gainsharing arrangements are a type of incentive program, and although gainsharing arrangements comprise the overwhelming majority of incentive programs, the two are not synonymous. An incentive program, in general, is anything that serves to motivate or induce a certain response. *See* AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 912 (Anne H. Soukhanov et al., 3d ed. 1992). Gainsharing arrangements, in the context of this Comment, refer to programs that serve to align the economic interests of hospitals and physicians by offering physicians financial incentives to achieve a specified result. *See* John R. Washlick, *Hospital/Physician Gainsharing Arrangements: The IRS Giveth and the OIG Taketh Away*, HEALTH LAW., Aug. 1999, at 1, 1, 3 (discussing the rationales for gainsharing arrangements and their benefits). Examples of gainsharing arrangements include bonus arrangements, compensation arrangements, joint ventures, increased risk sharing, and risk pools. *See infra* notes 86–129 and accompanying text.

2. *See* U.S. GEN. ACCOUNTING OFFICE, GAO/HRD-86-103, MEDICARE: PHYSICIAN INCENTIVE PAYMENTS BY HOSPITALS COULD LEAD TO ABUSE 1, 15 (1986) (Sup. Docs. No. GA1.13:HRD-86-103) [hereinafter GAO REPORT].

3. Diagnostic related groups (DRGs) are comprised of roughly 470 medical diagnoses for which Medicare has established corresponding set treatment costs. Michael K. Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits*, 21 AM. J. TRIAL ADVOC. 453, 468 (1998).

4. The prospective payment system (PPS) reimburses hospitals a set amount based on the Medicare beneficiary's DRG. Helena G. Rubinstein, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 HEALTH MATRIX 381, 407 (1997).

5. This Comment adopts the traditional Medicare definition of "physician," which includes doctors of medicine, osteopathy, dental surgery, podiatry, optometry, and chiropractors who meet certain criteria. 42 C.F.R. § 405.2401 (1999).

Prior to 1984, hospitals were paid the reasonable costs of providing services to

paid a portion of the difference between the Medicare payment and a pre-determined percentage of the hospital's charges.[6] Paracelsus's arrangement principally sought to reduce the length of patients' stay in the hospital in order to maximize hospital profits.[7]

Despite the lack of closure to the OIG's investigation, the hospital industry views the Parclesus case as the catalyst to Congress's enactment of the Civil Monetary Penalty (CMP) statute.[8] This statute establishes penalties for health care entities that "knowingly make a payment, directly or indirectly, to a physician as an inducement to reduce or limit services" that are provided to Medicaid and Medicare beneficiaries under the direct care of the

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Medicare and Medicaid beneficiaries. GAO REPORT, *supra* note 2, at 2. The Social Security Act of 1983 established the PPS, under which hospitals are paid a pre-established fee for services rendered to Medicare beneficiaries based on the patients' DRGs. Social Security Act of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149–63 (codified as amended in scattered sections of 26 U.S.C. & 42 U.S.C.). Hospitals seeking to save money by modifying their practice patterns and reducing patient stays have turned their focus to physicians who control the level, amount, and duration of inpatient services. Health Care Programs: Fraud and Abuse; Civil Money Penalties for Hospital Physician Incentive Plans, 59 Fed. Reg. 61,571, 61,572 (proposed Dec. 1, 1994) (to be codified at 42 C.F.R. pt. 1003). Because physicians, whose jobs are fundamentally altruistic, are reimbursed separately from hospitals for the services they render to Medicare and Medicaid beneficiaries, physicians do not always share the hospitals' incentive to reduce the costs associated with medical care. Robert G. Homchick, *OIG Says No to Hospital Gainsharing, in* OIG Issues Advisory Bulletin on Gainsharing Arrangements: What to Tell Your Clients? 12, 12 (Am. Health Law. Ass'n Telephone Seminar, Aug. 2, 1999) (on file with the North Carolina Law Review). Therefore, hospitals turned to incentive-type arrangements in an attempt to align physicians' interests with their own. *See id.*; *infra* notes 29–75 and accompanying text (explaining Medicare and Medicaid reimbursement and the rationale for hospital gainsharing arrangements).

6. GAO REPORT, *supra* note 2, at 14. The formula for the incentive payments was as follows:

> If the Amount of the Medicare Payment Falls Within the Range of the Following Percentages of Retail Charges then the Hospital Would Pay the Physician the Following Percentage of the Amount Within Each Such Range.
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> | | |
> |---|---|
> | 75–85% | 10% |
> | 85–95% | 15% |
> | 95% and greater | 20% |

Kathryn A Krecke, *Abusing the Patient: Medicare Fraud and Abuse and Hospital-Physician Incentive Plans*, 20 U. MICH. J.L. REFORM 279, 285 n.33 (1986) (citing the incentive agreement of one hospital within the Paracelsus chain).

7. When a patient's hospital stay is reduced, less fixed fees are generally spent on the patient, resulting in greater profits for the hospital. *See generally* Jacqueline Kosecoff et al., *Prospective Payment System and Impairment at Discharge: The "Quicker-and-Sicker" Story Revisited*, 264 JAMA 1980, 1980 (1990) (studying discharge rates after Medicare switched to the PPS and concluding that patients were discharged earlier following the change).

8. Pub. L. No. 104-191, § 231, 110 Stat. 1936, 2012–15 (1996) (codified as amended at 42 U.S.C.A. § 1320a-7a (West Supp. 2000)).

physician.[9] It also serves as an example of the noose the PPS and DRGs have tied around the hospital industry's neck.[10]

Since the enactment of the Medicare PPS, hospitals have struggled to align their financial interests with the often conflicting economic interests of physicians.[11] Although mindful of the Paracelsus investigation, numerous hospitals implemented or included gainsharing agreements as part of their future strategic plans[12] because they believed that such arrangements would effectively align physicians' pecuniary interests with the hospitals' desire to maximize profits. Yet fears that gainsharing arrangements could violate the Stark anti-referral laws,[13] the CMP statute, and the

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9. Social Security Act § 1128A(b)(1)(A)–(B), 42 U.S.C.A. § 1320a-7a(b)(1)(A)–(B) (West Supp. 2000); *see also* William S. Painter & Charles W. Ferguson, *Recent Legislation, Cases, and Other Developments Affecting Health Care Providers and Integrated Delivery Systems*, WL SE66 ALI-ABA 433 (2000) (noting the mandates and the effects of the CMP statute).

10. *See infra* notes 22–23 and accompanying text (discussing the CMP statute); *see also infra* notes 37–44 and accompanying text (discussing the PPS and DRGs). Commentators believe that the CMP statute was enacted to address the type of arrangement used by Paracelsus—individualized to each physician and focused on length of stay. *See* Telephone Interview with Marilou King, Partner, McDermott, Will, & Emery (Nov. 5, 1999). Paracelsus ended its physician incentive program largely as a result of the passage of the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313(c)(1)(E), 100 Stat. 2002, 2003, which specifically outlawed payments "directly or indirectly, to a physician as an inducement to reduce or limit services" for Medicare patients. *Id.* The Department of Health and Human Services Regional Inspector General subsequently ceased his investigation of the Paracelsus plan. Krecke, *supra* note 6, at 304. Although there was no OIG or court opinion, the Paracelsus case was pivotal in alerting the industry to the possible problems and ramifications associated with incentive programs.

11. *See infra* notes 45–50 and accompanying text (discussing the alignment of interests between physicians and hospitals).

12. Hundreds of hospitals have constructed gainsharing programs or are ready to implement them as soon as they receive guidance and clearance from the OIG and the Health Care Financing Administration (HCFA)—the division of the Department of Health and Human Services that administers the Medicare program. Mary-Chris Jaklevic, *Gainsharing Illegal: HHS: Docs Shouldn't be Paid to Limit Care*, MODERN HEALTHCARE, July 12, 1999, at 12, 12. Commentators have also estimated that there are several dozen programs currently "up and running." *Id.*

13. The Stark laws prohibit physician referrals to any entity that provides health care services if the physician (or anyone in the physician's immediate family) has a financial interest in the entity. 42 U.S.C.A. § 1395nn (West Supp. 2000). Prohibited arrangements include compensation arrangements providing direct or indirect cash remuneration. *Id.*; *see also* Shari Kleiner et al., *Healthcare Fraud*, 36 AM. CRIM. L. REV. 773, 779 (1999) (explaining how various compensation plans may violate the Stark laws); Melvyn B. Ruskin & Ellen F. Kessler, *Health Care Anti-Referral Laws Effective in 1995*, N.Y. L J., Jan. 5, 1995, at 1, 5 (explaining the Stark laws).

Similarly, the OIG has released Special Fraud Alerts addressing the anti-kickback and Stark anti-referral laws in relation to hospital incentive arrangements. Publication of OIG Special Fraud Alerts, 59 Fed. Reg. 65,372 (Dec. 19, 1994). According to the OIG,

anti-kickback laws[14] compelled many hospitals to request advisory opinions.[15] In response to hospital inquiries, the Internal Revenue Service (IRS) issued two private letter rulings on gainsharing arrangements in January 1999.[16] Both rulings seemed to authorize gainsharing-type arrangements.[17]

On July 8, 1999, however, the OIG issued a Special Advisory Bulletin[18] stating that gainsharing arrangements in connection with

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suspect incentive arrangements include "[p]ayment of any sort of incentive by the hospital each time a physician refers a patient to the hospital" and "[p]ayment for services (which may include consultations at the hospital) which require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of services rendered." *Id.* at 65,376. In short, if "one of the purposes of the incentive is to influence the physician's medical decision as to where to refer his or her patients for treatment," the arrangement violates federal law. *Id.*

14. *See* Social Security Act § 1128A(b), 42 U.S.C.A. § 1320a-7b(b) (West Supp. 2000) (prohibiting the solicitation or receipt of remuneration in return for referrals of program-related business).

In 1991, the OIG issued a management advisory report (MAR) intended to alert the industry to potential violations of the anti-kickback statute by physician compensation packages. OFFICE OF INSPECTOR GEN., OEI-09-89-00330, FINANCIAL ARRANGEMENTS BETWEEN HOSPITALS AND HOSPITAL-BASED PHYSICIANS 1 (1991). The MAR specifically targeted violations in connection with hospitals paying less than the fair market value for services rendered by physicians. *Id.* Richard J. Pollack, Executive Vice President of the American Hospital Association, criticized the report, stating that the "underlying premise in the MAR is misguided... [M]ore often than not, hospitals find it necessary to accommodate physicians' financial requests in order to secure needed physician services for their patients." Letter from Richard J. Pollack, Executive Vice-President, American Hospital Association, to Richard P. Kusserow, Inspector General, United States Government (Sept. 6, 1991), *reprinted in* OFFICE OF INSPECTOR GEN., *supra*, at app. B.

15. The Stark and anti-kickback laws are Medicare and Medicaid related statutes. *See infra* notes 166–96 and accompanying text. Marilou King and Robert Homchick, two prominent health care lawyers, both stated that much of the health care industry believed that gainsharing arrangements were more problematic in relation to the Stark and anti-kickback laws than the CMP statute. Telephone Interview with Marilou King, *supra* note 10; Telephone Interview with Robert Homchick, Partner, Davis Wright Tremaine L.L.P. (Nov. 3, 1999). In fact, both stated that it was surprising that the government chose the CMP statute to address the gainsharing issue. Telephone Interview with Marilou King, *supra* note 10; Telephone Interview with Robert Homchick, *supra*.

16. The specific gainsharing arrangements reviewed by the IRS involved hospital contracts with cardiologists. Patricia Meador, *Healthcare Fraud and Abuse*, WL 1175 PLI/Corp. 21, 67 (2000). The contracts included a "cardiovascular cost reduction/quality improvement program." *Id.* Ultimately, the IRS concluded that these arrangements did not violate private inurement rules because any payment in the arrangement required the objective improvement of cardiovascular care and the provision of more cost-effective health care. *Id.*

17. *See* Mary Chris Jaklevic, *IRS Ruling OK Doc Gain-Sharing*, MODERN HEALTHCARE, Apr. 5, 1999 at 12, 12.

18. The Department of Health and Human Services (HHS) established the OIG in 1976. Publication of the OIG Special Advisory Bulletin on Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to

the Medicare PPS are impermissible.[19] The Advisory Bulletin primarily focused on sections 1128A(b)(1) and (2) of the Social Security Act (the "Act"),[20] which outline the regulation of hospital-sponsored physician incentive plans.[21] The regulations, codified in the CMP statute, prohibit any hospital from knowingly making payments to physicians as inducements to limit or reduce services to Medicare or Medicaid beneficiaries directly under a physician's care.[22] Interpreting the CMP statute broadly, the OIG unequivocally stated that gainsharing arrangements, in which physicians receive a

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Beneficiaries, 64 Fed. Reg. 37,985, 37,985 (July 14, 1999) [hereinafter Special Advisory Bulletin]. Congress created the OIG to identify and reduce waste, fraud, and abuse throughout HHS programs and to establish and perpetuate efficiency in existing programs. *Id.* To that end, Congress granted the OIG the power to conduct audits, investigations, and inspections. *Id.* The Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 26 U.S.C., 29 U.S.C. & 42 U.S.C.), authorizes the OIG to offer advisory bulletins to provide direction to health care and related industries, to prevent fraud and abuse, and to maintain the highest levels of ethical and lawful conduct. *Id.* The bulletins inform the health care industry of practices and arrangements that may constitute fraud and abuse in Medicare and Medicaid programs and therefore are subject to enforcement by the OIG. *Id.*; Press Release, Department of Health and Human Services, Inspector General Issues Special Advisory Bulletin on Hospital-Physician "Gainsharing" (July 8, 1999), *at* http://www.oig.hhs.gov/other/gainnews.htm (on file with the North Carolina Law Review) [hereinafter OIG Issues Bulletin].

19. Special Advisory Bulletin, *supra* note 18, at 37,985; OIG Issues Bulletin, *supra* note 18.

20. Social Security Act § 1128A(b)(1)–(2), 42 U.S.C.A. § 1320a-7a(b)(1)–(2) (West Supp. 2000). Section 1128A(b) of the Social Security Act states:

> (1) If a hospital or critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—
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> (A) are entitled to benefits under part A or part B of subchapter XVIII of this chapter or to medical assistance under a State plan approved under subchapter XIX of this chapter, and
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> (B) are under the direct care of the physician, the hospital or a critical access hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.
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> (2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each individual described in such paragraph with respect to whom the payment is made.

Id.

21. Homchick, *supra* note 5, at 12.

22. Social Security Act § 1128A(b)(1)–(2), 42 U.S.C.A. § 1320a-7a(b)(1)–(2) (West Supp. 2000). Because Medicare and Medicaid are federal programs, those institutions receiving reimbursement dollars from Medicare and Medicaid programs must adhere to the relevant federal regulations. *See generally* Meador, *supra* note 16, at 60–61, 65–67, 69 & 71 (explaining federal regulations pertaining to Medicare and Medicaid).

share of hospital savings attributable to physicians' cost control efforts in connection with Medicare and Medicaid patients, violate the CMP statute and thus are prohibited.[23]

The OIG's conclusion that gainsharing arrangements are subject to the CMP statute serves as a troubling illustration of the government placing hospitals in an economic straitjacket.[24] In the face of mounting pressure on hospitals to contain costs—in a business where the physician controls the cost incurring items[25]—the prohibition of gainsharing arrangements presents yet another obstacle to providing cost-effective, high-quality health care.

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23. Special Advisory Bulletin, *supra* note 18, at 37,985; *see also* Telephone Interview with Robert Homchick, *supra* note 15 (noting that the OIG seized on the CMPs as the "silver bullet" to kill gainsharing programs even though the Stark and anti-kickback laws impose more significant restrictions).

24. The government has applied enforcement measures, including mandatory utilization of peer reviews, to gainsharing arrangements. *See* Peer Review Improvement Act of 1982, Pub. L. No. 97-248, §§ 141-143, 96 Stat. 324, 381–88 (codified as amended in scattered sections of 42 U.S.C.). The Peer Review Improvement Act requires peer review organizations (PROs) to emphasize monitoring and detecting quality of care problems created by the Medicare PPS. 42 U.S.C. § 1320c-3 (1994); *see also* GAO REPORT, *supra* note 2, at 10 (seeking to ensure that diagnosis and requested treatments correspond with existing protocols, thereby ensuring quality care). At the same time, the Department of Health and Human Services asked that PROs refer cases that might be subject to sanctions due to quality of care violations in connection with the PPS. GAO REPORT, *supra* note 2, at 10. PROs essentially have three objectives: (1) "to determine if services are reasonable and medically necessary," (2) "to assure services are of acceptable quality," and (3) "to make sure Medicare beneficiaries [are] more economically treated on an outpatient basis or in a more economical inpatient health care facility [and] are not treated as hospital inpatients." JOSEPH A. SNOE, AMERICAN HEALTH CARE DELIVERY SYSTEMS 404 (1998). PROs are specifically required to focus their efforts on premature discharges and unnecessary hospital admissions. *See* 42 U.S.C.A. § 1395cc(a)(1)(F) (West Supp. 2000). PROs also deny Medicare payments for unnecessary admissions and are required to report any physician or hospital suspected of abusing the system.

Although it was hoped that PROs would help reduce the number of inappropriate discharges and re-admittances, the OIG has implied that PROs have failed to prevent many of the abuses. A study by the OIG's Office of Analysis and Inspections stated, "[i]t appears that many PROs have not effectively used the authorities or the processes available to address instances of poor quality care associated with premature discharges." OFFICE OF ANALYSIS & INSPECTIONS, OFFICE OF INSPECTOR GEN., INSPECTION OF INAPPROPRIATE DISCHARGES AND TRANSFERS, *reprinted in Out "Sooner and Sicker": Myth or Medicare Crises?: Hearing Before the House Select Comm. on Aging*, 99th Cong., 10, 12 (1986) (Sup. Docs. No. Y4.Ag 4/2:C86/17).

25. Under Medicare and Medicaid, physicians are reimbursed on a fee-for-service basis in contrast to the hospital's pre-determined lump sum payment. *See infra* notes 44–48 and accompanying text; *see also* David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158 (1996) (explaining that "[t]he more services that are provided, the greater the physician's income").

This Comment first describes the Medicare and Medicaid reimbursement programs.[26] The Comment then defines gainsharing, explains its rationale, explores the various types of gainsharing arrangements, and discusses the strengths and weaknesses of gainsharing arrangements.[27] Next, the Comment examines the applicable regulatory issues and laws facing gainsharing arrangements with a special emphasis on the recent OIG Advisory Bulletin and the CMP statute.[28] Finally, this Comment discusses options for what can and likely will be done about gainsharing arrangements between hospitals and physicians.[29]

I. MEDICARE AND MEDICAID REIMBURSEMENT

Medicare and Medicaid are federal health care insurance programs.[30] Under the Medicaid program, the federal government provides individual states with funds for health care services and equipment provided to low-income individuals.[31] Under the Medicare program, the federal government directly reimburses designated health care providers for services and equipment provided primarily to the elderly and disabled.[32]

Prior to 1984, Medicare and Medicaid reimbursement was based on a fee-for-service schedule—payments were based on the reasonable costs of providing services to Medicare and Medicaid recipients.[33] Under this system, the government reimbursed hospitals for each service rendered to Medicare patients.[34] The greater the number of services rendered to Medicare patients, the more money the hospital received.[35] This created the incentive for hospitals to encourage physicians to "admit more Medicare patients, leave them in the hospital longer, and use more services while [the Medicare beneficiaries were] there."[36]

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26. *See infra* notes 30–50 and accompanying text.
27. *See infra* notes 51–152 and accompanying text.
28. *See infra* notes 153–242 and accompanying text.
29. *See infra* notes 243–305 and accompanying text.
30. *See* Health Insurance for the Aged Act, Pub. L. No. 89-97, tit. 1, 79 Stat. 290 (1965) (codified as amended in scattered sections of 26 U.S.C., 42 U.S.C. & 45 U.S.C.).
31. *See id.*
32. *See id.*; *see also* Kleiner et al., *supra* note 13, at 775 (providing an overview of the federal Medicare and Medicaid programs).
33. *See* GAO REPORT, *supra* note 2, at 2.
34. *Id.* at 8.
35. *Id.* at 9.
36. *See id.*; *see also* Orentlicher, *supra* note 25, at 158 (noting that the system served physicians' personal interests by encouraging more services for greater fees).

Congress's concern that the fee-for-service reimbursement system discouraged hospitals from providing efficient and economical health care prompted the Medicare Prospective Payment System (PPS).[37] In 1983, Congress introduced the PPS as the hospital reimbursement method for inpatient services provided under Medicare and Medicaid.[38] To be reimbursed under the PPS, hospitals must adhere to certain protocols for admittance and treatment.[39] Upon arrival or admittance to the hospital, the patient is diagnosed and a treatment plan is constructed.[40] The diagnosis is then matched to one of 492 established diagnosis-related groups (DRGs).[41] The hospital is reimbursed prospectively based on the established cost of treating the diagnosed DRG—the hospital receives a pre-determined sum regardless of the number and types of services rendered or the length of the patient's stay.[42] Recognizing that some patients could be treated at a cost less than the predetermined DRG rate, Congress hoped to provide hospital management with an incentive to control costs[43]—hospitals that successfully treat patients for less than Medicare's pre-set cost pocket the difference and realize a profit.[44]

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37. *See* Health Care Programs: Fraud and Abuse; Civil Money Penalties for Hospital Physician Incentive Plans, 59 Fed. Reg. 61,571, 61,572 (proposed Dec. 1, 1994) (to be codified at 42 C.F.R. pt. 1003) (crediting the reimbursement system's inherent incentive to admit higher numbers of Medicare recipients for increased in-patient stays and to provide more services while the Medicare beneficiary was in the hospital as the impetus for the PPS); *see also* U.S. GEN. ACCOUNTING OFFICE, INFORMATION REQUIREMENTS FOR EVALUATING THE IMPACTS OF MEDICARE PROSPECTIVE PAYMENT OF POST-HOSPITAL LONG-TERM-CARE SERVICES: PRELIMINARY REPORT (1985), *reprinted in Sustaining Quality Health Care Under Cost Containment: Joint Hearing Before the House Select Comm. on Aging and the Task Force on the Rural Elderly of the House Select Comm. on Aging*, 99th Cong., 1st Sess. app. at 102, 102 (1985) (Sup. Docs. No. Y4.Ag 4/2:H34/32) (stating that the purpose of the PPS was to help control the burgeoning health care costs); Theodore N. McDowell, Comment, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments: Their Impact on the Present Health Care System*, 36 EMORY L.J. 691, 703–05 (1987) ("The purpose of the [PPS was] to provide incentives for hospitals to contain costs.").

38. Health Care Programs: Fraud and Abuse; Civil Money Penalties for Hospital Physician Incentive Plans, 59 Fed. Reg. at 61,572.

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.* The dollar value assigned to the DRG varies between hospitals as the HCFA takes into account such factors as location and income levels. *See* Prospective Payment Systems for Inpatient Hospital Services, 42 C.F.R. § 412.63 (1999).

43. Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1172 (1986) (explaining the rationale for implementing the PPS).

44. *See id.* Section 1886 of the Social Security Act, 42 U.S.C.A. 1395ww(d)(5)(A)(i)–

To realize profits, however, hospitals must contend with the fact that physicians are not reimbursed in the same manner.[45] Under Medicare Part B,[46] physicians are compensated separately for their services.[47] Consequently, physicians do not inherently share the hospitals' incentive to curtail costs or reduce the number of services provided.[48] Because physicians control the number and types of services rendered to individuals,[49] hospitals have attempted to devise ways to encourage physicians to recognize the benefits of more efficient care.[50] The implementation of gainsharing arrangements represents one such attempt.

(ii) (West Supp. 2000), provides for additional reimbursement for those patients whose length of stay exceeds the calculated mean length-of-stay for all patients with a particular diagnosis, by a specified number of days or by a fixed number of standard deviations, whichever is less. *Id.* Further, additional reimbursement is possible if the Medicare charges surpass the DRG reimbursement by a fixed dollar amount or by a fixed multiple of the PPS rate, whichever is greater. *Id.* This rate is to be determined by the Secretary of Health and Human Services. 42 C.F.R. § 412.80(a) (1999).

45. *See* Krecke, *supra* note 6, at 286.

46. Medicare is organized into two parts, Part A and Part B. *See generally* SNOE, *supra* note 24, at 593–96 (explaining the structure of the Medicare program). Part A is financed through payroll deductions during the beneficiaries' working years and "covers hospitals, skilled nursing, home health care, and hospice care." *Id.* at 593. Medicare Part B covers physician services and many outpatient services. It is a voluntary program; individuals must enroll and pay a monthly premium to be beneficiaries. *Id.* The premiums are used to cover costs not covered from the general fund. *Id.*

47. *See e.g.*, Supplementary Medical Insurance (SMI) Benefits, 42 C.F.R. § 410.20 (1999).

48. Physicians are individually reimbursed by the HCFA based on the services they render to Medicare beneficiaries. The reimbursement amount is determined by a formula, which takes the region of the country, the type of patient, and the service rendered into account. *See* 42 C.F.R. §§ 410, 411, 414, 415 & 485 (1999). Essentially, Medicare reimburses physicians an amount it considers appropriate compensation for the services provided. *See* Krecke, *supra* note 6, at 284.

49. Krecke, *supra* note 6, at 283 n.26 ("[E]fficient hospital operation requires close cooperation between hospital administrators and physician staff .... [I]t is the physician who makes most of the decisions on patient care. A hospital will not be able to live within Medicare's prospective payment unless its physicians are willing to economize." (quoting R. Rubin, *in DRG's—What's Next? Two Views*, 1, 7 (1984) (remarks at seminar sponsored by the Mount Sinai School of Medicine, Department of Health Care Management) (on file with University of Michigan Journal of Law Reform))).

50. Richard X. Fischer, *Gainsharing and the Law: Key Legal Issues, in* OIG Issues Advisory Bulletin on Gainsharing Arrangements: What to Tell Your Clients? 1, 2 (Am. Health Law. Ass'n Telephone Seminar, Aug. 2, 1999) (on file with the North Carolina Law Review). Because the PPS forces hospitals to become more cost-efficient to achieve greater cost effectiveness, "hospital management must necessarily attempt to modify physician practice patterns." McDowell, *supra* note 37, at 736.

II. GAINSHARING

The term gainsharing encompasses an assortment of different compensation arrangements used to align the economic interests of an employer and an employee.[51] In the health care context, gainsharing arrangements are used to align the economic interests of hospitals and physicians. Gainsharing encourages "cost effective care"[52] by providing "payments to physicians of 'a portion of the hospital's cost-savings in exchange for identifying and implementing cost-saving strategies.' "[53] The majority of gainsharing arrangements target groups of physicians and specific hospital departments or medical service lines.[54] Departments with the highest patient volume and the greatest number of procedures are prime targets for gainsharing arrangements because modification of physician behavior in these departments presents the greatest possibility of improving the hospital's bottom line.[55]

A. The Cost-Containment Rationale for Gainsharing

The last two decades have produced enormous increases in health care costs,[56] which some largely attribute to the "perverse financial incentives created by the structure" of the Medicare and Medicaid programs.[57] In 1983, health care expenditures totaled $355.3 billion in the United States.[58] In 1990, these costs totaled

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51. Gainsharing is not unique to the health care industry; it has been used throughout the business community. *See* Stephen M. Bainbridge, *Privately Ordered Participatory Management: An Organizational Failures Analysis*, 23 DEL. J. CORP. L. 979, 988 (1998) (explaining gainsharing as an attempt to reward employees for assisting a business in meeting its goals).

52. Washlick, *supra* note 1, at 3 (noting that the general methods used to share in cost-savings are percentage payments, hourly fees, fixed fees, and combinations of the three).

53. *Align Docs', Hospitals' Money Incentives*, MODERN HEALTHCARE, Aug. 9, 1999, at 50, 50 (quoting the OIG Special Advisory Bulletin on gainsharing arrangements).

54. Washlick, *supra* note 1, at 3.

55. *Id.* It is commonly accepted in the health care industry that modifying physicians' financial incentives guarantees "easy savings." *See Align Docs' Hospitals' Money Incentives*, *supra* note 53, at 50. Gainsharing programs, however, are not limited to providers acting as clinicians. They are used with all levels of staff to improve overall quality of care, to reduce costs, and to achieve optimal operational efficiencies. *See* Washlick, *supra* note 1, at 3.

56. *See* Orentlicher, *supra* note 25, at 155 (detailing the recent rise in health care costs).

57. McDowell, *supra* note 37, at 699.

58. Health Care Financing Administration Office of the Actuary, *National Health Care Expenditures 1965–2008*, *at* http://www.hcfa.gov/stats/NHE-Proj (last modified July

$699.4 billion, and in 1997, they totaled $1092.4 billion.[59] Faced with the mounting costs of health care, the public and the government have increasingly pressured health care providers to contain costs. With almost forty-seven percent of health care expenditures funded by public sources,[60] the pressure to contain costs is not likely to subside.

Because the majority of the public health care expenditures are serviced under Medicare and Medicaid, cost-containment efforts have focused these programs.[61] Taking medical resources into account when determining physician payment[62] and the implementation of Medicare DRGs, serve as two examples of the government's increased effort to curtail public health care costs. The Balanced Budget Amendment of 1997[63] provides yet another. When originally enacted, the amendment was estimated to reduce hospital payments by $155 billion over a five-year period.[64] The American Hospital Association subsequently concluded that the amendment would actually result in a $226 billion reduction in payments to hospitals.[65]

These cost-containment efforts, coupled with increased patient demand for services and technology,[66] cut at hospitals' bottom lines.[67] Hospital operating margins dropped forty-five percent during the

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14, 1999) (on file with the North Carolina Law Review).

59. *Id.* According to the Bureau of Labor Statistics, medical inflation has outpaced overall inflation for nine of the last ten years. Bureau of Labor Statistics, U.S. Dep't of Labor, *Medical Inflation up in 1999*, *at* http://stats.bls.gov./opub/ted/2000/Jun /wk4/art01.htm (last updated June 30, 2000) (on file with the North Carolina Law Review).

60. *See By the Numbers, Medicare and Medicaid*, MODERN HEALTHCARE, July 19, 1999, at 30, 30 [hereinafter *By the Numbers*].

61. *See id.*; *see also* McDowell, *supra* note 37, at 691 (stating that the introduction of Medicare and Medicaid marked the beginning of a national health care policy that emphasizes cost containment).

62. *See* 42 U.S.C.A. § 1395w-4 (West Supp. 2000). *See generally* BARRY R. FURROW ET AL., HEALTH LAW § 11-20 (2d ed. 2000) (explaining Medicare payment methodologies). Under the Resource Based Relative Value Scale, physician reimbursement is a function of the service rendered, the physician's locale, and the population served. *See* SNOE, *supra* note 24, at 623.

63. Balanced Budget Amendment of 1997, Pub. L. No 105-33, 111 Stat. 251 (instituting reductions in Medicare reimbursement).

64. Barbara Kirchheimer, *The Other Shoe Drops*, MODERN HEALTHCARE, July 12, 1999, at 6, 6 (citing an estimate from the Congressional Budget Office).

65. *Id.*

66. Bryan A. Liang, *Patient Injury Incentives in Law*, 17 YALE POL'Y REV. 1, 3 (1998).

67. *See* Stephen G. Reed, *Monitoring Profits Hospital Officials Say the Industry's Prognosis is Dire, and They're Keeping a Nervous Eye on the Bottom Line. But is that Bottom Line Really Suffering?*, SARASOTA HERALD TRIB., Oct. 25, 1999, at 12.

fourth quarter of 1998.[68] Results from the first quarter of 1999 evidence a further decline in profitability.[69] A 1999 Ernst & Young survey estimated that the changes in Medicare spending will result in a reduction in hospital Medicare margins from 4.3% in 1997 to 0.1% in 1999.[70] These changes will reduce total hospital margins from 6.9% in 1998 to 3.6% in 2002.[71] Hospital outpatient margins will become even more unprofitable, falling from –17.0% in 1998 to –28.8% in 2002; rural hospital margins are expected to fall from 4.2% in 1998 to –5.6% in 2002.[72] In short, the "nation's hospital industry is ailing."[73]

To combat the net effect of increased expenses and reduced payments, hospitals have attempted to implement arrangements that marginally reduce beneficial services and overall costs to the hospital, improve the quality of patient care, and secure the allegiance of referring physicians.[74] These remedies include reductions in institutional waste and increased efficiency of administrative services, including the streamlining of processes and the restructuring of practice procedures.[75] These administrative remedies, however, have brought limited relief.[76] One reason for the limited success of these cost-saving measures is that physicians largely control the costs and spending of the hospital.[77] Physicians order the treatments, write the prescriptions, and control the overwhelming majority of the cost

68. *See* J. Duncan Moore Jr., *Chasm Grows Between Rich and Poor*, MODERN HEALTHCARE, June 7, 1999, at 34, 34 (citing HBS International, a health care outcomes management company).

69. *See id.*

70. Robert Laszewski, *Trends in Healthcare Financing Market*, *at* http://www.dartmouth.edu/~hist6/section9/week6/c_links.html (last visited Oct. 12, 2000) (on file with the North Carolina Law Review).

71. *Id.*

72. *Id.*

73. Reed, *supra* note 67.

74. *See* Orentlicher, *supra* note 25, at 155–57; *see also* Washlick, *supra* note 1, at 1 (discussing the importance of physician referrals and noting that a hospital would have very few patients without physicians to refer and admit them).

75. *See* Orentlicher, *supra* note 25, at 156–57; Reed, *supra* note 67. Hospitals have achieved savings through mergers, cost-cutting measures, over-hauling support services, and joining with other institutions for such things as laundry services and purchasing. *See generally* Orentlicher, *supra* note 25, at 156–57 (noting the many ways in which hospitals have attempted to achieve greater efficiency and reduce costs over the past decade). Nonetheless, there are still too many empty hospital beds; consequently, hospitals are losing money. *See id.* Other programs utilized to contain costs, including education, peer education, and restriction of staff privileges, have also been used in attempts to develop cost-conscious behavior on the part of physicians. McDowell, *supra* note 37, at 711.

76. *See* Orentlicher, *supra* note 25, at 156.

77. McDowell, *supra* note 37, at 711.

incurring items.[78] Without a "financial framework that aligns the economic incentives of physicians and hospitals, making them partners in solving the problem," neither the modification of physicians' financial incentives nor operational savings achieved through active collaboration of the medical staff can be attained.[79] Accordingly, the number and types of physician gainsharing plans used by hospitals have increased.[80]

The imbalance in incentives that resulted from the need for and proliferation of gainsharing programs was an unintended, though foreseeable, result of the PPS.[81] Those involved in the construction and development of the Medicare PPS readily admitted that, absent an alignment of hospital and physician economic incentives, there would be "major structural dysfunction, which would forever compromise the PPS."[82] The reimbursement scheme established by the Health Care Financing Administration (HCFA) presented an "extraordinary anomaly"—physicians controlled hospital costs but were reimbursed on a fee-for-service basis, while hospitals controlled only a small minority of the costs but were reimbursed based on the physicians' diagnosis rather than services rendered.[83] Hospitals soon

78. *See* Telephone Interview with Robert Homchick, *supra* note 15 (explaining that gainsharing is an effective method of making doctors consider basic things, such as prescribing generic products or medications in place of more expensive brand items). Absent an incentive to be cost-conscious, physicians are unlikely to cut costs on their own initiative. *See id.*; *see also* Health Care Programs: Fraud and Abuse; Civil Monetary Penalties for Hospital Physician Incentive Plans, 59 Fed. Reg. 61,571, 61,572 (proposed Dec. 1, 1994) (to be codified at 42 C.F.R. pt. 1003) (recognizing physicians' ability and authority to control costs); JEFF CHARLES GOLDSMITH, CAN HOSPITALS SURVIVE? 161–62 (1981) (stating that conflicts with medical staff are particularly dangerous for hospitals because physicians control hospital utilization); McDowell, *supra* note 37, at 711 (noting that physicians control sixty to eighty percent of hospital costs).

79. *Align Docs', Hospitals' Money Incentives*, *supra* note 53, at 50.

80. *See generally* Danielle A. Dolenc & Charles J. Dougherty, *DRGs: The Counterrevolution in Financing Health Care*, HASTINGS CTR. REP., June 1985, at 1, 24–25 (noting that the PPS was the impetus for hospitals to start offering financial rewards to those physicians who save money on Medicare patients); David M. Frankford, *Managing Medical Clinicians' Work Through Use of Financial Incentives*, 29 WAKE FOREST L. REV. 71, 71 (1994) (noting the common use of financial incentives in plans for health care reform); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 483 (1988) (stating that the "most effective motivational force is likely to be financial incentive").

81. *See infra* notes 83–85 and accompanying text.

82. *Align Docs', Hospitals' Money Incentives*, *supra* note 53, at 50 (quoting individuals involved in developing the prototype for the Medicare PPS).

83. Hall, *supra* note 80, at 434. More specifically, doctors determine where, when, how long, and how intensively the treatment will be administered. *Id.* Because physicians also order lab tests, x-rays, pharmaceuticals, and surgery, they control short-term hospital costs and "long-term demand for capital resources and insurance coverage." *Id.* Most

realized that under the PPS, the shorter a patient's stay, the greater the number of admits, and the fewer services provided, the greater the hospital's profit.[84] Because physicians control the treatment and diagnosis of patients, hospitals realized the advantage of aligning the physicians' pecuniary interests with the economic goals of the hospital through gainsharing arrangements.[85]

B. *Types of Gainsharing Arrangements*

Gainsharing arrangements are typically several hundred pages long and are written after countless hours of meetings with consultants, physicians, and administrators.[86] Most arrangements have quality assurance guidelines that serve as the trigger for payment.[87] In other words, the physician must meet the quality of care standard before being eligible for payment.[88] Many hospitals use patient satisfaction surveys to assess the quality of a physician's care.[89] The physicians or departments must achieve certain cumulative scores before they are eligible for compensation from the gainsharing program.[90] Arrangements generally cover all of the physicians in the department, or on the active medical staff, and thereby avoid the specter of the Paracelsus investigation of individually paid physicians.[91] Most gainsharing programs provide strong incentives to physicians to utilize fewer high cost items and to

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estimates put physician control of health care expenditures at seventy to ninety percent. *Id.*

84. *See* GAO REPORT, *supra* note 2, at 10.

85. *See* Hall, *supra* note 80, at 434. Salary and capitated service payments both control the costs of hospitals and present no incentive for physicians to over-prescribe services. *See generally* Orentlicher, *supra* note 25, at 158–59 (noting the alternatives to the fee-for-service method of reimbursement). Conversely, they present no incentive for the physicians *not* to over-prescribe. *See* Hall, *supra* note 80, at 434. Further, neither salary nor capitation has been viewed favorably within the medically community. *See generally* Victor R. Fuchs, *No Pain, No Gain: Perspectives on Cost Containment*, 269 JAMA 631, 631–32 (1993) (explaining the relatively small value in utilizing either salary or capitation as a cost containment measure).

86. Telephone Interview with Marilou King, *supra* note 10.

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id*; *see also supra* notes 1–7 and accompanying text (discussing the Paracelsus arrangement). By constructing the gainsharing arrangement to include all of the physicians in a given department or on the medical staff, hospitals also believed they were eliminating many of the abuses that the government and regulatory bodies were concerned with regarding gainsharing arrangements and Medicare beneficiaries. Telephone Interview with Marilou King, *supra* note 10.

use discounted or generic products or drugs.[92] Although each facility constructs its own specially tailored gainsharing arrangement, common components and arrangements include bonuses, structured compensation arrangements, joint ventures, increased risk sharing, and risk pools.[93]

In a typical bonus arrangement, a hospital reserves a set amount of money to pay for designated types of services.[94] At the conclusion of a designated period of time, generally a month or a year, the hospital pays any surplus from the fund to the physicians.[95] The intended goal of bonus arrangements is for physicians to recognize that providing fewer services leaves more money in the fund to share.[96]

In contrast to bonuses, some gainsharing arrangements are designed as part of the physician's compensation package.[97] Compensation arrangements differ from bonuses in that the arrangement forms the basis of the physician's salary.[98] These arrangements are often based on a percentage of gross charges, a percentage of net or adjusted charges, or a percentage of net collection.[99] These financials figure into a specially designed formula;[100] the product or end result is the physician's

92. *See* Telephone Interview with Robert Homchick, *supra* note 15. Physicians also often receive financial rewards for reducing a patient's stay and for decreasing the number of services provided. *See id.*

93. *See infra* notes 94–152 and accompanying text (explaining the various types of arrangements and their strengths and weaknesses).

94. For a summation and exploration of differing types of physician compensation arrangements, see James F. Owens & Michael Wilson, Physician Compensation—Aligning Incentives 1–4 (Am. Health Law. Ass'n Annual Meeting, Washington, D.C., July 1998) (on file with the North Carolina Law Review).

95. *See generally* Alexander M. Capron, *Containing Healthcare Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 725 (1986) (explaining that physicians in bonus arrangements with HMOs or joint ventures with hospitals may receive surplus payments when "cost-effective" care is rendered); E. Haavi Morreim, *The MD & the DRG*, HASTINGS CTR. REP., June 1985, at 30, 34–35 (noting ways in which physicians can be compensated, including the use of bonus-type arrangements).

96. *See* Orentlicher, *supra* note 25, at 160.

97. Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604, 605 (1995).

98. *Id.* (discussing financial incentives and explaining that increases and decreases in a physician's compensation are dependent on the "cost implications of his or her clinical choices or the organization's profitability"); *cf.* Owens & Wilson, *supra* note 94, at 2 (explaining the role of structured compensation arrangements in maximizing profitability).

99. *See* Owens & Wilson, *supra* note 94, at 2. (noting that percentage of net or adjusted charges and percentage of net collections are preferable over percentage of net collections because they more realistically measure financial performance).

100. *See id.*

compensation.[101] Some of the more popular types of compensation arrangements evaluate each physician's hospital charges for Medicare patients and compare this number, on a monthly basis, to the Medicare prospective payments received by the hospital for those same patients.[102] The physician is then entitled to a set percentage of the amount of Medicare payments in excess of the costs attributable to those patients.[103]

By basing physician compensation on a formula encompassing charges and collections, the hospital encourages efficiency and provides the physician with incentives to perform only those services that can be charged to and reimbursed by the government.[104] By providing mostly reimbursable services, physicians increase the hospital's rate of return.[105] The more money the hospital takes in, the greater the physicians' personal income.[106]

A third type of gainsharing arrangement is the Medical Staff Hospital Joint Venture (MSHJV).[107] Under this type of arrangement, the gainsharing program is established as its own separate entity—a "DRG Venture"[108]—controlled and operated by the MSHJV, which is jointly owned by the hospital and participating medical staff.[109] If the costs associated with the care of Medicare beneficiaries are below a targeted amount, the hospital allocates money for physician incentive payments according to the terms of a contract signed by the hospital and the DRG Venture.[110] The contract sets standard unit costs for each hospital service and thereby accounts for costs controlled by physicians and costs controlled by the hospital.[111]

The contract also establishes a target discharge rate for each Medicare beneficiary based on the corresponding DRG; the target rate is generally below the Medicare reimbursement rate.[112] Subsequently, the DRG Venture tracks the physicians' discharge

101. *See id.*
102. *See id.*
103. *See id.*
104. *See id.*
105. *See generally id.* at 1–4 (explaining the intricacies of differing arrangements).
106. *See id.*
107. *See* GAO REPORT, *supra* note 2, 16–18.
108. *Id.* at 16.
109. *Id.*
110. *Id.*
111. *Id.* at 17.
112. *Id.*

rates, both individually and collectively.[113] The average costs of all admitted Medicare beneficiaries—of both the participating and nonparticipating physicians—must be at or below the established target amounts before incentive payments are disbursed.[114] Although the payment is predicated on the collective activities of all the physicians, the payments themselves are distributed only to those physicians who saved costs and are based on the amount the physician was personally able to save.[115]

Physician responsibility for saving costs is even more acute in gainsharing arrangements specifically designed to increase risk sharing. Under an increased risk sharing arrangement, the hospital contracts with or establishes a separate agency to assume the financial risks associated with patient care.[116] Typically, a group of physicians will enter into a contract with the hospital allocating the financial risk associated with the costs of medical care and hospitalization for a given group of individuals.[117] Through these types of arrangements, the hospital, primarily responsible for the care of a Medicare beneficiary, contracts away some of its responsibility to the physician or another outside entity.[118] This type of arrangement is more common in joint ventures, physician-owned hospitals, and risk pools,[119] and is usually connected with a managed care plan and groups of primary care physicians.[120] The contract between the entities can take the form of a global capitalization contract involving a mutual Physician Hospital Organization (PHO)[121] or one under which the physician group and the hospital are both paid directly by

113. *Id.*
114. *See id.*
115. *See id.*
116. *See id.* at 16–18.
117. *See* Jacob S. Hacker & Theodore R. Marmor, *The Misleading Language of Managed Care*, 24 J. HEALTH POL. POL'Y & L. 1033, 1040–42 (1999).
118. *See generally* William T. Lifland, *Monopolies and Joint Ventures*, *in* 1 41ST ANNUAL ANTITRUST LAW INSTITUTE 153 (PLI Corp. L. & Practice Course, Handbook Series No. B1180, 2000) (explaining the various types of PHO arrangements and how entities contract to shift risk and responsibility).
119. *See id.* at 252–54; *see also* Robert J. Herrington, Note, Herdrich v. Pegram: *ERISA Fiduciary Duty Liability and Physician Incentives to Deny Care*, 71 U. COLO. L. REV. 715, 718–19 (2000) (explaining capitation and risk sharing).
120. *See* Lifland, *supra* note 118, at 270–77 (explaining risk sharing arrangements between managed care entities and joint ventures).
121. A Physician Hospital Organization (PHO) is a form of managed care. A PHO is comprised of a hospital and its affiliated physicians and offers centralized management in a less integrated structure than a typical HMO. *See* FURROW ET AL., *supra* note 62, § 5-49(b).

the managed care plan for the individual services they provide.[122] Because the separate entity is run (and sometimes owned) by the providers themselves and because the providers have contracted to assume more of the risk, there is a strong incentive to provide care in the most efficient and cost-effective manner in order to increase profits.[123]

A fifth type of gainsharing arrangement, risk pools, has also been employed by some hospitals.[124] In a typical risk pool arrangement, part of the physicians' incomes are withheld and pooled in a fund,[125] which is then used to pay the costs of medical services for which the hospital is not reimbursed.[126] At the end of some specified time period, the physicians divide the pool or share in the loss.[127] The participating physicians' share may be based on such factors as utilization, or use of services, and cost.[128] Currently, there are risk pools made up solely of Medicare and Medicaid beneficiaries.[129]

C. *The Weaknesses of Gainsharing Arrangements: Incentives Not to Treat or Not to Treat Well*

Although gainsharing arrangements are a generally effective means of providing cost-efficient health care, a 1986 report on hospital-physician incentive plans by the General Accounting Office noted the most troublesome element of such arrangements: the incentive for physicians not to see, admit, or treat Medicare beneficiaries.[130] The report also identified the likelihood of problems

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122. *See* Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J. L. & MED. 7, 10–14 (2000) (discussing managed care, capitation, and physician-hospital organizations).

123. *See id.*

124. *See* Owens & Wilson, *supra* note 94, at 1–2.

125. *See* Tom J. Manos, Comment, *Take Half an Aspirin and Call Your HMO in the Morning—Medical Malpractice in Managed Care: Are HMOs Practicing Medicine Without a License?*, 53 U. MIAMI L. REV. 195, 217–18 (1998).

126. *See id.*

127. *See id.*

128. *See* Owens & Wilson, *supra* note 94, at 2.

129. Risk pools of Medicare and Medicaid beneficiaries are generally not mixed with regular indemnity insurance populations because of the distinct needs of these populations. Robert B. Hackey, Commentary, *The Politics of Reform*, 25 J. HEALTH POL., POL'Y & L. 211, 219 (2000) (noting the use of separate risk pools for Medicare and Medicaid beneficiaries).

130. The most troublesome elements were listed as:

> Basing the decision to pay an incentive on the cost performance of a single physician, who, in most cases, will not admit a large number of Medicare patients to the hospital during any given period.
>
> Basing the decision to pay an incentive on the cost performance of a physician or

with physician incentive plans that do not contain clear provisions for utilization and quality of care review.[131]

Some fear that gainsharing arrangements encourage physicians to limit the care they provide patients, including limiting or denying tests or treatments and underscheduling return appointments.[132] For example, if an incentive plan is based on a one-month time period, during any particular month, a physician might schedule as many low-cost patients as possible while postponing appointments with patients in greater need of care.[133] Moreover, physicians may be tempted to hasten a patient's discharge before it is prudent or medically safe.[134] Even if such cost-cutting behavior is of no medical consequence to the patient, it could potentially weaken the bonds of the fiduciary, doctor-patient relationship.[135] Physicians participating in incentive programs may weigh the benefits of certain treatments not against the best interests of the patient, but against the hospital's bottom line.[136]

In addition to the legal and regulatory problems raised by gainsharing arrangements, hospitals also must contend with the

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group of physicians over a short period of time, such as a month, which also reduces the number of patients over which cost performance is measured.

Basing the amount of the physician's incentive payment on a percentage of the physician's contribution to the hospital's savings or profit.

GAO REPORT, *supra* note 2, at 3–4; *see also* Special Advisory Bulletin, *supra* note 18, at 37,986 ("[N]o combination of features could guarantee that such plans would not be subject to abuse.").

131. GAO REPORT, *supra* note 2, at 4.

132. *See* Orentlicher, *supra* note 25, at 161 (noting the possible consequences of financial incentives to limit care); *see also* Edmund D. Pellegrino, *Rationing Health Care: the Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. POL'Y. 23, 31 (1986) (explaining that pressures for physicians to minimize costs may encourage them to delay testing, treatment, or consulting specialists, thereby putting patients at risk).

133. *See* GAO REPORT, *supra* note 2, at 15.

134. Kosecoff et al., *supra* note 7, at 1980. Some commentators disagree, noting that physicians adhere to a value system where the guiding principle is always the welfare of the patient and profitability is merely a secondary consideration. *See* McDowell, *supra* note 37, at 711; *see also* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 23 (1982) ("[M]edicine and other professions have historically distinguished themselves from business and trade by claiming to be above the market and pure commercialism.").

135. Orentlicher, *supra* note 25, at 161–62. Although these arrangements could compromise the traditional value system of the medical profession, the PPS and the current state of hospital finance make it "critical" that physicians become more cost-conscious. *See* Bruce E. Spivey, *The Relation Between Hospital Management and Medical Staff Under a Prospective-Payment System*, 310 NEW ENG. J. MED. 984, 986 (1984).

136. *See generally* William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1753, 1757–59 (1999) (discussing the effects of new forms of compensation on physician behavior).

possibility that the arrangement will not effect the physician's behavior. Physicians are loath, or perhaps unable, to give up a tradition of fee-for-service and the belief that more is better.[137] Further, the accounting systems needed to monitor and regulate the arrangements and patient care are costly and complex.[138]

D. *Strengths of Gainsharing Arrangements: Cost Effective, Quality Care*

Although gainsharing arrangements have received their share of criticism from government and regulatory bodies, such arrangements have also been applauded as effective and beneficial devices.[139] Gainsharing programs share the goals of the PPS, including the desire to provide cost-efficient health care.[140] Because most programs condition payments to physicians on the physicians' ability to maintain or achieve certain levels of quality in the services they provide, gainsharing arrangements enhance the quality of care received by the beneficiary.[141] In recognition of this positive effect, the OIG Special Advisory Bulletin stated that "appropriately structured gainsharing arrangements may offer significant benefits."[142] For hospitals, the benefits of gainsharing arrangements include lower hospital costs, improved operational efficiencies, and established procedural and medical protocols that improve the overall quality of patient care.[143]

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137. *See* Orentlicher, *supra* note 25, at 158; *see also* Hall, *supra* note 80, at 434 ("Effective institutional control strategies, however, are unlikely to fit well within a legal structure that has evolved under a traditional, unrestrained reimbursement environment in which physician interests and authority have predominated."). Others contend physicians' deeply embedded professional sovereignty makes it foolish to predict the collapse of their dominance based on a few cracks in the surface. ELIOT FREIDSON, PROFESSIONAL POWERS 129 (1986). "Thus, preserving their professional sovereignty is likely a primary motive for [the AMA and physicians] attacking DRG incentive plans." Hall, *supra* note 80, at 503.

138. *See* Washlick, *supra* note 1, at 3.

139. Telephone Interview with Robert Homchick, *supra* note 15.

140. *See* McDowell, *supra* note 37, at 732. It has also been argued that gainsharing arrangements are less conducive to the typical fraud situation in which physicians are paid for referrals, thus creating incentives for over-utilization. *Id.* at 733. In contrast, gainsharing arrangements emphasize reduction in utilization for admitted patients. *Id.*

141. Fischer, *supra* note 50, at 2.

142. Special Advisory Bulletin, *supra* note 18, at 37,985.

143. Washlick, *supra* note 1, at 3 (explaining that the standardization of procedures and medical protocols serves as an inducement for physicians to follow the established 'best practices' in order to achieve the highest levels of quality of care and cost efficiency).

Gainsharing programs are also reported to improve worker performance.[144] For physicians, gainsharing arrangements offer the opportunity for increased income.[145] Also, such arrangements encourage an atmosphere where the physicians, administrators, and other medical staff are personally invested in the management of departmental activities.[146] Aligning the interests of physicians and administrators helps to "improve[] quality and efficiency of care."[147]

Further, gainsharing arrangements do not sacrifice "the ability of the physicians to individualize the care they provide their patients."[148] Although some suggest that physicians should not ration care,[149] physicians are still better equipped to perform this function than any other entity, group, or individual. Because physicians have the technical education and experience and are familiar with their patients, they are best equipped to judge the appropriateness of particular treatments, tests, and products, given the particular situation, patient, and symptoms.[150] By and large, arrangements today seek to encourage physicians to use certain brands, generic products, and alternative treatments, while maintaining the necessary

144. *See* Daniel J.B. Mitchell et al., *Alternative Pay Systems, Firm Performance, and Productivity*, *in* PAYING FOR PRODUCTIVITY: A LOOK AT THE EVIDENCE 15, 67–68 (Alan S. Blindered ed., 1990).

145. *See generally* Owens & Wilson, *supra* note 94, at 1–4 (explaining how different elements of gainsharing programs offer increases in physician compensation).

146. *See* Washlick, *supra* note 1, at 3 (explaining that the increased focus and interest in the management of departmental activities is not typical of hospital settings).

147. Hall, *supra* note 80, at 504–08 (explaining the historic divergence of interests of physicians and administrators and the current need to align their goals).

148. Orentlicher, *supra* note 25, at 173.

149. Many observers argue that physicians should not ration health care because a doctor is incapable of ascertaining all of the necessary information to make a qualified decision as to whether or not she should ration care. *See* Orentlicher, *supra* note 25, at 165; Daniel P. Sulmasy, *Physicians, Cost Control and Ethics*, 116 ANNALS INTERNAL MED. 920, 921 (1992); John E. Wennberg et. al., *Are Hospital Services Rationed in New Haven or Over-Utilised in Boston?*, THE LANCET, May 23, 1987, at 1185, 1185. It is hard to imagine, for example, a physician is capable of knowing the extent of benefit a patient may receive from a particular form or type of treatment, the likelihood that such a benefit would be realized, the costs of the treatment, and the benefits other patients may have received if the funds had alternatively been spent on them. *See* Sulmasy, *supra*, at 921.

Moreover, physicians historically lack experience in making rationing decisions. *See* Orentlicher, *supra* note 25, at 166. Primarily concerned with the needs of individual patients, physicians do not typically weigh those needs against the greater needs of society. *See* Sage, *supra* note 136, at 1753–59. Arguably, a considerable conflict of interest exists between the needs of a specific patient, the needs of the provider's other patients, and the provider's own financial needs. *See id.* at 167.

150. Orentlicher, *supra* note 25, at 170 (noting that the factors affecting the decision about what type of treatment is most appropriate include cost, potential for benefit, and likelihood of favorable outcome).

flexibility to leave the important medical decisions to the doctor.[151] These arrangements provide physicians with the options and the personal autonomy necessary to be effective caregivers.[152]

III. REGULATORY AND LEGAL OBSTACLES TO GAINSHARING ARRANGEMENTS

Despite the benefits gainsharing arrangements offer, the current regulatory climate has sealed the fate of most plans. As noted, the CMP statute addressed by the Special Advisory Bulletin is not the only regulatory challenge facing gainsharing arrangements.[153] Such arrangements must comply with a myriad of federal laws and regulations. Hospitals regularly file advisory opinion requests with regulatory agencies and the IRS hoping to discover what arrangements comply with current laws and regulations.[154] Among the laws and regulations of greatest consequence to gainsharing arrangements are the anti-kickback laws,[155] the Stark anti-referral laws,[156] tax-exempt regulations,[157] and the CMP statute.[158]

A. Anti-Kickback Statutes

The anti-kickback laws were not intended to apply to payments made in connection with physician incentive plans[159] and do not specifically address gainsharing programs.[160] Nonetheless, arrangements that directly or indirectly induce physicians to order or purchase treatments or services reimbursed by a federal program in exchange for payment are within the laws' scope.[161] Thus,

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151. *See id.*

152. *See generally id.* at 177 (explaining that physicians still have the freedom and control to make the treatment decisions they deem appropriate).

153. For a discussion of the Special Advisory Bulletin, see *infra* notes 16–21 and accompanying text.

154. *See* Telephone Interview with Marilou King, *supra* note 10.

155. *See infra* notes 159–69 and accompanying text.

156. *See infra* notes 170–84 and accompanying text.

157. *See infra* notes 185–201 and accompanying text.

158. *See infra* notes 202–17 and accompanying text.

159. *See* GAO REPORT, *supra* note 2, at 12.

160. Fischer, *supra* note 50, at 5. This omission, however, does not necessarily mean that the regulations do not apply.

161. *See* Social Security Act § 1128A(b), 42 U.S.C.A § 1320a-7b(b) (West Supp. 2000). The anti-kickback laws include provisions prohibiting the knowing or willful "offering, paying, soliciting or receiving" of any "remuneration in exchange for, or to induce, the referral of a patient for an item or service covered by a federal program ... or to recommend or arrange for the purchase of such an item or service." *Id.* § 1320a-7a(b); *see also* Washlick, *supra* note 1, at 6 (recounting the application of the applicable anti-kickback statutes to gainsharing arrangements).

gainsharing arrangements that compensate physicians based on increased profits attributable to such conduct likely violate the anti-kickback laws.[162]

To protect themselves and their incentive programs, some hospitals have sought refuge in the anti-kickback safe harbor provision[163] for Personal Services and Management Contracts.[164] Because this safe harbor requires that compensation be predetermined and volume-neutral,[165] most gainsharing arrangements will not likely qualify. If a gainsharing program cannot consider the number of referrals in fashioning incentive structures, it will be unable to target those physicians who most often refer patients to the hospital—the group of physicians most likely to influence expenses and savings.[166]

The importance of adhering to the anti-kickback laws is underscored by the laws' criminal component—a violation could constitute a felony.[167] Convictions carry fines up to $25,000, imprisonment up to five years, or both.[168] More significantly, if

162. *See* Washlick, *supra* note 1, at 6. Gainsharing arrangements attempting to comply with existing laws and regulations have employed various formulas. Some formulas exclude the number of cases referred to the hospital in excess of the year prior to the implementation of the gainsharing program from the incentive compensation pool. Fischer, *supra* note 50, at 7. Other formulas exclude those portions of payments reflecting an increase in "relative market share" by the hospital at the time of the gainsharing program. *Id.* Still others calculate "savings on commercial cases and then extrapolat[e] those savings to the hospital's traditional Medicare/Medicaid patient mix." *Id.* Because the health care needs and costs of Medicare and Medicaid recipients vary greatly from those privately insured patients, these types of formulas are problematic and often prove less successful. *Id.*

163. SNOE, *supra* note 24, at 643.

164. 42 C.F.R. § 1001.952(d) (1999). This safe harbor is also commonly known as the Personal Services Exception.

165. *See id.*; *see also* Fischer, *supra* note 50, at 5 (discussing the scope of the safe harbor provision); Washlick, *supra* note 1, at 6 (describing compliance with safe harbor requirements). Specifically, the safe harbor requires that the gainsharing program (1) be "set out in writing and signed by the parties;" (2) "specif[y] the services to be provided;" (3) be for a term of not less than one year; and (4) set out the aggregate compensation a physician may receive. 42 C.F.R. § 1001.952(d)(1)–(2), (4). The regulations mandate that the physician's compensation be "consistent with fair market value ... and not [be] determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made ... under Medicare." *Id.* § 1001.952(d)(5). The most problematic element of the requirements is that the bonuses must be determined in advance, including bonuses determined according to a formula. Washlick, *supra* note 1, at 6.

166. *See id.* at 5–6.

167. Meador, *supra* note 16, at 23 (listing the penalties for anti-kickback violations).

168. 42 U.S.C.A. § 1320a-7b(b) (West Supp. 2000).

convicted, the hospital or physician may be prohibited from participating in all federal health care programs.[169]

B. *Stark Anti-Referral Laws*

Another area of continuing concern for hospitals that have implemented gainsharing programs and for hospitals considering implementing such arrangements is the Stark anti-referral laws.[170] The Stark laws prohibit physicians from referring patients to entities in which the physicians or an immediate family member have a financial interest.[171] These laws strongly imply that gainsharing programs are impermissible because they provide remuneration that could effectively limit the care given to patients.[172] Statutory exceptions exist for some types of arrangements, but qualifying for these exceptions while maintaining an effective gainsharing program is difficult—any incentive suggesting that physicians limit or reduce care could be deemed violative.[173]

As stated, the Personal Services Exception[174] requires that any compensation paid to the providing physician be pre-determined and not a function of the "volume or value of any referrals between the physicians and the hospital."[175] Regulatory agencies charged with enforcing the Stark laws have not definitively indicated that a pre-set formula that uses the number or volume of referrals in calculating incentive payments would qualify as compensation set in advance.[176]

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169. *See id.*; Washlick, *supra* note 1, at 6. The government bears the burden of proving that the parties "knowingly and willfully" engaged in the respective payment practice in violation of the anti-kickback statute. Washlick, *supra* note 1, at 6.

170. 42 U.S.C.A. §§ 1395nn, 1396b(s) (West Supp. 2000).

171. *See* § 1395nn; 42 C.F.R. § 411.350 (1999). The Stark laws are largely interpreted as the congressional response to physician self-referrals and the consequential increase in the costs of the medical services funded by Medicaid and Medicare. *See* FURROW ET AL., *supra* note 62, §§ 13-8 to 13-9; Douglas A. Blair, *The "PIP" Regulations in Perspective: Analysis and Comparisons with Other Federal Regulations Governing Physician Incentive Plans*, 29 U. MEM. L. REV. 137, 153 (1998) (noting that, in general, the regulations do not allow physicians to make referrals for certain health services to entities in which the physician or a member of the physician's immediate family has a financial relationship).

172. Washlick, *supra* note 1, at 6.

173. *See id.* at 6 (noting that none of the exceptions particularly applies to gainsharing arrangements); *see also infra* notes 174–84 and accompanying text (explaining exceptions).

174. 42 U.S.C.A. § 1395nn.

175. 42 C.F.R. § 1001.952(d) (1999); Fischer, *supra* note 50, at 3; *see also* Nursing Home Consultants, Inc. v. Quantum Health Serv., 926 F. Supp. 835, 844 (E.D. Ark. 1996) (holding that these safe harbor provisions were not applicable to a marketing agreement because the "compensation was directly pegged to the number of sales generated").

176. *See* Blair, *supra* note 171, at 163. The Fair Market Value (FMV) Exception appears to indicate that pre-set formulas are permissible under the Stark laws. *See id.* Yet, for whatever reason, the same wording was not employed in the Personal Services

The HCFA,[177] however, has stated that the use of referrals, either directly or indirectly, when determining compensation, does not fall under the Personal Services Exception, and thus violates the Stark laws, even if set in advance.[178] Therefore, when patients are referred to a hospital by a physician participating in a gainsharing program, and the referral generates compensation, either directly or indirectly, the referral and the gainsharing arrangement violate the Stark laws. Both the physician and hospital would therefore be subject to civil penalties.[179]

In contrast, the Fair Market Value (FMV) Exception,[180] which has not yet been codified or implemented, provides greater flexibility in the use of gainsharing arrangements.[181] The language of the exception suggests that it would be permissible to use formulas to determine physician compensation provided these formulas and compensation are determined in advance of the arrangement's implementation.[182] The FMV exception, however, requires that the compensation not take into account the volume of referrals; it further requires that gainsharing programs either fall within the anti-kickback safe harbor or otherwise comply with the anti-kickback laws.[183] These anti-kickback compliance requirements present considerable obstacles for gainsharing arrangements because such arrangements are unlikely to qualify for the anti-kickback safe harbor or otherwise comply with the anti-kickback laws—setting a physician's compensation prior to any services being rendered in an incentive-type program is simply too difficult.[184]

Exception. *See id.*

177. The HCFA is charged with the responsibility of issuing advisory opinions relating to the Stark laws as well as administering Medicare and Medicaid. *See* Fischer, *supra* note 50, at 5.

178. *See id.* at 4.

179. *Id.*

180. Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships, 63 Fed. Reg. 1659, 1686 (proposed Jan. 9, 1998) (to be codified at 42 C.F.R. pts. 411, 424, 435 & 455). *See generally* Washlick, *supra* note 1, at 6–7 (noting that the FMV Exception was introduced with the proposed regulations).

181. *See generally* Andrew B. Wachler & Phyllis A. Avery, *Stark II Proposed Regulations: Rules Offer Additional Guidance While Regulators Seek More Input from Health Care Community*, HEALTH LAW., Jan. 1998, at 1, 11 (explaining the proposal and its benefits).

182. *See* Fischer, *supra* note 50, at 5.

183. *See id.*; Washlick, *supra* note 1, at 7 (explaining that the arrangement must be commercially reasonable and further the legitimate business purposes of the parties).

184. *See* Fischer, *supra* note 50, at 5 (noting that the difficulty stems from an inability to construct a formula and resulting compensation statement prior to any services actually

C. *Tax Obstacles Including Exemptions and Joint Ventures*

In addition to the anti-kickback and Stark anti-referral laws, hospitals must also consider the ramifications of gainsharing arrangements on the tax-exempt status of bonds used to generate capital to fund the hospitals' operations. If a gainsharing arrangement utilizes hospital facilities and space financed by tax-exempt bonds, to maintain tax-exempt status, the arrangement must comply with the tax-exempt bond rules and the IRS guidelines for permissible business uses.[185] Revenue Procedure 97-13,[186] a safe harbor provision, establishes the guidelines for the "duration and compensation methodology" of certain hospital contracts, including gainsharing arrangements,[187] which are related to portions of the hospital financed by tax-exempt bonds.[188] Conforming to this safe harbor assures hospitals that the particular contract will not be deemed "private business use" under the Internal Revenue Code and that the bonds will remain tax-exempt.[189]

Under Revenue Procedure 97-13, physicians can receive no more than fifty percent of their total compensation from incentives.[190] The remainder must constitute a fixed fee not in excess of the fair market value of the services rendered.[191] The fixed fee may be an

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being rendered).

185. *See* Washlick, *supra* note 1, at 4.

186. *See* Rev. Proc. 97-13, 1997-1 C.B. 632.

187. According to the IRS, "any service contract that confers a preferential right to any use of hospital assets financed by the proceeds of tax-exempt bonds ... is subject to 97-13." Fischer, *supra* note 50, at 8 (discussing Revenue Procedure 97-13).

188. *Id.* at 7.

189. *See id.* at 7–8.

190. Rev. Proc. 97-13, 1997-1 C.B. 632; Fischer, *supra* note 50, at 8 (explaining physician compensation limits). For hospitals without any outstanding tax-exempt bonds Revenue Procedure 97-13 is a non-issue. *See* Fischer, *supra* note 50, at 8–9. Thus, for-profit hospitals need not concern themselves with 97-13. This dichotomy is important; private hospitals may implement programs that base physician compensation at levels greater than fifty percent of the costs saved by those physicians. *See id.* These hospitals face little to no risk, and the programs pay for themselves. *See id.*

191. *See* Rev. Proc. 97-13, 1997-1 C.B. 632 (explaining that the fixed fee and percentage requirements are applicable when dealing with five-year agreements). In some agreements of shorter duration, it is permissible to base physician compensation on percentages of expenses or revenues. *See* Fischer, *supra* note 50, at 8 (noting the greater latitude allotted to two-year agreements but explaining that these agreements must be unilaterally terminable by the hospital at the end of the first year). Understandably, physicians are hesitant to enter into agreements where the hospital is free to terminate the contract, without penalty, after the first year. *See id.* To comply with the terms of the safe harbor, the maximum duration a gainsharing arrangement is allowed to extend is two years. For practical purposes, however, a longer duration is not really effective. *See* Washlick, *supra* note 1, at 5.

established rate, such as fifty dollars an hour;[192] it may not, however, be based on a share of the hospital's net profits.[193] In sum, the only safe way to avoid Revenue Procedure 97-13 is not to use tax-exempt bonds for capitalization. If a gainsharing arrangement allows a physician to share in cost-savings generated by assets financed through tax-exempt bonds, the gainsharing arrangement is subject to 97-13.[194] While ensuring that no more than fifty percent of a physician's compensation is incentive-based should guarantee the arrangement's survival under 97-13, the arrangement would likely violate other regulations such as the Stark anti-referral laws or anti-kickback laws.[195]

In addition to Revenue Procedure 97-13, the IRS has issued a series of private letter rulings addressing the tax consequences of gainsharing arrangements. For example, in the early 1990s, the IRS issued a series of private letter rulings involving physician joint ventures.[196] In these rulings, the IRS invalidated the arrangements, stating that the ventures constituted a reward system to physicians for patient referrals rather than an institutional effort to improve patient care.[197] The rulings led hospitals to consider and construct new arrangements to align physicians' financial incentives with those of the hospitals.[198] In January 1999, the IRS issued two letter rulings, just prior to the Special Advisory Bulletin.[199] Consistent with the earlier rulings, the IRS implied that certain arrangements do not jeopardize a hospital's tax-exempt status.[200] As long as the

192. *See* Fischer, *supra* note 50, at 8.

193. Rev. Proc. 97-13, 1997-1 C.B. 632.

194. *See id.*

195. If the overall amount is greater than the fair market value for compensation, there is a potential anti-kickback violation. *See* Social Security Act § 1128(b), 42 U.S.C.A. § 1320a-7b(b) (West Supp. 2000). If compensation is viewed as an inducement for referrals to the hospital, there is a potential Stark violation. *See id.* § 1395nn.

196. *See* Priv. Ltr. Rul. 92-33-037 (Aug. 14, 1992); Priv. Ltr. Rul. 92-31-047 (July 31, 1992).

197. *See* Priv. Ltr. Rul. 92-33-037 (Aug. 14, 1992); Priv. Ltr. Rul. 92-31-047 (July 31, 1992); *see also* Jaklevic, *supra* note 17, at 12 (discussing the rulings).

198. Jaklevic, *supra* note 17, at 12.

199. *See* Priv. Ltr. Rul. 99-16-037 (Jan. 25, 1999); Priv. Ltr. Rul. 99-18-054 (Jan. 11, 1999).

200. The cases dealt with hospitals paying physicians a certain percentage of the cost-savings that the physicians had realized. *See* Priv. Ltr. Rul. 99-16-037 (Jan. 25, 1999); Priv. Ltr. Rul. 99-18-054 (Jan. 11, 1999). Specifically, the hospitals entered into "Participation Agreements" with a group of cardiologists who were on staff at the hospitals. *See* Priv. Ltr. Rul. 99-16-037 (Jan. 25, 1999); Priv. Ltr. Rul. 99-18-054 (Jan. 11, 1999). Under the agreements, the cardiologists would engage in those activities necessary to assist the hospital in developing and implementing processes aimed at cost-effective utilization of hospital resources and improving the quality of care provided to cardiac patients. *See*

arrangement is aligned with the improvement of the health care services rendered by the hospital, it complies with the current tax laws.[201]

D. *Civil Monetary Penalty Statutes (CMPs) and their Crippling Effect on Gainsharing Arrangements*

Perhaps the greatest threat to gainsharing arrangements is the CMP provision of the Social Security Act.[202] According to the OIG's recent Special Advisory Bulletin, hospital-physician gainsharing arrangements involving Medicare and Medicaid beneficiaries violate the CMP statutes per se.[203] Focusing on sections 1128A(b)(1) and (2) of the Act, which regulate hospital-sponsored physician incentive plans,[204] the Bulletin addressed the concern that the use of incentive programs was reducing the number of services provided to Medicare and Medicaid beneficiaries.[205] According to the OIG, the purpose of the Bulletin and the Act was to prevent hospital payments from influencing and "corrupting" the providing physician's "medical

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Washlick, *supra* note 1, at 4–5. Included in the agreements were "program integrity requirements" aimed at eliminating the chance for adverse or unintended effects on the care received by the cardiac patients. *See id.* After one year, if there were cost-savings related to the delivery of cardiac services and the pre-established patient satisfaction and medical outcomes thresholds had been met, some of the costs saved would be put into a fund. *See id.* The money in the fund would then be disbursed to the participating physicians based on the physician group's performance. *See id.* at 3–4. The amount paid was subject to review by an independent third party appraiser to ensure the amount was a true reflection of the fair market value of the services rendered (protecting against inflation of payments given to physicians). *See id.* at 4–5. The IRS mandated that certain criteria for medical outcomes and patient satisfaction must be met before any physician groups could share in the pooled money generated by cost-savings. *See id.* Further, the money would need to be allocated according to how well the different groups met designated process improvement initiatives. *See id.* These same arrangements have been submitted to the OIG, but the OIG has not yet ruled on them. *See* Jaklevic, *supra* note 17, at 12.

201. *See* Washlick, *supra* note 1, at 4–5. A new revenue procedure providing a safe harbor to gainsharing programs could alleviate concerns about compliance and tax-exempt status under the current tax laws. *See* Fischer, *supra* note 50, at 9. This could help alleviate the distinct disadvantage for those hospitals that have outstanding tax-exempt bonds and consequently cannot create more "cost-efficient" gainsharing programs. *See id.*

202. Social Security Act § 1128A(a), 42 U.S.C.A. § 1320a-7a (West Supp. 2000).

203. Special Advisory Bulletin, *supra* note 18, at 37,985 (explaining the Act's application to hospital-sponsored physician incentive plans).

204. *See supra* note 20 (quoting section 1128A(b)(1)–(2) of the Act).

205. *See* D. McCarty Thornton & Kevin G. McAnaney, *Recent Commentary Distorts HHS IG's Gainsharing Bulletin* (Aug. 1999), *at* http://oig.hhs.gov/frdalrt/bnagain.htm (last visited Nov. 13, 2000) (on file with the North Carolina Review). Thornton is Chief Counsel to the Inspector General of the U.S. Department of Health and Human Services; McAnaney is Chief of the Industry Guidance Branch of the Office of Counsel to the Inspector General).

judgment as to the provision of hospital services to his or her patients."[206] As the House Committee Report accompanying section 1128A(b) of the Act advanced, "such incentive payments may create a conflict of interest that limits the ability of the physician to exercise independent professional judgment in the best interest of his or her patients."[207]

The mandates of the Special Advisory Bulletin drew the attention and concern of the health care industry—it effectively prohibits all gainsharing programs between physicians and hospitals that provide services to Medicare and Medicaid beneficiaries.[208] According to the Bulletin, facilities and providers that knowingly make or accept payments that reduce or limit services to Medicare and Medicaid beneficiaries at the facility, or under the physician's care, are subject to civil monetary penalties of up to $2000 per act per each Medicare or Medicaid beneficiary involved.[209] While the OIG recognized that some gainsharing arrangements could be ultimately

206. *See id.* at 3 (responding to commentaries on the Special Advisory Bulletin); *see also* Washlick, *supra* note 1, at 5 (explaining the OIG's position that gainsharing arrangements offered too great a risk for abuse). This risk of corruption is attributed to the increasing pressure felt by hospitals to increase the percentage of savings shared with the physicians. This increase could lead to the manipulation of hospital accounts and balance sheets in order to construe the documents to appear as though there were greater savings, and therefore, the physician was entitled to a greater benefit. The OIG apparently believes that the health care industry currently lacks adequate self-monitoring programs that could regulate and temper these types of abuses. *See id.*

207. H.R. REP. NO. 99-727, at 444 (1986) (Sup. Docs. No. Y1.1/8:99-727), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3841. The prohibition of gainsharing programs in an effort to protect Medicare beneficiaries and maintain the quality of patient has been questioned. *See generally* Homchick, *supra* note 5 (addressing the Bulletin, its merits, and its consistency with current statutes and previous statements by the OIG). Some speculate whether the government was actually concerned with quality of care or whether the government wanted to share in the profits achieved at Medicare's expense. *See generally* Mary Chris Jaklevic, *HCFA May Revive Doc Bonus Idea*, MODERN HEALTHCARE, Aug. 16, 1999, at 42, 42 (explaining the HCFA's new managed care demonstration project and the possible rationale for its use). The HCFA's recent demonstration announcement illustrates the possibility of an ulterior motive. Recently, the HCFA announced that it was contemplating a new demonstration project in which Medicare would "pay windfalls to large multi-specialty physician groups that lower total Medicare expenditures." *Id.* Specifically, this "gainsharing" arrangement would benchmark participants "against their own experience." *Id.* Subsequent bonuses would be tied to direct physician services and Medicare spending as a whole. *Id.* Those advocating the HCFA's proposal stress that these arrangements differ from hospital gainsharing arrangements which usually involve small specialty groups; the HCFA plan would involve large multi-specialty groups. *Id.* It remains to be seen how the HCFA will achieve these goals in light of the OIG's unequivocal pronouncement that similar arrangements constructed by hospitals violate the CMP. *See id.*

208. Fischer, *supra* note 50, at 1.

209. *Id.*

beneficial, absent a change in the law, these programs are impermissible,[210] and the OIG was without authority to offer regulatory relief.[211]

In August 1999, following some confusion concerning the Bulletin's mandates, the OIG released a notice attempting to clarify some of the rumored interpretations of the Bulletin.[212] The OIG stated that language suggesting that the provider needs to possess the specific intent either to directly or indirectly induce physicians to withhold "medically necessary" treatments and services from Medicare and Medicaid beneficiaries was misinterpreted.[213] Further, the OIG sought to dispel the belief that for there to be an actual violation, the incentive arrangement must "*actually cause* a reduction or limitation of medically necessary services."[214] The OIG stated that the Act encompasses all services, not just medically necessary ones, and only requires a "showing of intent to induce a reduction of services, not an actual reduction."[215]

The OIG's broad interpretation of section 1128A(b) clearly ends any and all physician incentive plans that condition payments on savings that can be linked, in any way, to reductions in hospital costs for treatment to Medicare and Medicaid beneficiaries.[216] As D. McCarty Thornton, Chief Counsel to the Inspector General of the U.S. Department of Health and Human Services noted, no regulation mandates proof of "actual adverse effects on particular patients."[217]

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210. Special Advisory Bulletin, *supra* note 18, at 37,985 (stating that "appropriately structured gainsharing arrangements may offer significant benefits").

211. *See id.*; Fischer, *supra* note 50, at 1.

212. American Health Law. Ass'n, *DHHS OIG Clarifies Gainsharing Ruling; Managed Care Incentive Deals Not Subject to Penalties*, *at* http://www.healthlawyers.org/ofnote%5Foiggainsharingletter.htm (last visited Nov. 1, 2000) (on file with the North Carolina Law Review).

213. *See* Thornton & McAnaney, *supra* note 205.

214. *Id.*

215. *Id.*

216. *See id.* ("[W]e believe that any honest reader of the broad, unqualified statutory language will concede that it clearly encompasses gainsharing arrangements involving monetary payments by hospitals to physicians conditioned on the physicians reducing their patients' hospital treatment costs.").

217. *Id.* Payment under a gainsharing arrangement need not be tied to an actual "diminution" in care. *See id.* If the hospital is aware that the payment could serve as an influence that ultimately results in a reduction or limitation of the number of services provided to a physician's Medicare or Medicaid beneficiaries, the arrangement is impermissible. *See id.*

E. *The OIG's Proposed Rules for Incentive Programs in Health Care Plans*

In addition to the OIG's attempted clarification of the permissibility of gainsharing arrangements, the OIG's proposed rules for incentive programs offer further guidance to hospitals trying to grasp the complexity of the situation.[218] These rules were proposed in 1994,[219] and although the OIG has not promulgated a final rule, it explicitly relied on the proposed rules as support for its position in the Special Advisory Bulletin.[220] The OIG's proposed rules address which physician incentive plans should be prohibited and explain the application of the proposed rules to gainsharing arrangements.[221] Significantly, the preamble emphatically iterates the OIG's position that incentive plans based on reduction of care should be prohibited.[222]

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218. Health Care Programs: Fraud and Abuse; Civil Money Penalties for Hospital Physician Incentive Plans, 59 Fed. Reg. 61,571, 61,571 (proposed Dec. 1, 1994) (to be codified at 42 C.F.R. pt. 1003).

219. *See id.*

220. *See* Thornton & McAnaney, *supra* note 205.

221. *See* Health Care Programs: Fraud and Abuse; Civil Money Penalties for Hospital Physician Incentive Plans, 59 Fed. Reg. at 61,572.

222. The preamble states:

> With PPS permitting hospitals to profit from Medicare and Medicaid patients when such patients are treated at a lower cost than the present payment level, many hospitals have had a new range of financial incentives made available to them for (1) underproviding services to program beneficiaries; and (2) shortening their length-of-stay by discharging them too early.
>
> ....
>
> We believe ... there may be certain types of hospital incentive plans to physicians, such as those designated to reward the timely review and completion of medical records which do not impact on direct patient care responsibilities or do not affect patient referral patterns, that may be acceptable and therefore not be subject to civil money penalties under this provision.
>
> ...
>
> We believe, however, that it is impossible and impractical for the OIG to specifically indicate in regulations what specific criteria may make up an acceptable hospital physician incentive plan ... [a]s with all [CMP] cases, the OIG will review and assess the nature and scope of each suspect incentive plan on a case-by-case basis to determine its specific intent and acceptability.

See id. at 61,572–73; *see also* Thornton & McAnaney, *supra* note 205 (stating that the preamble and Special Advisory Bulletin are wholly congruent). To combat the criticisms of the OIG's reasoning in the Bulletin, Thornton and McAnaney state that those plans that include "some or all of the 'safeguards' " noted in the report will not automatically be viewed as permissible, as noted in the preamble of the CMP statute. *See id.* at 5–6; *see also* Homchick, *supra* note 5, at 14 (explaining the preamble statement); Thornton & McAnaney, *supra* note 205 (rejecting the industry's interpretation that the OIG agrees that there in fact needs to be a case-by-case evaluation in order to determine whether or

Although some in the healthcare industry argued that the proposed rules indicated that suspect incentive plans would be dealt with on a case-by-case basis to determine whether a violation had occurred, the OIG has since clarified its position.[223] According to the OIG, the proposed rules' case-by-case determination applies to those physician incentive plans "*not relating to direct patient care responsibilities*" and that there will be no case-by-case evaluations involving direct patient care gainsharing arrangements.[224]

Those hospitals considering implementing joint ventures, as well as those ventures already in place, would also be subject to the proposed rules. The final paragraphs of the Special Advisory Bulletin intended to serve as a "yellow cautionary flag"[225] indicating the OIG's position that joint ventures constitute gainsharing programs and thus could be subject to the CMP statute.[226] The possibility that joint ventures violate the CMP statute troubles many

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not incentive plans are permissible). Thornton and McAnaney argue that the preamble to the 1994 Notice of Proposed Rulemaking is consistent with the Special Advisory Bulletin and that these alternative beliefs are part of the false impressions circulating in the industry. *See id.*; *see also* Homchick, *supra* note 5, at 15–17 (noting industry interpretations and concerns).

223. *See* Thornton & McAnaney, *supra* note 205. The statement was issued in rebuttal to a recent commentary on the OIG Special Advisory Bulletin authored by the Bureau of National Affairs, which was circulating throughout the industry. *See* American Health Law. Ass'n, *OIG Rebuts Commentary on Gainsharing Bulletin*, *at* http://www.healthlawyers.org/ofnote%5Foiggainsharinghcfrrebut.htm (last visited Aug. 27, 2000) (on file with the North Carolina Law Review).

224. *See* Thornton & McAnaney, *supra* note 205. Most gainsharing arrangements involve physicians with direct patient care responsibilities and seek to modify physicians' behavior with respect to the services and procedures they provide. *See* Washlick, *supra* note 1, at 3 ("Hospital departments generally targeted for gainsharing consideration are those with high volume, involving procedure-driven specialties, such as cardiology, where changes in physician behavior will have the greatest impact ...."). Therefore, most gainsharing arrangements would not be permissible under the proposed rules.

225. Deanna Bellandi & Mary Chris Jaklevic, *What Gainsharing?*, MODERN HEALTHCARE, July 26, 1999, at 8, 8 (quoting HHS spokeswoman Alwyn Cassil). According to the HHS, specialty hospitals, completely owned by staff physicians, which monitor costs and alert the staff to the cost-profit ratio, could very likely be deemed a gainsharing arrangement in violation of the CMP provision. *Id.*

Payments characterized as inducements for referrals have been found illegal even when it was an independent contractor referral source and a portion of the payment is compensation for services rendered. *See* United States v. Kats, 871 F.2d 105, 108 (9th Cir. 1988); United States v. Greber, 760 F.2d 68, 71–72 (3d Cir. 1985). The HCFA has stated, however, that return on investment will not necessarily be deemed remuneration or a kickback when it is strictly tied to ownership and the venture is not a sham. *See* Medicare Program; Physician Financial Relationships With, and Referrals to, Health Care Entities that Furnish Clinical Laboratory Services and Financial Relationship Reporting Requirements, 60 Fed. Reg. 41,914, 41,959 (Aug. 14, 1995) (codified at 42 C.F.R. 411).

226. *See* Special Advisory Bulletin, *supra* note 18, at 37,987.

in the health care industry.[227] Under the Stark laws, Congress carved out a special exception for physicians invested in whole hospitals.[228] The OIG's suggestion that Congress would have created an exception that violated other regulations seems suspect.[229]

F. The Managed Care Exception

Hospitals seeking to maintain incentive programs may benefit from the managed care exception to the scope of the CMP statute. Under this exception, managed care plans are permitted to implement physician incentive plans provided they do not induce the reduction of medically necessary care to individual Medicare or Medicaid patients and do not place physicians at substantial financial risk for services not provided by the physician.[230]

Under Congress's original scheme, all payments by hospitals or managed care plans to physicians that serve as inducements for cost-savings through the reduction of services to Medicare and Medicaid beneficiaries were subject to civil monetary penalties.[231] The 1990 amendment, however, excludes managed care plans from the scope of the CMP statute.[232] According to the OIG, the language in amended sections 1876(i)(8) and 1903(m)(2)(A)(x) of the Social Security Act demonstrate Congress's intent to regulate Medicare and Medicaid managed care arrangements involving physician incentive programs separately.[233] The separate regulation of managed care arrangements include Medicare risk-based managed care plans that directly contract with the HCFA and physician incentive plans

227. *See* Bellandi & Jaklevic, *supra* note 225, at 8.

228. *Id.*

229. *Id.* (quoting Carrie Valianti, partner with Epstein, Beckner & Green, a Washington, D.C. law firm).

230. 42 U.S.C.A. § 1395mm(i)(8)(A) (West Supp. 2000). Substantial financial risk exists when a financial incentive puts more than twenty five percent of the physician's income at risk and the patient panel size is equal to or less than 25,000. There is no limit on panel sizes greater than 25,000. *See generally* Orentlicher, *supra* note 25 (explaining that where there is substantial financial risk, as defined in the statute, the entity must provide stop-loss insurance to protect the provider).

231. *See* 42 U.S.C.A. § 1320a-7a(b) (West Supp. 2000).

232. Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 57 Fed. Reg. 59,024, 59,025 (proposed Dec. 14, 1992) (to be codified at 42 C.F.R. pts. 417, 434 & 1003). The proposed rules were published in December 1992. *See id.* at 59,034–40. The final rules were issued in March 1996. *See* Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 61 Fed. Reg. 13,430–50 (Mar. 27, 1996) (codified at 42 C.F.R. pts. 417, 434 & 1003).

233. *See* Thornton & McAnaney, *supra* note 205; *see also* 42 U.S.C.A. § 1395mm (addressing managed care regulations).

connected to subcontracting arrangements between managed care plans and physician groups or other intermediate entities.[234]

The physician incentive regulations, enforced through the CMP statute, also do not apply to Medicare+Choice managed care plans.[235] Medicare+Choice plans, part of the Medicare program, offer a broader array of health care services based on the types of plans available in the service area.[236] The exemption of Medicare+Choice plans is based, in part, on the statutory language Congress adopted in regulating these entities.[237] The language mirrored section 1876(i)(8) of the Act and delegated to the Secretary the authority to regulate these arrangements.[238]

The disparate treatment of non-managed care hospitals seems unjustified.[239] The OIG, however, believes that, given the differences in the entities themselves, the unequal treatment is warranted.[240] The OIG argues that beneficiaries in Medicare risk-based managed care programs understand the inherent economic incentive for the physician to manage the beneficiaries' care in the most cost efficient manner.[241] Moreover, because the beneficiary also receives a share of the savings—generally in the form of increased benefits, reduced co-payments, and greater outpatient prescription drug coverage—the competing interests are adequately balanced.[242]

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234. *See* 42 C.F.R. § 417.479(i) (1999); Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 61 Fed. Reg. at 13,439; Letter from Lewis Morris, Assistant. Inspector General for Legal Affairs, Office of Counsel to the Inspector General, to an unnamed individual 1 (Aug. 19, 1999), *at* http://www.hhs.gov/progorg/oig/frdalrt/gsletter.htm (on file with the North Carolina Law Review) (responding to questions concerning the applicability of CMPs to risk-based Medicare and Medicaid managed care programs).

235. Letter from Lewis Morris to unnamed individual, *supra* note 234, at 1 (stating that CMPs do not apply to Medicare managed care programs).

236. Press Release, HCFA Press Office, *New Health Options Available Under Medicare+Choice* (June 18, 1998), *at* http://www.hcfa.gov/news/pr1998/pr61898.htm (on file with the North Carolina Law Review).

237. 42 U.S.C.A. § 1395w-22 (West Supp. 2000); Letter from Lewis Morris to unnamed individual, *supra* note 234, at 1.

238. Letter from Lewis Morris to unnamed individual, *supra* note 234, at 1.

239. Competition from alternative delivery systems like HMOs serves as a threat to the financial stability of hospitals. *See* Robert S. Bonney, *Hospital Survival Strategies for the 1980's*, 40 AM. J. HOSP. PHARM. 1483, 1483 (1983).

240. Thornton & McAnaney, *supra* note 205.

241. *Id.* at 4.

242. *Id.* In contrast, under fee-for-service arrangements, individuals incur much higher costs in exchange for unlimited access to physicians and providers of their choice. *Id.* ("Fee-for-service beneficiaries incur substantial additional financial obligations ... in exchange for unfettered access to physicians of their choice."). The fees paid for services rendered, as well as any cost-savings by the provider, benefit the hospitals and

IV. OPTIONS AND POSSIBLE SOLUTIONS

Although, the OIG's position concerning gainsharing is troubling, "as a practical matter, ... people are going to have to accept [it] whether they like it or not."[243] The risk of testing the applicability of the CMP provision, with the possible exclusion from the Medicare program, is a chance that hospitals are not willing to take.[244] Moreover, hospitals are loath to risk violation of the anti-kickback and Stark anti-referral laws. Thus, the hospital industry is eager to know what, if any, incentive arrangements will comply with federal law.[245]

The OIG has carefully avoided taking a position on what it considers appropriate and compliant gainsharing arrangements. Nevertheless, based on the OIG's Special Advisory Bulletin and current federal law governing incentive arrangements involving the Medicare and Medicaid programs, as well as previous actions and statements by the regulating agencies, hospitals have some room to utilize some types of incentive arrangements.[246] Hospitals' options include creating incentive programs that do not include Medicare and Medicaid beneficiaries, basing physician compensation on patient satisfaction and efficiency of care, adhering to the General Accounting Office's 1986 recommendations, lobbying for the explicit permission of gainsharing and incentive programs, and soliciting advisory opinions to assess an arrangement's permissibility on an individualized basis.[247]

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participating physicians—not Medicare or the beneficiaries. *Id.* The OIG believes that this was Congress's rationale for the differing regulation of the incentive plans. *Id.*

243. Jaklevic, *supra* note 12, at 12 (quoting Jim Gaynor, a health care lawyer with McDermott, Will & Emery).

244. *Id.* Further, as previously noted, there are statutes and regulations in place, including the Stark and anti-kickback laws and the CMP statute. If the arrangements violate these laws, they will be sanctioned accordingly. Office of the Inspector General, HHS/OIG Fiscal Year 2000 Work Plan—Health Care Financing Administration 37, *at* http://www.dhhs.gov/progorg/oig/wrkpln/2000/hcfa.pdf (last visited Sept. 6, 2000) (on file with the North Carolina Law Review). The work plan for fiscal year 2000 has Medicare fraud and abuse detection and regulation among those projects that will receive continued attention. *Id.*

245. Telephone Interview with Robert Homchick, *supra* note 15 (noting the hospital industry's desire to comply with federal law but emphasizing the industry's need for cost-saving options).

246. 42 U.S.C.A. § 1320a-7a(b)(1)–(2) (West Supp. 2000); GAO REPORT, *supra* note 2, at 2–4; Special Advisory Bulletin, *supra* note 18, at 37,985; Homchick, *supra* note 5, at 1; Thornton & McAnaney, *supra* note 205.

247. *See infra* notes 248–305 (explaining possible options and solutions for hospitals looking to implement or change their current physician programs).

A. *Incentive Programs that Exclude Medicare and Medicaid Beneficiaries*

Obviously, excluding Medicare and Medicaid beneficiaries from gainsharing programs would solve many of the compliance problems facing hospitals and providers because the arrangements would no longer be subject to federal regulations and statutes. The OIG has unequivocally stated that discretionary enforcement against those gainsharing arrangements that were "expeditiously" terminated after the publication of the Bulletin and were not in violation of any other federal law is the only "favorable" treatment it would provide to a gainsharing arrangement including or aimed at Medicare and Medicaid beneficiaries.[248] At a minimum, such arrangements would have to provide assurance that there was minimal risk of fraud or abuse and that the quality of care for Medicare and Medicaid beneficiaries was in no way compromised.[249]

Considering that Medicare and Medicaid beneficiaries receive nearly fifty percent of all services rendered, excluding Medicare or Medicaid recipients from gainsharing arrangements is not a viable option for most hospitals.[250] Further, because recipients of Medicare and Medicaid are generally less healthy than non-recipients,[251] gainsharing programs that do not include these individuals will fail to address the areas where there is the greatest potential for cost reduction.[252]

Creating Medicare and Medicaid HMOs is one alternative to excluding Medicare and Medicaid recipients altogether. These types of plans are not subject to the Social Security Act under the managed care exception,[253] and are therefore not subject to the penalties established under the Act's CMP provision.[254] The complexity and financial instability of Medicare and Medicaid HMOs, however,

248. Special Advisory Bulletin, *supra* note 18, at 37,985. This favorable treatment, however, presumes compliance with section 1128A(b) of the Social Security Act. Section 1128A(b) prohibits any incentive arrangement that constitutes an inducement to reduce or limit services to individuals entitled to Medicare or Medicaid benefits. Social Security Act § 1128A(b)(1)(A)–(B), 42 U.S.C.A. § 1320a-7a(b)(1)(A)–(B) (West Supp. 2000).

249. Special Advisory Bulletin, *supra* note 18, at 37,985.

250. *By the Numbers, Controlling Costs Starts with Medicare and Medicaid*, MODERN HEALTHCARE, July 19, 1999 (Supp.), at 30, 30.

251. Fischer, *supra* note 50, at 4.

252. *Id.*

253. For a discussion of the managed care exception, see *infra* notes 230–42.

254. Homchick, *supra* note 5, at 24. Medicare and Medicaid HMOs are not subject to CMPs because of the managed care exception. *Id.*

undercuts the viability of this alternative.[255] Indeed, the characteristic losses suffered by Medicare and Medicaid HMOs has led many to consider the prospect of serving a Medicaid population under a managed care plan impossible.[256]

B. *Base Physician Compensation on Patient Satisfaction and Efficiency of Care*

A second option is for hospitals to link physician payments to efficiency as opposed to the cost of care.[257] Under this option, physicians who achieved not only cost-savings with respect to the care provided, but also sustained appropriate care outcomes would be rewarded with incentive payments. Conceivably, these types of incentive programs would encourage physicians to become more efficient in their testing and treatment decisions and the way they conduct their patient interviews and examinations.

Because only physicians with direct, patient-care duties are banned from gainsharing incentive payments,[258] hospitals could focus their gainsharing programs on administrative staff or physicians with no patient contact or control of services rendered.[259] For example, administrative staff may be successful in cutting costs by setting limits on the length of a patient's stay or the number of procedures that doctors can order, or by suggesting the use of certain protocols for specific procedures.[260] Hospitals, however, must ensure that, although the administration would be paid based on their ability to control departmental costs, the payments could not be characterized as a direct or indirect incentive to reduce patient services.[261]

To ensure that quality of care is not sacrificed for efficiency, hospitals could implement increased performance measures such as

255. *See* Raymond Hernandez, *Some HMO's Pulling Away on Medicaid*, N.Y. TIMES, May 8, 1997, at B1 (describing the losses by HMOs providing care to Medicaid recipients).

256. *See generally* Peter T. Kilborn, *Largest H.M.O.s Cutting the Poor and the Elderly*, N.Y. TIMES, July 6, 1998, at A1 (noting that the losses suffered by HMOs are not appealing to hospitals).

257. Homchick, *supra* note 5, at 16.

258. *See* Fischer, *supra* note 50, at 5–6.

259. Hospital administration may be able to reduce costs by purchasing in bulk or establishing a Shared Service Organization or a Group Purchasing Organization. *See* McDowell, *supra* note 37, at 745–46. Both the HHS and the American Hospital Association agree that these business practices do not warrant prosecution. *See id.* The Department of Justice, however, has refused HHS's request to state affirmatively that these activities would not be prosecuted. *Id.* at 746.

260. Hall, *supra* note 80, at 453.

261. *See id.*

customer satisfaction surveys to serve as checks for quality control.[262] Patient surveys could be used to determine whether patients received appropriate care and how and when they received that care.[263] The OIG, however, has concluded that, due to cost constraints and the resources and time required to verify audits and arrangements, this cost-saving option is simply not viable.[264]

To date, the OIG has been unwilling to accept any of the proposed quality measures.[265] The OIG's overriding rationale for rejecting the proposed arrangements was a lack of evidence that Medicare and Medicaid beneficiary care would not be compromised. Patient surveys provide no assurance that physicians, in an effort to save costs, will not be influenced into reducing or limiting "items or services" provided to their patients.[266]

Despite the OIG's express position, hospital administrators and attorneys argue that the OIG erred in equating reductions in costs with reductions in care.[267] Whereas the CMP statute does not specifically prohibit payments that serve as incentives to reduce *unnecessary* costs, some providers may seek a court declaration that the practice is permissible.[268] In fact, the Special Advisory Bulletin implies that some cost-saving measures that do not affect the quality

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262. *See* Homchick, *supra* note 5, at 16. Moreover, arrangements based solely on patient satisfaction and quality of services provided may be deemed acceptable because they are not focused on procedures. *Id.* Hence, there would be no incentive for physicians to reduce care. Further, quality of care, arguably the OIG's foremost concern, would be the driving factor. *See generally* Special Advisory Bulletin, *supra* note 18, at 37,985–86 (observing that the initial prohibition of physician incentive arrangements was prompted by the possibility of a diminution in the quality of care).

263. *See generally* Homchick, *supra* note 5, at 16 (discussing the possibility of customized surveys).

264. *See* Special Advisory Bulletin, *supra* note 18, at 37,987.

265. The reasons for not accepting these proposals included: (1) they "were more or less subjective," (2) they "[w]ould be applied to patient volumes that were insufficient to yield statistically significant results," and (3) they "were not subject to independent verification under the various gainsharing proposals." Thornton & McAnaney, *supra* note 205.

266. Special Advisory Bulletin, *supra* note 18, at 37,986. According to the OIG Bulletin, the "plain language" of section 1128A(b)(1) of the Social Security Act "prohibits tying the physicians' compensation for such services to reductions or limitations in items or services provided to patients under the physicians' clinical care." *Id.* This interpretation implies that the Act prohibits the use of formulas for such things as drugs and incentives to purchase the most 'cost-effective' piece of medical equipment. *Id.*

267. Homchick, *supra* note 5, at 14–15; *see generally Health Care-Physician Incentives: Law Firm Organizes Health Industry Group, Seeks Reversal of OIG's Gainsharing Bulletin*, 68 U.S.L.W. 2100, 2100 (Aug. 24, 1999) (noting that a "coalition of health industry players" is being formed to contest the OIG's finding that gainsharing programs violate CMPs).

268. Jaklevic, *supra* note 17, at 12.

of patient care, including "substituting lower cost but equally effective medical supplies, items or devices; re-engineering hospital surgical and medical procedures; reducing utilization of medically unnecessary ancillary services; and reducing unnecessary lengths of stay" are permissible.[269]

A second alternative for increasing efficiency is to combine Medicare Part A and Part B payments, thus systematically aligning the financial interests of physicians and hospitals.[270] The HCFA has already identified several sites for such a demonstration.[271] The combination of Medicare Part A and Part B payments would drastically alter the entire PPS—no longer would physicians be paid based on each service rendered; rather, they too would be paid based on the patient's diagnosis.[272] This payment scheme would also allow for a redistribution of Medicare dollars between hospitals and physicians—each would receive a proportion of the pre-determined Medicare payment.[273] Undoubtedly, it would result in concerns about the relationship between physician compensation and financial performance—society would have to be willing to accept physicians providing fewer services and tests in exchange for increased efficiency.[274]

A third alternative for increasing efficiency while maintaining quality care is to cap the amount of incentive payments a physician can receive. Capping incentives would alleviate some fears that physicians will reduce care and services to an extreme level in order to reap a greater share of the profits.[275] By limiting the maximum amount of compensation any one physician can receive, incentive compensation caps reduce the incentive to withhold medically necessary care. Further, national quality care benchmarks, such as

269. Special Advisory Bulletin, *supra* note 18, at 37,986.

270. *See Align Docs', Hospitals' Money Incentives*, *supra* note 53, at 66; *see also supra* note 46 (explaining Medicare Parts A and B).

271. *Align Docs', Hospitals' Money Incentives*, *supra* note 53, at 66.

272. *Id.* Comparatively, if gainsharing arrangements were deemed permissible, no changes to the PPS would be necessary because hospitals would have the cost-saving device—incentive plans—they need to create greater efficiencies and save money. *Id.*

273. *Id.* at 50, 66.

274. *See id.* at 66 (explaining that society and the industry would then be forced to decide what it wanted and what it was willing to allow).

275. *Id.* Included among the quality of care goals is assurance that beneficiaries are not receiving a diminution in medically necessary care, making sure that individuals are not released from the hospital prematurely, and that there are no improper admissions. *See* GAO REPORT, *supra* note 2, at 2.

patient surveys, could also be implemented to ensure that the OIG's quality standards are being maintained.[276]

Those most familiar with the PPS and the challenges it presents to hospitals recognized that there must be some permissible means to align the economic interests of hospitals and physicians.[277] The developers of the PPS have suggested two ways that the industry and government could work together to loosen the legal noose of current federal regulations and the recent OIG Special Advisory Bulletin. The first proposal focuses on neutralizing disincentives to performance.[278] The second focuses on creating performance-based incentives.[279]

Neutralizing disincentives to performance may be achieved through the use of a singular payment to the attending physician or the hospital for all of the professional services related to the admission of the beneficiary.[280] DRGs are an example of this type of singular payment scheme. This approach is considered "risk-free" because it is not profit oriented[281] and can serve as an incentive for enhanced operational improvements without rewarding physicians for withholding services to patients.[282] The second proposal, creating performance based incentives, mirrors the previous recommendations and suggests that physicians be compensated based on their overall performance, including quality of care as perceived by the patient.[283] Both of the proposals offer new ways for hospitals to achieve cost-savings through physician compensation without implementing a gainsharing arrangement.

D. 1986 Recommendations

With so much ambiguity over the future treatment of gainsharing arrangements by regulatory agencies, in 1986 the General Accounting Office (GAO) to the Subcommittee on Health,

276. *Align Docs', Hospitals' Money Incentives, supra* note 53, at 66.
277. *Id.* at 50, 66.
278. *Id.*
279. *Id.* at 50.
280. *Id.*
281. *Id.* (noting that this is feasible based on the "development of severity-adjusted DRG-based patient classifications"). This would allow payments for physician services and the elimination of under-compensation to those physicians who treat sicker patients. *Id.*
282. *Id.* This approach would eliminate the appearance of "bonuses" often negatively associated with gainsharing arrangements. *Id.*
283. Patient satisfaction levels can be determined through the use of surveys. *See supra* notes 87–90 and accompanying text (noting the use of surveys).

Committee of Ways and Means issued recommendations as to the suggested treatment of physician incentive plans.[284] The GAO report recommended that new regulations be enacted to allow incentive plans if the hospital's decision to pay a physician is based on the cost performances of a group of physicians and not on the individual performance of a given physician over the course of a year.[285] The report further suggested that incentive plans be required to have detailed instructions and requirements for utilization and quality review.[286] In addition, the report recommended a mandate prohibiting physician incentive plans based on the physician's cost performance.[287]

These recommendations provide guidance as to the direction the government might take concerning gainsharing arrangements. Hospitals may implement these costly and time consuming changes based on these recommendations, but may still face harsh penalties for noncompliance with federal law. The recommendations also serve as a starting place for new legislation governing physician incentive programs.

E. Legislation

Federal legislation is perhaps the most effective means by which hospitals can gain assurance as to the permissibility of gainsharing arrangements because legislation would provide the requisite legal foundation to legitimize gainsharing arrangements.[288] The OIG Bulletin stated that, absent a legislative or regulatory change permitting some kind of gainsharing or incentive-based program between physicians and hospitals, the OIG could not ignore its mandate to strictly enforce federal regulatory prohibitions of such arrangements.[289] Coalitions are already forming on behalf of the

284. *See* GAO REPORT, *supra* note 2, at 1.

285. *Id.* at 4.

286. *Id.* at 24.

287. *Id.* at 17–18. The GAO Report observed that although some incentive arrangements call for quality review and separate incentive payment pools based on patient satisfaction, these features are likely to be ineffective. *Id.* Measuring patient satisfaction is an extremely difficult task and one that demands prompt response, something rarely seen in the health care industry. *Id.* at 18.

288. *See* Special Advisory Bulletin, *supra* note 18, at 37,985 (stating that "regulatory relief from CMP prohibition will require statutory authorization").

289. *Id.* The OIG noted that there are some circumstances and arrangements in which appropriately structured gainsharing programs may offer beneficial results for hospitals and physicians while not detracting from the quality of care a patient receives. *Id.* In the Special Advisory Bulletin, the OIG acknowledged that savings generated by substituting lower-priced, equally effective products; re-engineering surgical and medical procedures;

hospital industry to promote legislative change.[290] The coalitions' primary goal is to amend the Social Security Act "by introducing legislation that would prohibit only payments that encourage doctors to limit 'medically necessary' care."[291] Although the coalitions are working for change, the timing and makeup of any proposed legislation remains unresolved.[292] Similarly, Congress must also enact legislation providing safe harbors that account for the possible benefits of gainsharing.[293] These safe harbors should allow flexibility and account for the rapidly changing and extremely complex nature of modern health care.

In addition to amending the Social Security Act to permit gainsharing arrangements, legislation amending the Balanced Budget Act of 1997 is also needed.[294] Congress can ease the financial pressure faced by hospitals by relaxing some of the amendment's provisions that reduce Medicare reimbursement to hospitals. Legislation addressing this issue has already been introduced in Congress.[295] For example, the proposed[296] Medicare Common Sense Hospital Payment Act[297] and Triple-A Rural Health Improvement Act[298] would provide exemptions and relief for those facilities

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and reducing unnecessary utilization and inpatient stays would not affect patient care, but would still violate section 1128A(b)(1) of the Social Security Act. *Id.* at 37,986.

290. *Health Care-Physician Incentives: Law Firm Organizes Health Industry Group, Seeks Reversal of OIG's Gainsharing Bulletin*, 68 U.S.L.W. 2100, 2100 (Aug. 24, 1999).

291. Mary Chris Jaklevic, *Gain-Sharing OK in Managed Care*, MODERN HEALTHCARE, Sept. 6, 1999, at 24, 24.

292. *Id.* The OIG admits that the process of amending the Social Security Act and granting the agency the necessary authority to develop comprehensive rules would take years. Jaklevic, *supra* note 12, at 12.

293. With additional safe harbors, gainsharing arrangements could achieve greater innovation and efficiency. *See* James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 220–21 (1996).

294. *See supra* text accompanying notes 64–65 (explaining the impact of the Balanced Budget Amendment on the hospital industry).

295. *See* Jonathan Gardner, *Relief Gestures Fail to Charm Providers*, MODERN HEALTHCARE, July 12, 1999, at 8, 8.

296. Jonathan Gardner, *Congress to Consider Budget-Law Relief Bills*, MODERN HEALTHCARE, June 7, 1999, at 10, 10. The bill carves out "disproportionate share payments from Medicare+Choice capitation rates and pays them directly to hospitals." *Id.*

297. Medicare Common Sense Hospital Payment Act, H.R. 405, 106th Cong. (1999). Introduced by Senator Charles Grassley (R-Iowa) and Representative Jim Nussle (R-Iowa), the bill would repeal measures that reduce certain hospital payments for patients discharged to post-acute providers. Gardner, *supra* note 296, at 10.

298. The Triple-A Rural Health Improvement Act, H.R. 1344, 106th Cong. (1999). Introduced by Rep. Jim Nussle (R-Iowa), the bill places a "floor on Medicare outpatient department payments for rural hospitals." Gardner, *supra* note 296, at 10. Exemptions from the requirements of federal laws are among the relief measures sought. *See* H.R.

operating in historically impoverished or rural areas that struggle to maintain adequate physician coverage.

F. Advisory Opinions

In the absence of legislation, hospitals have resorted to soliciting advisory opinions from various agencies for guidance in establishing viable gainsharing arrangements. The OIG Bulletin implied, however, that there was little future advisory opinions could offer because the CMP statute is clear as to what constitutes permissible arrangements.[299] Nonetheless, several requests for advisory opinions are pending with the HCFA and the OIG seeking further guidance on how to tailor gainsharing arrangements to comply with the applicable rules and regulations.[300] Ideally, the industry would like an opinion stating that compliance with the CMP statute is sufficient to comply with the anti-kickback and Stark anti-referral laws.[301]

The HCFA and the OIG, however, have been reluctant to provide individual advisory opinions.[302] One reason for the delay is the OIG's fear that a favorable advisory opinion may confer a competitive advantage to a particular institution.[303] Moreover, if individual advisory opinions are issued, other hospitals may elect to forgo the process, and construct arrangements based on previous opinions, in hopes the arrangement is similar enough to be protected

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299. Washlick, *supra* note 1, at 7; *see also* OIG Issues Bulletin, *supra* note 18 (explaining the Special Advisory Opinion). The press release accompanying the OIG Bulletin stated that "[a]fter consulting with experts inside and outside the federal government and reviewing the legislative history of the prohibition on hospital payments to physicians to reduce or limit care, [the OIG had] determined that gainsharing arrangements raise significant issues that cannot be resolved through the advisory opinion process." *Id.*

300. *See* Telephone Interview with Robert Homchick, *supra* note 15. Any opinions that are released, however, will likely come from the OIG. To date, the HCFA has issued only two opinions, both related to the Stark anti-referral laws. *Id.* Further, where the HCFA will come out on this issue is not entirely clear. *Id.*

301. *See generally* Fischer, *supra* note 50, at 7 (noting what may and may not qualify as sufficient for compliance). Homchick and King also note that such an opinion is something the industry would like to see; however, neither anticipates its arrival anytime soon. Telephone Interview with Robert Homchick, *supra* note 15; Telephone Interview with Marilou King, *supra* note 10.

302. The OIG recognizes the potential for hospitals to persuade high-referring physicians to stay with them by manipulating accounts to evidence savings, thereby leading the physician to think she would be recovering more. *See* Special Advisory Bulletin, *supra* note 18, at 37,987. Further, advisory opinions do not offer the oversight that the government deems necessary to prevent deterioration of quality and increases in fraud. *Id.*

303. *Id.*

from sanctions.[304] Finally, published advisory opinions may lead to a rash of requests for more advisory opinions—something the OIG is simply not equipped or willing to handle.[305] The individual hospitals ultimately will have to comb through the possible solutions to determine the best course of action.

CONCLUSION

Congress misaligned the incentives of physicians and hospitals when it created the PPS and the method by which physicians are reimbursed for services rendered to Medicare and Medicaid beneficiaries.[306] The creators of the Medicare DRG prototype insist that arrangements that align the differing incentives of hospitals and physicians are necessary for the current reimbursement system to be effective.[307]

Gainsharing is an effective way to achieve this goal. Gainsharing is an essential means to curtail the "incentives toward ever-increasing health care costs" while at the same time offering a means to expedite "individuation of patient care and physician autonomy."[308] The recent Special Advisory Bulletin effectively prohibits all gainsharing arrangements that influence the way physicians treat their patients. The Bulletin and the applicable regulations, however, ignore the benefits of the arrangements including increased productivity and decreased costs. It further ignores most hospitals' efforts to construct the arrangements that ensure that quality of care is maintained.

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304. *See id.* Advisory opinions rendered are binding on the HHS (OIG) and the requesting party. 42 U.S.C.A. § 1320a-7d(b)(4)(A) (West Supp. 2000). This may play a role in the OIG's hesitation to render opinions.

305. The OIG stated that the commonalties in requests lend themselves to Special Advisory Bulletins versus individualized advisory opinions. *See* Special Advisory Bulletin, *supra* note 18, at 37,987. Further, the OIG stated that case-by-case determinations with advisory opinions are inadequate and inequitable. *Id.* Time and cost also serve as formidable deterrents. *Id.*

306. *See* Telephone Interview with Robert Homchick, *supra* note 15.

307. *Align Docs', Hospitals' Money Incentives*, *supra* note 53, at 50; *see also* U.S. DEP'T OF HEALTH & HUMAN SERVICES, HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE: REPORT TO CONGRESS 17 (1982), *reprinted in* [Extra Edition No. 374] Medicare & Medicaid Guide (CCH) (Jan. 5, 1983). The Secretary of Health and Human Services' Report to Congress, which prompted the passage of the DRG legislation, stated that "the ability of a hospital to respond to prospective payment incentives depends on the ability of the hospital administrator to transmit these incentives to the attending physician staff." *Id.*

308. Orentlicher, *supra* note 25, at 191.

The government apparently desires to reduce health care costs and help patients, yet it continues to thwart the industry's efforts to achieve these same goals. Changes allowing gainsharing would help achieve the same money saving and quality care goals that both hospitals and the government share. Unless legislation is passed or further advisory opinions are generated, it appears this attempt to control escalating health care costs will have to be abandoned.

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