

MODERNIZING GAIN SHARING OPPORTUNITIES

Recommendations of the Task Force on Delivery System Fragmentation October 2005

**Approved by the Board of Trustees
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Health care is about teamwork and requires the talent and dedication of many—doctors, nurses, technicians, nutritionists and many others. Hospital care is especially dependent on the ability of hospital leaders and physicians to work together to improve the efficiency of patient care and to get patients the right care, at the right time, and in the right setting.

There are many forces today driving hospitals and physicians apart. The situation is made worse by federal laws and regulations that prohibit or limit interactions between hospitals and physicians. While these laws are well-intentioned—to avoid conflicts of interest—they need to be modernized to improve the ability of hospitals and physicians to work together, to improve the efficiency of hospital care, to improve the quality and safety of care, and to better serve and provide greater benefit to patients and communities.

The Problem

Today, the ability of hospitals and physicians to share financial incentives to improve care is extremely limited. What is allowed today is known as “gain sharing”—sharing cost savings between hospitals and physicians that stem from specific actions to improve the efficiency of care. But the Department of Health and Human Services’ Office of Inspector General (OIG), which is charged with enforcing some of the laws that affect hospital-physician relationships, issued a ruling in 1999 that effectively banned gain-sharing arrangements.

Earlier this year, the OIG issued several advisory opinions that now allow a very narrow approach to reducing costs of cardiac care. But these exceptions are too limited. They apply only to the hospitals that received the advisory opinions. Gain sharing programs also are limited to a one-year duration – not enough time to make the needed investment of time and money involved in obtaining permission worthwhile for either hospitals or physicians. And today’s Civil Money Penalty Law prohibits use of any incentive that would “reduce care,” even if that care is duplicative or unnecessary. Aspects of other laws, including the Ethics in Patient Care Referral Law, Anti-kickback Law and Tax Exemption Law, also unnecessarily limit reasonable and desirable collaboration between physicians and hospitals.

A Better Approach

Public policy changes are needed to simplify and modernize these laws—to allow physicians and hospitals to come together, using incentives, to not only reduce costs, but also improve access to and the efficiency, quality and safety of hospital care. This kind of collaboration, by improving care, can benefit patients and the communities we serve.

Federal laws that affect hospital-physician relationships should be amended to:

- Allow hospital-physician incentive arrangements designed to improve access to care or improve the safety, effectiveness, patient-centeredness, timeliness, efficiency or equity of care (the six aims of health care delivery included in the Institute of Medicine’s *Crossing the Quality Chasm* report).
- Allow hospital-physician incentive arrangements to:
 - Achieve needed improvements in the health care delivery system even if they do not produce an immediate cost savings.
 - Sustain community access to services that are essential. With physicians less dependent on hospitals as a place to practice, new incentives should be allowed in order to maintain community access to services (such as trauma and emergency department services), support community outreach efforts, care for the uninsured, and other aspects of hospital operations that require physician support.
 - Promote the integration of clinical care across providers, across settings, and over time.
 - Adopt and integrate information technology (IT) systems and technology. IT linking hospitals, physicians, and other providers together is essential to improving patient safety, productivity, quality monitoring, and coordination across care settings.
 - Enhance institutional or practitioner productivity or achieve other efficiencies.
- Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes-conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements is a significant barrier. Few arrangements can be structured without very significant legal expense. Permission must be sought on a case-by-case basis and are time-limited. Even then, it is often unclear whether the arrangements might be challenged in the future.
- Enable hospital-physician contracting with health plans and purchasers as a single unit, especially when pay-for-performance provisions are utilized. Health plans and purchasers often adopt different approaches to payment for hospitals and physicians that in turn create different and sometimes-conflicting incentives. As more purchasers move toward pay-for-performance methods, the need to align hospital and physician payment incentives becomes critical.

Allowable Incentive Arrangements

More specifically, AHA believes that the following types of arrangements should be allowed under simpler, more consistent rules:

- Sharing of cost savings from efficiencies
- Incentives to meet quality indicators (even when savings do not accrue to the hospital)
- Incentives to clinically integrate services and coordinate care across settings
- Sharing of pay-for-performance bonuses from payers
- Joint recruitment of physicians by hospitals and physician practices
- Joint hospital and physician contracting with payers to ensure aligned performance incentives
- Service contracts with physicians to build new service capacities
- Management contracts with physicians
- IT and other technology sharing to enable communication across settings
- Ability to purchase or operationally support IT for other providers to increase IT adoption and integration
- Hospital assistance to physicians in obtaining malpractice insurance

Patient and Program Safeguards

New types of physician/hospital incentive arrangements should be allowed as long as the following conditions are met:

- Hospitals must be able to demonstrate how their initiatives would improve access to care or improve the safety, effectiveness, patient-centeredness, timeliness, efficiency or equity of care (the six aims identified by the IOM).
- Incentives must be tied to the achievement of specific measurable objectives.
- Transparency must be present in all incentive arrangements.
- Periodic reviews of quality of care must be conducted by an independent organization to protect beneficiaries from any inappropriate effects on quality of care or utilization as a result of incentives.
- Incentives must not be rewards for increasing referrals to the hospital.

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