FEATURE STORY

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# gainsharing in health care
# meeting the quality-of-care challenge

In health care, gainsharing carries unique challenges, but the benefits are worth the effort.

**AT A GLANCE**

- In health care, most gainsharing arrangements have focused on aligning economic incentives between hospitals and physicians.
- At one time, the Office of Inspector General had declared such arrangements flatly illegal, but recent advisory opinions suggest that the OIG is taking a more lenient stance.
- Today, in addition to hospital-physician arrangements, payer-provider and payer-patient arrangements are viable forms of gainsharing.

The healthcare industry today is taking small steps along a path well worn by the manufacturing and services industries—the path toward embracing gainsharing as a means to align incentives between parties with different economic interests. And as it ventures forth, at times with trepidation, the healthcare industry can take courage from what these other industries have discovered: Gainsharing works.

But what is meant by *gainsharing*? There are some distinct differences between how it is practiced by the manufacturing and services industries, and how it must be applied in health care. In the manufacturing and services industries, such arrangements are between management and the frontline workers, with management offering workers pay incentives to improve processes and minimize or reduce costs. And the history of these gainsharing arrangements includes many significant success stories (see the sidebar on page 73.) In health care, the situation is more complicated: The two parties are hospitals and physicians, and the arrangements typically have involved payments from hospitals to physicians for assistance in generating cost savings. Such arrangements have the potential to foster efficiency and cohesiveness between physician groups and hospitals. But they also raise important legal questions and potentially threaten clinical quality.

It also is important to note that gainsharing is not the same as profit sharing. Under a gainsharing arrangement, workers receive bonus payments independent of firm profitability; bonuses are based on specific behaviors and a narrowly defined outcome and process.

## The Challenge of Gainsharing in Health Care

Health care provides a natural setting for gainsharing because the misalignment of incentives between hospitals and physicians is deeply entrenched in the industry. Like frontline workers in manufacturing and service industries,

physicians are in a unique position to understand how processes may be streamlined to reduce costs, and like their counterparts in the other industries, physicians typically will not participate in modifying processes unless they are given incentives to do so.

But there the comparison ends. The significance and sophistication of physicians' decision making, and the inherent ethical implications, make the healthcare industry's situation much more complex. And because most payment arrangements reimburse physicians and hospitals separately, physicians typically prescribe treatments and tests and consume disposables independent of the cost to the hospital or the patients.

This separation in payment structure is historically rooted in the desire to ensure that physician decisions about services and tests be dictated by quality-of-care concerns rather than by an interest in personal rewards. Any loss of efficiency is outweighed by the value of keeping physician decision making independent of an additional profit motive.

Yet increasing healthcare costs and attention to quality improvement have given rise to the pay-for-performance movement, as hospital leaders have sought ways to use financial incentives to improve efficiency and clinical quality. Gainsharing has been one approach that has received considerable attention.

## A Rocky Path

Gainsharing was first proposed and tested in healthcare settings in the 1990s, when several hospitals and physician groups experimented with payments to physicians to reward cost savings. In July 1999, however, the U.S. Office of Inspector General (OIG) issued a "Special Advisory Bulletin" noting that gainsharing arrangements were in violation of the civil monetary penalty law of the Social Security Act, and

### GAINSHARING IN INDUSTRIAL SETTINGS

Gainsharing has a long history of industrial applications that has been traced back to the 1930s. Manufacturing and service industries have recognized that frontline workers often have little economic incentive to reduce production and sales costs because the savings are enjoyed entirely by management, not the workers. In many situations, improvements in efficiency were seen as a potential threat to job security. Gainsharing was introduced as a way to give workers incentives to suggest process improvements. A typical gainsharing agreement ties specific savings targets to bonuses for workers. In this way, workers have incentives to improve processes and reduce wasteful costs. Such agreements require careful cost accounting systems but, when present, can produce dramatic savings.

At appliance manufacturer Whirlpool's Benton Harbor, Mich., plant, management reported excessive part rejections in the range of 800 parts per million; the part rejections resulted in considerable losses for the plant and led company executives to consider its closure. When workers were given incentives to participate in quality improvement initiatives, they observed a 19 percent productivity gain and a reduction of part rejections to only 4 parts per million. Plant workers were given an average pay increase of $3,000 per year.[a]

Similarly, at Ford Motor Company, parts managers at dealerships are given purchasing price points. If they are able to purchase parts for less than the stated price point, they are given a share of the savings they produce. If not, their income is unaffected.[b]

These types of gainsharing have been credited with producing alignment in organizations where there were previously apathetic or antagonistic relationships between workers in management. In a 1981 report, *Productivity Sharing Programs: Can They Contribute to Productivity Improvement?*, the U.S. General Accounting Office found that gainsharing resulted in "labor cost savings averaging 17 percent, along with improved worker relations, reduced absenteeism, reduced turnover, and fewer grievances."

a. Saver, R., "Squander the Gain: Gainsharing and the Continuing Dilemma of Physician Financial Incentives," *Northwestern University Law Review,* 2003.
b. Linda Boudiab, former Ford junior executive, interview with author, Nov. 18, 2006.

**LEGAL PROHIBITIONS HAVE HISTORICALLY LIMITED GAINSHARING IN HEALTH CARE**

| Law | Interpretation |
|---|---|
| Stark Law | Prohibits a physician from referring designated health services paid for by Medicare or Medicaid to entities with which the physician has a financial relationship |
| Anti-Kickback Statute | Prohibits payments by a hospital to physicians that create incentives to refer patients to the hospital for services or supplies paid for by Medicare or Medicaid |
| Civil Monetary Penalty Law | Prohibits payments by a hospital to physicians that create incentives to reduce or limit medical services to Medicare or Medicaid |

that they also may implicate the anti-kickback statute and the physician self-referral prohibitions of the act.

The combined intent of these laws is to prevent referral of patients to facilities on the basis of physician financial incentives and to prevent physicians from denying necessary services or offering unnecessary services to patients on the basis of added financial incentives. Of particular concern is the fear of "cherry-picking"—the idea that gainsharing would be used as a means of offering physicians incentives to sort healthier patients to hospitals with gainsharing programs and sicker patients to hospitals without gainsharing programs.

In a Jan. 18, 2001, advisory opinion, the OIG voiced its approval of a single gainsharing agreement, but did so within a legal framework that seemed narrow to most healthcare leaders; accordingly, few organizations attempted gainsharing agreements.

In 2003, the Centers for Medicare and Medicaid Services participated in an eight-site New Jersey-based gainsharing pilot that was struck down by a court in 2004 as violating the civil monetary penalty law. By 2005, the Medicare Payment Advisory Committee made a strong statement in support of gainsharing agreements ("Issues in Physician Payment Policy," *Report to the Congress: Medicare Payment Policy*, March 2005), just as the OIG issued several advisory opinions in support of particular instances of gainsharing.

It bears emphasizing that the OIG's 2005 opinions are intended to apply only to the particular arrangements under the OIG's consideration, and are thus not intended to be interpreted as blanket endorsement of all similar arrangements. The opinions are predicated upon a cautionary framework that seeks to address many objections and legal obstacles to gainsharing agreements. The framework suggests the following basic requirements should be in place: [a]

- Disclosure of the agreements to patients
- Precise disaggregated measurement of cost savings
- Maximum 50/50 split of savings between physicians and hospitals
- Caps on maximum rewards
- Universal application of agreements to apply to all patients and all payers
- Use of a third-party administrator to govern the program and ensure data monitoring accuracy

The intent of this framework is to create careful limits on how gainsharing might affect physician behavior; to provide defined limits on payments from hospitals to physicians to deter any inducement to refer; and to promote transparency across patients, physicians, and hospitals. In the absence of these features, an OIG representative has indicated that the agency is unlikely to approve a gainsharing agreement between physicians and hospitals.[b]

a. Reynolds, M., and Goodroe, J., "The Return of Gainsharing," *hfm*, November 2005.
b. Interview with author, July 2006.

Perhaps because of an environment that is increasingly focused on cost reduction, the apparent reversal of position reflected in the OIG's 2005 advisory opinions has been viewed as more durable than its previous positions. In 2006, CMS sponsored two gainsharing projects: the 5007 program for six hospitals and the 646 program for up to 72 hospitals, which focus on hospital systems. In 2007, the OIG issued two more advisory opinions that acquiesced to each of the programs commencing while using an escrow account to hold the intended cost savings until a favorable advisory opinion was issued.

Also, in response to the OIG's perceived increased latitude toward gainsharing, a small industry group of gainsharing consultants, hospitals, and physicians nationwide has expressed interest in pursuing gainsharing agreements that focus on the following clinical areas.

*Waste reduction.* Gainsharing to reduce waste is in part intended to address the practice of opening noncritical supplies during procedures to prepare for the possibility that the supplies will be needed only to have the supplies go unused. It also is intended to help minimize the practice of administering expensive drugs prophylactically to all patients during surgeries, when the drugs could more effectively be given to a smaller target population.

For example, before a recent controversy developed about increased risk of stroke with aprotinin, the drug, which costs $1,080 per dose, was given to most patients during coronary artery bypass graft procedures, regardless of the patients' risk for coagulation defects. Clinical evidence had shown that aprotinin might be given equally effectively only to patients with a poor coagulation profile. Because under many payer contracts the drug cost was part of the hospital payment, a gainsharing agreement would give physicians a share of cost savings when they are more selective with their use of supplies and drugs.

*Product standardization and substitution.* Under the status quo, physicians make independent purchasing decisions for expensive implants and devices; the costs of these implants are borne by the hospital as part of its insurer fee or billed from the hospital to the insurance company. Because hospitals typically have many different physicians with different preferences for implants and devices, the hospital is forced to purchase and stock a wide variety of implants and devices and is thus unable to achieve the economies of bulk purchasing. The OIG advisory opinions state that physician choice may not be limited, but in practice, by allowing physicians a share of cost savings, the programs addressed in the opinions encourage the physicians to voluntarily limit their choices of implants and devices.

*Quality improvement.* Clear examples exist of where improved quality results in diminished payments to physicians, but cost savings to hospitals. If, for example, a patient is hospitalized and the physician is able to improve the quality of inpatient care provided and reduce the length of stay for that patient, a hospital on a diagnosis-related-group-based payment system achieves savings in bed costs and the ability to admit an additional patient to that bed. However, the physician, if paid on a per diem or per visit basis, would lose that revenue. One proposal to circumvent this situation is to permit physicians who achieve quality improvements or superior clinical outcomes that result in savings to receive a share of those savings.

### A MATTER OF TRUST

The goal of gainsharing is to capitalize on what Woodruff Imberman, a leading gainsharing consultant to manufacturers, refers to as the "hidden knowledge of the workforce" by paying workers to identify opportunities for reducing costs ("All You Ever Wanted to Know About Gainsharing, But Were Afraid to Ask," *Target, The Periodical of the Association for Manufacturing Excellence*, May/June 1993).

Although gainsharing generates considerable savings potential, it has as a prerequisite an extremely trusting relationship between the sharing parties. In a July 2006 interview with one of the authors of this article, Imberman commented that gainsharing agreements should exhibit three characteristics:

- Simplicity in design and measurability of results
- Transparency about methodology, implementation, and results
- Direct employee control of the behavior/metric that is being rewarded

Imberman noted that gainsharing agreements tend to be successful only when contracting parties express adequate trust in one another—and that a "breakdown in trust" is the most frequently cited reason for the failure of the agreements.

## Gainsharing Involving Other Parties

Hospitals and physician groups are not alone in exploring gainsharing as a cost-reduction strategy. In the wake of the OIG's 2005 opinions, payers have become increasingly interested in gainsharing as a way to reduce costs. At least one major national payer is developing and executing a nationwide gainsharing strategy.[c] Payers are pursuing two different kinds of gainsharing strategies involving providers and patients.

*Payer-provider gainsharing agreements.* Payers have expressed interest in gainsharing because many of their contracts with providers involve a carve-out for device and implant costs. Although many contracts with providers involve a global cost (i.e., diagnosis-related group), others, depending on the market in which they are operating, involve a separate payment (i.e., carve-out) for large expenses such as devices and implants. In the absence of negotiated discounts or rationalized physician purchasing of devices from implant and device manufacturers, payers find themselves seeking to control high and rising costs.

Payers are also viewing gainsharing as a potential approach to improving the physician and hospital "business case for quality." A well-documented dilemma for hospitals and physicians is the notion that improvements in healthcare quality often result in decreased utilization of services and decreased costs, resulting in decreasing payments from payers. (See, for example, Leatherman, S., Berwick, D., et al., "The Business Case for Quality: Case Studies and an Analysis," *Health Affairs*, July-August 2003.) Accordingly, physician groups and hospital groups operating on thin margins are reluctant to introduce process improvements that may decrease admission rates, lengths of stay, or other units of service they deliver.

A major academic medical center, Duke University Health System, encountered this problem in the development of a novel approach to managing congestive heart failure (CHF). When its outpatient management of CHF improved, its admission rates for CHF patients dramatically fell, resulting in improved patient outcomes, but major losses of inpatient revenue. (See Bohmer, R.M.J., and Feldman. L., "The Duke Heart Failure Program," HBS Duke Heart Failure Case No. 9-604-033, Boston: Harvard Business School Publishing, 2003.)

Gainsharing has been proposed as an approach to solving this conundrum. Under current payment methodologies, improvements in care can often result in savings that are enjoyed exclusively by payers. Under a gainsharing agreement that rewards physicians for improvements in performance, payers might be able to stimulate a movement to higher quality models of care.

*Payer-patient gainsharing.* In an environment of increasing cost and quality transparency, a new type of gainsharing is being considered that rewards patients for participating in generating cost savings. Although payers have long tried to modify patient behavior using tiered patient copayments, they have until recently seldom attempted to share major cost savings with patients in the form of bonuses. In Wisconsin, the Wisconsin Collaborative for Health Care Quality and the Wisconsin Health Information Organization have published extensive cost and quality data, much of which is available to patients on an interactive web site (www.wchq.org). The availability of this information inspired one self-insured employer in South Bend, Wis., to pay bonuses to patients to have radiology examinations completed at lower-cost centers. Insured employees are paid $500 bonuses for computed tomography and magnetic resonance imaging scans completed at the lower-cost center because the total cost for an examination is $1,000 cheaper to the employer.[d]

## Criteria for Gainsharing Program Selection

The costs of implementing gainsharing are another important factor to consider. There are

c. National insurance company executive in a confidential interview with author, November 2006.

d. John Touissant, CEO, ThedaCare, interview with author, Nov. 13, 2006.

three criteria for determining the likelihood that a gainsharing agreement will prove worthwhile for all parties:

> Agreements should be focused on high-cost, high-volume expenses (e.g., pharmaceuticals, implants, and medical devices)
> Agreements should be executed only in high-volume institutions
> Agreements should be structured so as to not permit reductions in quality and/or patient satisfaction

If any of these three criteria is not met, the agreement is likely not to produce sufficient savings and may not safeguard quality to warrant the considerable effort and expense required to execute it.

### Challenges to Implementation

While gainsharing has obvious potential to reduce costs and improve alignment between physician groups and hospitals, it also poses many risks to both types of organizations.

*Legislative risk.* Gainsharing agreements have seen such diverse legal interpretations over the years that any investment in gainsharing agreements could be quickly lost with a change in the legal environment. Several legislators, most notably Rep. Pete Stark (D-Calif.), have gone on record as opposing gainsharing agreements on the grounds that they bind physicians and hospitals in unethical financial relationships that are likely to produce clinically unsound referral patterns.

The medical device industry, likely because it fears a reduction in its leverage for selling devices, has been lobbying Congress to ban gainsharing. One argument the industry posits is that gainsharing may stifle innovation by disadvantaging smaller device manufacturers that are less able to bundle products for volume discounts (see www.medicaldevices.org/public/issues/gainsharing.asp).

If either Stark or the device industry is successful in creating increasing regulatory scrutiny, gainsharing agreements could be rendered moot.

*Duration of the agreement.* Although paying bonuses to physicians for practices that reduce costs for a hospital seems reasonable, it is unclear how long the payment of such bonuses should persist. On the one hand, physician groups should be adequately rewarded under a gainsharing agreement for losses in autonomy in decision making or improvements in clinical quality. On the other hand, physicians should not have unlimited claim to rewards from improvements in inefficiency.

If not managed properly, the length of gainsharing agreements and disbursement of bonus payments could disturb relationships between physicians and hospitals. In practice, cost savings will likely be fully achieved within three years. Therefore, it is prudent to establish a "quality savings bank" so that funds can be set aside from a successful gainsharing program to seed the next gainsharing program to retain the interest of the medical staff. Payer involvement may also foster ongoing savings to be shared.

> Physicians should not have unlimited claim to rewards from improvements in inefficiency.

*Administrative challenges.* Even when a gainsharing agreement targets high-volume expenses at high-volume institutions, there is considerable question of whether such agreements are truly worth the effort. They require tremendous levels of cooperation and the creation of a system for monitoring results that ensures the validity of the data collected and the appropriateness of the bonuses disbursed. The history of gainsharing in manufacturing industries underscores the importance of transparency and trust, yet the high degree of cost-accounting transparency needed to execute a gainsharing agreement typically does not exist in many healthcare settings.

*Quality challenges.* A basic assumption that underlies all discussions of gainsharing is that such agreements should not undermine quality of care. Although scant evidence suggests that gainsharing agreements have diminished the quality of care, many potential scenarios exist in which they might influence physician behavior to produce suboptimal patient care outcomes. And discomfort with this possibility lies at the center of the regulatory ambivalence to gainsharing. Any decline in quality of care due to gainsharing creates could produce negative fallout for health plans, hospitals, and physicians far outweighs the potential benefits of gainsharing.

Quality of care could also be enhanced as gainsharing programs mature by fostering their applicability across an episode of care, beginning before a hospitalization and ending after a hospitalization, so that physicians who participate in and foster continuity of care are also rewarded.

## Implementing Safeguards

Gainsharing's history of successful application in other industries has long served as an example for the healthcare industry as a strategy for reducing costs. In an industry structured to include misaligned incentives, gainsharing could provide a basis for cooperation.

In an ideal world, physician groups, hospitals, payers, and patients should work together to reduce waste and unnecessary expenses. In devising structured ways to do so, they could improve relationships with each another, limit the rate of growth of healthcare costs, and make care more affordable.

As encouraging as the upside to gainsharing might be, safeguards must be put in place to ensure that the quality of care is maintained or, better yet, improved for the patients participating in the gainsharing program. These safeguards include:

- Basing payments on transparent and clearly documented actions taken by the physicians to improve quality and reduce costs, and not based on the number of admissions or the value of the business generated by the admitting physician
- Ensuring clinical and financial transparency of quality indicators
- Using a proven risk-adjusted system
- Implementing ongoing measurement and monitoring to determine the program's success and to confirm that the program is not having an adverse impact on clinical outcomes
- Basing payments to physicians on all procedures to avoid disproportionate participation of federal healthcare program beneficiaries
- Capping potential payments to the physicians
- Using baseline thresholds to guard against inappropriate reductions in service
- Providing clear feedback to physicians about their quality and efficiency
- Terminating physician participation if noncompliant
- Defining fair market value in advance with the participating physicians
- Limiting total savings by meeting appropriate utilization standards

In the wake of the OIG's 2005 and 2007 advisory opinions, many healthcare organizations are considering, or have begun implementing, gainsharing arrangements to reduce costs and improve alignment of incentives. Careful monitoring of the effects of these arrangements will allow us to evaluate their ultimate effects on the cost and quality of care—and their usefulness as a tool for healthcare leaders. ●

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