

Physician-owned Group Purchasing Organizations: An Alternative to Gainsharing



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Through a handful of advisory opinions released earlier this year regarding certain gainsharing arrangements between physicians and hospitals, the Department of Health and Human Services Office of Inspector General (OIG) is allowing new ways for physicians and hospitals to share in savings. As has been widely published, the opinions present essentially identical analyses, concluding that while the arrangements raise concerns under the Civil Monetary Penalty and anti-kickback sections of the Social Security Act, there are sufficient safeguards built in that the OIG would not impose sanctions.

These advisory opinions have come out at a time when federal regulators are looking into potential conflicts of interest arising from certain financial relationships between equipment makers and physicians users of their products. In addition, there has been tremendous scrutiny on the inability of large Group Purchasing Organizations (GPOs) collecting inappropriate administrative fees while having no leverage or effectiveness with regard to the high-dollar, physician-preferred implant products.

While the OIG opinions are limited to cardiology and cardiac surgery devices and supplies, the broad range of devices contemplated in the opinions suggests that similar gainsharing arrangements involving, for instance, orthopaedic devices are permissible. Similarly, the OIG has indicated that under certain circumstances involving gainsharing, product standardization is now an acceptable mechanism for achieving cost savings for hospitals.

However, product standardization can also be implemented in cost-containment structures other than the specific gainsharing model approved in the aforementioned OIG opinions. In particular, there are other effective, legal and ethical ways to realize significant cost-savings for hospitals and healthcare systems while allowing physicians to share in these savings, ensuring that patient safety and quality of care is safeguarded and requiring little or no change in the day-to-day operations of the hospital systems and manufacturers.

Our company has developed an alternative model for aligning physician and hospital incentives through Group Purchasing Organizations (GPOs) and standardization. Under this model, physician groups may invest in one of several GPOs controlled by a parent company. As with the physician groups discussed in the recent gainsharing OIG opinions, the groups participating in a physician-owned GPO model are required to actively participate in the clinical evaluation of surgical devices, with clinical advisory panels charged with the task of selecting certain devices as clinically preferred items for the GPO to seek discounts from the manufacturers. The GPOs negotiate pricing and arrange for contracts between the manufacturers and participating hospitals (at which the physician investors have staff privileges).

Consistent with standard GPO practices, the manufacturers pay administrative fees to the physician-owned GPO based on percentage of

sales to the hospitals, and the GPOs distribute profits to investors, including physician investors, strictly proportionate to investment interest. As in the gainsharing approved by the OIG, the physician investors in the GPO model retain their clinical autonomy to select any device they wish. However, the hope is that the alignment of incentives between physicians and the hospitals will encourage physicians to select devices for which the GPO has negotiated discounted prices, consistent with patient-by-patient determinations of medical appropriateness.

Alternative models such as GPOs should incorporate as many as are possible of the safeguards that the OIG found noteworthy in its advisory opinions; for example, the transparency of the transactions and ease of identifying specific cost savings, the use of credible clinical support in recommending preferred devices, not restricting physician choice of devices, and the distribution of profits strictly on the basis of ownership interest.

Further, where product standardization is used as the primary mechanism to drive these cost-containment models, hospitals are given much more leverage with which to negotiate pricing with manufacturers than in other models. Such arrangements also do not typically require significant upfront capital from participating hospitals or deviation from the mechanics of hospitals' current purchasing practices.

The world of high-priced physician-preference items such as surgical implants presents a tremendous opportunity for alternative cost-containment models such as physician-owned GPOs to succeed. Hospitals have historically had little success in negotiating discounts on such "physician preference" items, because selection of such items, as the name implies, has largely been up to the individual surgeon. Critical to the success of any such model, participating physicians must have some financial incentive to change their utilization practices, consistent, of course, with quality of care, ethical considerations and compliance with anti-kickback, Stark and CMP (not to mention all other applicable state and federal laws).

If successfully implemented, such models can result in participating physicians receiving an ancillary revenue stream that can supplement their income while preserving quality of care and clinical independence of each such physician to select appropriate technology for the individual patient. Such legal sources of ancillary income are particularly welcome in the current climate of increased scrutiny over "consultancy" and other fees paid directly to physicians by device manufacturers.

The current practice in hospitals regarding high-cost surgical devices leaves the financial transaction (the hospital paying the manufacturer) dissociated from the product selection decision (the surgeon ordering the specific device). A successful cost-containment model, be it the gainshar-

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ing arrangements or GPO-style example, must integrate these two aspects of the transaction and effectively align the incentives of the hospital and the physicians.

Where such an alignment of incentives is achieved, the result is likely to be lower costs to hospitals for high-cost surgical devices and supplies and increased competition among manufacturers. In particular, successful programs should serve to level the playing field for small- and mid-sized medical device manufacturers.

A key element of this alternative model is the performance of extensive legal research, and subsequent review by several national health care law firms on the design of the business model specifically addressing the big three federal health care statutes: the civil monetary penalty statute prohibiting a hospital from making a payment to a physician as an inducement to reduce or limit items or services to Medicare or Medicaid beneficiaries (the "CMP Statute"); the federal health care program anti-kickback law ("AKL" or "Anti-Kickback Law"); and the federal physician self-referral law ("Stark Law").

In our case, we retained former OIG Chief Counsel, D. McCarty (Mac) Thornton, at Sonnenschein, Nath & Rosenthal, Washington, D.C.

and have been favorably analyzed by the firm.

The physician-owned GPO model is predicated on the ability to provide physician owners with control of the implant selection process and with an ethical, legal and sustainable ancillary revenue source. It is also of paramount importance to be able to supply hospitals with fair and predictable pricing with a rational clinical selection process encouraged by the intrinsic alignment of incentives in this construct, with no fees, consultant charges or operational changes to the hospital.

Without question, gainsharing and physician-owned GPOs will effect the contracting process and will offer new opportunities to manufacturers and hospitals, and will require a transition in strategy in certain markets. Just as there is currently variation in pricing and physician consultant agreements from market to market, we anticipate offering this unique model with requisite variations designed to support the needs of each member physician and hospital, tailored to their specific situations.

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A Surgeon's Views on Gainsharing

The following is an excerpt from a letter sent to California Congressman Davis Dreier.

I do not believe that gainsharing is a good method by which to promote healthcare savings through the involvement of physicians. The problem with gainsharing is that this solution provides an economic incentive for the doctor which does not promote quality care for the patient. The assumption is that the doctor will make a decision that saves money on the medical device used and yet will not compromise quality for the patient.

Within the bills that would be passed on gainsharing there would be provisions that supposedly insure that quality was not compromised. I can assure you that there will be situations in which patients do not get the correct implant, or the best technology because of the economic gain available to the physician. This type of economic incentive for the physician is almost like free money and is going to provide a temptation that is very, very difficult to resist.

Secondly, the insurances for quality will be very difficult to enforce because there simply is not data available on many implants that are used. There will be many implants that do not have evidence based data that clarifies their use and outcomes and this will clearly impact the enforcement of quality control over choices made by hospitals and physicians in this gainsharing arrangement.

Finally, it must be remembered that if a surgeon elects a different implant to use because of economics, and that is a new implant to that surgeon, the surgeon does not have the technical experience to perform the operation with that implant as ably as would be done with the implant with which the surgeon was familiar.

I do support, and vigorously, an arrangement that promotes healthcare savings with rewards for physicians. What I do support is there be a

reward for providing quality outcomes for patients. I have long supported the necessity for physicians to provide quality outcomes for which they are accountable.

Most physicians are responsible in their decisions and give their best to insure an optimal outcome for the patient. Still, a program that provides economic incentives for outcomes, enforced by accountability, will elevate medical care. An example of healthcare savings that is possible by a qualitysharing type program is the change that we have made in our care of patients in our practice.

We have changed our pain management for total joint replacement, changed our rehabilitation program, and changed our surgery to smaller incisions. The consequence of these changes is that we now send every patient home, rather than to a rehabilitation unit, and that some patients can go home the same day of surgery. We calculate that from 2002 we have saved \$3.6 million in healthcare dollars by not sending patients to rehabilitation units.

The patients self-assessed themselves as having an improvement in their quality outcomes. This healthcare savings is the product of the changes in a single practice and I think it gives an indication of the amount of savings that are available to the healthcare system with a qualitysharing type program.

I think this is the type of program and savings for which doctors need to be rewarded. This quality outcome reward program would elevate medicine, physicians, and patients.

*Sincerely,
Lawrence D. Dorr, M.D.*

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