Proposed gainsharing program passes federal antitrust review

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The Greater New York Hospital Association (Association) has proposed a voluntary gainsharing program (Proposed Program) that it plans to make available to the 100 New York hospitals that are its members. The Association explains its gainsharing program as being designed "to encourage physicians to take into account their use of hospital resources in their decision-making process and to reward them by providing them with a portion or 'share' of the savings or 'gain' that results from more efficient use of those resources."

The Antitrust Division of the U.S. Department of Justice (DOJ) recently announced that it would not challenge the Proposed Program because, as proposed, the Program should not adversely affect competition since hospitals will independently determine physician gainsharing amounts and the hospitals will not exchange any confidential information. See the DOJ Business Review Letter of January 16, 2013.

The Proposed Program is designed to provide a framework by which participating hospitals can measure physician performance against certain benchmarks and award bonuses to physicians for improvements in quality and efficiency. The physicians who meet the hospital-specific quality standards while reducing costs could be compensated financially with a share of the savings realized by the participating hospital.

The Association represented to the DOJ that its proposed gainsharing is similar to the gainsharing demonstration programs that Medicare has created; in particular, the Medicare gainsharing demonstration involving hospitals and the Medicare gainsharing demonstration involving physicians and hospitals. A significant difference with the Association's Proposed Program is that it applies to commercial health insurance and Medicare and Medicaid managed care products, while Medicare's gainsharing demonstration programs apply only to Medicare patients.

The key aspects of the Proposed Program are that it is voluntary for the Association's New York members and competitively sensitive data is not shared among the hospitals. The Proposed Program requires that the hospitals that wish to participate provide publicly available data about their costs for various procedures and treatments. The hospitals will also submit quarterly patient discharge data that every hospital in the State of New York regularly maintains and submits to the State of New York for ongoing public reporting purposes. The patient discharge data will use the All Patient Refined Diagnosis Related Group (APR DRG) that Medicare has designated for the specific treatment or procedure.

A third-party software company hired by the Association will then take this publicly available historical data and determine the 25th percentile of the cost among all the hospitals in the State of New York for the particular APR-DRG. The data used will be at least three months old, supplied by at least five providers with no individual provider's data representing more than 25 percent on a weighted basis of that statistic, and sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider. The third-party software company would then generate best practice norms for any APR-DRG that will be common across the hospitals. The third-party software company will include in their computation the cost associated with specific inpatient services performed by specific physicians. For each participating hospital, the third-party software company will use the compiled cost data to measure individual physician performance relative to the best practice norm for the APR-DRG in question.

Each participating hospital will independently and unilaterally cap the amount of money that the hospital will make available for incentive payments to its participating physicians (Cap). This Cap is the amount of money that a hospital makes available for incentive payments to its participating physicians. This information will not be shared with other hospitals.

The individual hospitals will then unilaterally and independently allocate the total incentive amount across two incentives, which include a performance incentive comparing a physician's performance to his/her peers based on the best practice norm, and the improvement incentive, which compares the physician's performance to his/her own performance over time. These incentives, once calculated, are then conditioned on the physician's satisfaction of quality metrics that are established and modified by each participating hospital. Each hospital must, at a minimum, measure physician performance against a basic set of quality metrics established by the Medicare demonstration programs.

The Association has implemented certain procedures to assure that the Proposed Program complies with fraud and abuse laws and regulations. Those procedures include a required legal opinion from each hospital that the participating hospital, to the best of its ability based upon existing federal guidance, is acting in compliance with applicable laws and regulations for the purposes of the program, including the Civil Monetary Penalties Law, the Physician Self-Referral or STARK Law, and the Anti-Kickback statute.

Other than the best practice norm for the various APR-DRGs, none of the information and data will be shared among the various participating hospitals. That is, the other data, such as the Cap, the allocation between the incentives, the performance incentive and the improvement incentive, and the quality metrics established by each participating hospital will not be shared among the hospitals.

Because each hospital independently and unilaterally determines a hospital-specific incentive payments cap and hospitals voluntarily elect to participate in the Proposed Program and are not obligated to make any incentive payments, the DOJ concluded that this would indicate that the Proposed Program does not "involve any agreement, coordination or discussion concerning the prices that participating hospitals or physicians charge for their services." The Association does reserve the right to exclude any particular hospital to prevent fraud and abuse issues and the Association will be using a fair market value analysis to ensure that each hospital and its physicians have actually taken concrete steps to justify the award and incentive payments. Both of these requirements are for the purpose of assuring compliance with the fraud and abuse laws and regulations. The Antitrust Division found that such requirements by the Association were ancillary to the overall legitimate purposes of the Proposed Program and concluded that these are the least restrictive means possible to achieve the Proposed Program's purposes.

As to the question of whether this Proposed Program may involve anticompetitive information exchange, the DOJ said that it is relying upon the restrictions on dissemination of competitively sensitive information. The only information that the Association will be sharing among the participating hospitals as a group will be the developed statewide best practice norm for each APR-DRG, which will be developed based upon data that is at least three months old, supplied by at least five providers with no individual's data representing more than 25 percent of the weighted basis of the norm, and the norm will be sufficiently aggregated so that it does not allow any of the hospitals to determine any individual hospital's pricing, charges or compensation paid to any particular provider. The DOJ concluded that the proposed information sharing program consequently is unlikely to facilitate collusion or otherwise raise competitive concerns.

In summary, the DOJ, based upon the specific description of the operation of the proposed gainsharing program, concluded that it had no present intention to challenge the formation or operation of the gainsharing program under the antitrust laws. The DOJ did emphasize, however, that if the use of the provisions of the Proposed Program by the Association are a pretense for coordinating hospital payments to physicians, then such conduct would be subject to prosecution under the antitrust laws.

Authors