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Provider Response to Cost Containment: Fraud & Abuse Issues

*Introduction by Charisse Logarta**

I. INTRODUCTION

Joan Polacheck is an accomplished partner in the Health Department at McDermott, Will & Emery, L.L.P. Ms. Polacheck has vast experience in general, corporate, and regulatory health law. She represents health care providers, provider networks, and suppliers on regulatory compliance matters, focusing on health care fraud and abuse. Ms. Polacheck also advises hospitals, hospital systems, health care vendors, and suppliers in performing legal audits in the course of establishing and effectuating compliance programs. She adeptly aids her clients to develop and implement provider networks and advises them on self-insurance and captive insurance issues.

As a member of the Illinois Bar Association and the American Health Lawyers Association, Ms. Polacheck speaks passionately on various topics of health law for different groups within the health care industry. She earned her Bachelor of Arts from Yale University, *summa cum laude*, and her Juris Doctor from Harvard Law School, *cum laude*.

Ms. Polacheck spoke enthusiastically at Loyola University Chicago School of Law's Annual Health Law and Policy Colloquium, *Cost and Quality in Health Care: Does Anyone Get What They Pay For?* Focusing on health care providers' responses to government cost containment initiatives, she addressed the tension between cost savings and quality of care, as well as how the dispute over gainsharing practices enhances that tension. She emphasized the effects of health care fraud and abuse laws and how they may not only inadvertently prevent health care providers from developing creative responses to cost containment, but also hinder the delivery of high quality health care. The following analysis briefly summarizes the major health care regulations and expands on how they place pressure on health care providers' abilities to save costs without

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sacrificing quality. It then explains the ramifications of gainsharing practices and how they affect the health care industry.

II. FRAUD AND ABUSE LAWS

Federal health care fraud and abuse laws address the containment of government health costs, the balancing of the health care market, and the protection of patients. In an effort to contain government costs in light of the rising cost of health care, Congress enacted laws to monitor Medicare and Medicaid payment mechanisms. Specifically, the Anti-Kickback Statute, the Stark Laws, the False Claims Act, and the Civil Monetary Penalties Law all police provider responses to cost containment that inappropriately maximize payment of government dollars.¹

The federal Anti-Kickback Statute imposes criminal penalties for soliciting, paying or receiving illegal remunerations, in return for referrals of health care goods or services paid for, wholly or partially, under Medicare or Medicaid programs.² These penalties only apply to intentional and improper attempts to save or earn money among health care providers at the expense of patients or the government.³ The Stark Law, also known as the Ethics in Patient Referrals Act, prohibits self-interested referrals of health care services under Medicare (or Medicaid in some cases) to institutions in which the referrer has a financial interest.⁴ Unlike the Anti-Kickback Statute, the Stark Law operates under strict liability and does not require proof of intent for a violation.⁵ A significant provision of the False Claims Act allows private parties, or “whistleblowers,” to challenge and recover for fraud regarding health care paid for by the federal government.⁶ Lastly, the Civil Monetary Penalties Law imposes fines for certain violations of health care fraud and abuse laws.⁷ This law penalizes the provision or receipt of incentives to reduce or limit medical services without regard to whether the services are medically necessary, which becomes problematic when providers try to contain costs.⁸

Ms. Polacheck acknowledged the necessity of these laws for the

1. Joan Polacheck, Partner, McDermott Will & Emery, LLP, Address at the Loyola University Chicago School of Law Institute for Health Law Fifth Annual Health Law and Policy Colloquium (Nov. 10, 2005).

2. 42 U.S.C. § 1320a-7b(b) (2003).

3. § 1320a-7b(b)

4. § 1395nn (2000).

5. Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241, 244 (2004).

6. See 31 U.S.C. § 3730 (2000).

7. See 42 U.S.C. § 1320a-7a(a) (2000).

8. § 1320a-7a(b) (2000).

prevention of fraud on the government and for cost containment.⁹ However, she recognized that these regulations may effectively prevent providers and physicians from creatively keeping costs down while maintaining quality of care.¹⁰

III. COST CONTAINMENT VERSUS QUALITY OF CARE

The other side of the double-edged sword of fraud and abuse laws yields a larger controversy with respect to provider responses to these laws. Hospitals' goals of furnishing competitive and up-to-date medical care naturally conflict with the goals of cost containment. For example, the implementation of Medicare Part A Diagnosis Related Groupings ("DRGs") and the growth of managed care have placed mounting pressure on hospitals to reduce costs.¹¹ Therefore, in order to comply with fraud and abuse regulations, health care providers must creatively form arrangements with physicians that balance their own cost-effectiveness with quality of care.¹² The question then arises: *should* providers use economic incentives to encourage physicians to consider the cost-effectiveness of their services, and if so, *how* can they achieve this without violating the law?¹³

IV. GAINSHARING

In the past, hospitals and providers created gainsharing arrangements to deal with the dilemma that health care fraud and abuse laws pose. Gainsharing in this setting usually refers to arrangements where a hospital enjoys reduced costs attributable to physicians' efforts and then shares a percentage of those savings with the physicians.¹⁴ For example, under the Medicare Prospective Payment System, a hospital receives a uniform pre-established payment for each patient under sets of DRGs, regardless of how much expense each patient actually incurs.¹⁵ At the same time, Medicare compensates physicians on a fee-for-service basis, which pays physicians for each individual reimbursable service rendered.¹⁶ However, even though a gainsharing attempt to align hospitals' and physicians' economic interests by providing physicians with financial incentives to engage in cost-effective

9. Polacheck, *supra* note 1.

10. *Id.*

11. Marcelo N. Corpuz, III & Celestina Owusu-Sanders, *OIG Issues Advisory Opinions on Gainsharing Arrangements*, 17 NO. 3 HEALTH LAW 16, 16 (2005).

12. Polacheck, *supra* note 1.

13. Richard S. Saver, *Squandering the Gain: Gainsharing and the Continuing Dilemma of Physician Financial Incentives*, 98 NW. U. L. REV. 145, 150 (2003).

14. Corpuz & Owusu-Sanders, *supra* note 11, at 16.

15. Saver, *supra* note 13, at 156.

16. 42 U.S.C. §§ 1395w-4(a) – (j) (2000); Saver, *supra* note 13, at 157.

care, this payment schedule actually creates incentives for physicians to perform additional services.¹⁷

Gainsharing arrangements have come under fire because of their potential to violate fraud and abuse laws. The effectiveness and legality of these arrangements present a quandary for the Health and Human Services Office of the Inspector General (OIG). In 1999, the OIG issued a Special Advisory Bulletin indicating that health care gainsharing violates laws that prohibit "payments by or on behalf of a hospital to physicians with clinical care responsibilities, directly or indirectly, to induce a reduction or limitation of services to Medicare or Medicaid patients."¹⁸ Yet the OIG recently issued five opinions that did approve of specific gainsharing arrangements involving cardiac catheterization and cardiac surgery programs, even though they potentially violated the Anti-Kickback Statute and the Civil Monetary Penalties Law.¹⁹ While these opinions only considered very narrowly tailored programs that were carefully crafted with safeguards against diminishing quality of care, they signify that hospitals may have the option to legally implement particular gainsharing arrangements. Still, the legal climate surrounding gainsharing remains unclear and the dispute over such arrangements only increases the strain on the tension between cost containment and quality of care.²⁰

Gainsharing's strengths and weaknesses arguably leave the issue in a stalemate. In 1986, the Government Accounting Office issued a report identifying the main abuse risk of gainsharing as "the incentive for physicians not to see, admit, or treat Medicare beneficiaries."²¹ Such arrangements may cause physicians to compromise quality of care given to patients because of cost-efficient practices, creating a standard of care based on provider finances rather than on the patients' best interests.²² The OIG's concerns highlight several dangers of gainsharing plans: encouraging physicians to "cherry pick" (selecting healthier and less expensive patients), promoting paid referrals, and creating unfair competition.²³ Additionally,

17. Betsy McCubrey, *OIG Bulletin Highlights Schizophrenic Attitude in Cost-Saving Measures: Gainsharing Arrangements - Their History, Use, and Future*, 79 N.C.L. REV. 157, 166 (2000); Corpuz & Owusu-Sanders, *supra* note 11, at 16; Saver, *supra* note 13, at 157.

18. Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries, 64 Fed. Reg. 37,985 (July 14, 1999).

19. See Corpuz & Owusu-Sanders, *supra* note 11, at 16.

20. Polacheck, *supra* note 1.

21. McCubrey, *supra* note 17, at 174; see U.S. Gen. Accounting Office, GAO/HRD-86-103, Medicare: Physician Incentive Payments by Hospitals Could Lead to Abuse 1, 3-4 (1986) (Sup. Docs. No. GA1.13:HRD-86-10).

22. See McCubrey, *supra* note 17, at 175.

23. Corpuz & Owusu-Sanders, *supra* note 11, at 18.

these arrangements can also prevent incentives to invest in new, more expensive technology and treatments.

Alternatively, proponents of gainsharing emphasize improved quality of services as one of its major strengths.²⁴ Under carefully structured arrangements, providers may “condition payments to physicians on the physicians’ ability to maintain or achieve” specified higher standards.²⁵ Gainsharing also helps to align providers’ and physicians’ interests in “lower[ing] hospital costs, improv[ing] operational efficiencies, and establish[ing] procedures . . . that improve the overall quality of patient care,”²⁶ while still allowing physicians to maintain the flexibility and autonomy necessary to individualize the care they provide.²⁷

On October 7, 2005, the Ways and Means Subcommittee on Health held a hearing to address health care gainsharing issues.²⁸ At this hearing, witnesses and panelists made statements before the Subcommittee regarding the advantages and disadvantages of gainsharing arrangements.²⁹ The variance in opinions presented at this hearing illustrates the current depth of the dispute and indicates that the views of gainsharing advocates and opponents seem unlikely to converge within the near future. Ms. Polacheck analyzed several statements from this hearing and clearly depicted the many dimensions of this problematic issue.³⁰

V. CONCLUSION

Increased government regulations in the health care industry seem to create just as many problems as they attempt to address, if not more. Health care providers face significant pressure to contain costs without violating federal health care fraud and abuse laws. At the same time, hospitals must depend on physicians to provide high quality and cost-efficient care for patients. Gainsharing arrangements arose as the logical response to these needs, aligning the interests of providers and physicians. Due to the limitations that fraud and abuse laws impose, these arrangements became widely observed as illegal, but new opinions issued by the OIG have again placed the issue on the table.

As shown in the transcript that follows, Ms. Joan Polacheck presented

24. McCubrey, *supra* note 17, at 176.

25. *Id.*

26. *Id.*

27. *Id.* at 177-78.

28. Hearing on Gainsharing before the Subcomm. on Health of the H. Comm. on Ways & Means, 109th Cong. (2005), <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=4671>.

29. *Id.*

30. Polacheck, *supra* note 1.

the complexities in this area with a keen knowledge of the tension between health care fraud laws, cost containment, and quality of care. Focusing on statements made at the October 7, 2005, hearing held by the Ways and Means Committee on Health, she questioned the necessity of gainsharing arrangements and their ability to ease this tension. Ms. Polacheck illustrated the cloudiness of the federal government's position on the legality of gainsharing and warned that problems in this area may continue to plague the health care and legal fields well into the future.