ALICE G. GOSFIELD
& ASSOCIATES, P.C.

Westlaw Key Authors Interview-2009
Alice G. Gosfield

Q: How did you become interested in health care law?

I needed a job during the summer between my second and third year of New York University Law School. One of my law school roommates who had gone to Antioch College as an undergrad went home to Antioch (her Dad was a professor there) and went through the 'work-study' job opportunities. Because Antioch required its undergraduates to spend one trimester of every three doing work in some setting, they always had job opportunities available. There was an organization called the Health Law Project of the University of Pennsylvania that was looking for an office assistant. My roommate said, "You should see if they have legal jobs there since it's in Philadelphia where you are from and your father is a doctor." I said, "There is no such thing as health law" and I was right in 1972. It turned out to be a program funded as part of the War on Poverty to develop a consumer perspective on health law which did not yet exist as a discipline. In fact, Edward Sparer, the Penn professor who ran the program, was developing a curriculum for health law as part of the project. Because I grew up working in my father's cardiology practice, and at the hospital, I was arguably more familiar with the practice of medicine than the practice of law.

The substantive issues fascinated me. The policy issues really resonated for me and I could see how they applied to the real world. The first thing I worked on was a new law to review care in accordance with 'norms, criteria and standards' in the Medicare and Medicaid programs --- a program to improve quality and lower costs. These are the most persistent challenges in the public programs even today. I thought it was so interesting that I might be able to sustain a career working on those issues, and so I have.

Q: Tell us about your treatise: the Health Law Handbook.

The Health Law Handbook is an entirely new book every year. I dragoon colleagues all around the country who are working on topics that are interesting, controversial, complex, or hot and ask them to write substantive chapters. Their charge is to write something that might be didactic, analytical, polemical, or discursive, but it has to be usable by practicing lawyers in the field. I myself write a major substantive chapter every year. Some folks have written in virtually every one of the 21 editions. Others participate episodically. I always try to find new young experts to renew the field.

Although I don't work on all the topics the book addresses, I find it really broadening to read all the chapters. I'd actually recommend that to other health lawyers who far too often don't read outside of their subspecialty areas.

Q: You've also written a book on Medicare and Medicaid fraud and abuse. How has the focus on Medicare fraud changed in recent years? Where do you think the focus will be in coming years?

Although the first real fraud and abuse aspects of the public programs were enacted in 1972, it was not until 1977 that the first Medicare and Medicaid Anti-fraud and Abuse Amendments were enacted. That was the beginning of real fraud and abuse enforcement. But it was not until the Supreme Court case of US v. Greber in 1985 out of the Eastern District of Pennsylvania US Attorney's Office that the industry began to take fraud and abuse risks seriously. Now there is a vast armamentarium of fraud and abuse laws, and a growing army of fraud enforcers and auditors. There are criminal penalties, civil penalties and administrative civil money penalties. We have moved from fraud being straightforward issues such as billing for services never rendered, to today's world where implied quality statements in claims where the care is substandard can be considered actionable. The advent of whistleblower cases under the Federal False Claims Act has created a sub-industry of a plaintiffs' bar in this context. New amendments passed this year are expected to expand the bases for enforcement considerably. At the same time, because of the enormous drain on the federal budget that is represented by fraud and waste, new government task forces have been formed and have already garnered headlines. This is a burgeoning area of the law and shows no signs of abatement.

Q: What do you focus on in healthcare law?

I have always had a strong emphasis on representing physicians. When I began as a health lawyer, to the extent anyone could figure out what health law was, they thought the only clients would be hospitals. I was very interested in physicians, who didn't even realize they needed lawyers back then. I thought that rather than try to steal business from some lawyer who already represented any hospital, it would be better to represent the physicians. Besides, I really understood viscerally what they were about. I knew them "up close and personal". Because of my beginning as a lawyer working on policy analysis, I have also always been involved in the policy world in some ways and particularly on issues related to quality, value, cost containment and the like.

So, my practice is heavily focused on transactions involving physicians and those who seek to do business with them, (I draft and review lots of contracts), guidance on compliance with the fraud and abuse laws including false claims, Stark and anti-kickback. I write and review medical staff bylaws. I've read literally hundreds of managed care contracts. I don't litigate, although I have occasionally been engaged as an expert witness. Now, because of their ascent into regulation, I also work in my

practice on issues involving quality improvement and value, clinical guidelines, and evidence-based medicine. I also work on arcane issues of Part B Medicare reimbursement.

Q: Health care spending continues to rise at a rapid rate. Is this sustainable? What are the solutions to this problem?

We can see from the fervor of the health reform debates that there is real concern in this country with respect to the competitive impact of rising costs on employers who finance health care. From the federal budget perspective, we will never be able to provide universal coverage and decent benefits if costs are not contained; and Medicare will go bankrupt while federal money will dwindle for states to have Medicaid programs. Many believe that improved fraud enforcement will help contain costs. The range of auditors who are reviewing care has grown exponentially, although I can't say I think the "inspection-investigation" approach to containing costs will help over the long haul. One of the primary dilemmas is that the provider payment models today contain incentives to either overuse (fee for service where you get paid for each additional thing you do irrespective of its quality or medical necessity) or underuse (capitation and DRGs where you make money by doing less). None of these payment models has anything to do with what patients need to treat their conditions. Nor does it assure high quality or safety in the delivery of care. I think a better payment model that helps providers – all of them – do the right thing and get paid fairly for doing so --- avoiding unnecessary and inappropriate care-- will help a lot.

Q: Tell us about your work with PROMETHEUS Payment, Inc.

PROMETHEUS Payment® Inc (www.prometheuspayment.org) is a not for profit, tax exempt organization funded now by the Robert Wood Johnson Foundation to test a new provider payment model that starts with paying providers to work together to deliver the care which good clinical practice guidelines say are the services patients need to treat their specific clinical conditions. It entails bundled budgets not bundled payments, with a scorecard. It does not require any particular organizational configuration and will work for small physician practices as well as giant integrated delivery systems. All of the design and methods are transparent. There are no black boxes.

The project began in 2004 when a group of us came together to create a different way of paying for care. A design team of folks with very different skillsets and backgrounds – health policy, methodology and research, business and management, health economics, health insurance, medicine, law – met every month for more than four years to come up with the system and operational concepts. I was one of the original design team members and have been completely involved in the development of the model. Even more so, since my skillset is not what is really needed methodologically, I have had a considerable role in writing about and

explaining the model to the industry, with particular attention to providers and especially physicians. The website is replete with articles and white papers I've authored. We are testing the program in pilot sites all around the country. It's quite remarkable how the concepts are being accepted. It is really personally rewarding to have helped develop something that has the potential to significantly improve quality, pay providers more fairly and save considerable sums of money at the same time. I am the first Chairman of the Board of PROMETHEUS Payment, Inc.

Q: How is the care given by physicians affected by the fear of lawsuits?

The data shows that physicians over-estimate their risk of being sued by about threefold what their real risk is. This leads them to engage in defensive medicine, where they order tests and services they don't need because they think a plaintiff's lawyer will make an issue if they don't order it and something goes wrong. While this adds to costs, it is nowhere near as significant a cost elevator as many people think. Physicians, however, are so fearful of being sued, that they raise tort reform as an issue whenever payment reform is discussed. My personal views are that tort reform in terms of a different compensation forum and model for injured patients, should be available only for these providers who can demonstrate they generally are providing high quality care and not everyone. All health care and all doctors are not equal. America is only beginning to understand this.

Q: You have a two person practice, but a national reputation and presence. How did this happen and is your writing a part of this phenomenon?

Because I started my legal life doing policy analysis, writing about my analysis was always part of what I did. I published my first book in 1975, although it was probably read by 15 people. Thanks to the internet though, it's existence, if not any copies, can be found without much difficulty. When my husband and I began a real law practice in 1978, I had to build an interest among physicians in the regulatory issues on which I wanted to work. Writing and doing public speaking about the regulations, contracts and bylaws was essential. I wasn't going to get business on a golf course. It turned out I was really good at the public speaking and people started asking me to do a lot of it. They paid me for my marketing because I was able to take complex, arcane ideas and make them understandable in an entertaining way. Because I was interested in these strange topics that most lawyers didn't understand – fraud and abuse avoidance, physician reimbursement, quality control and cost containment – I was able to become a national expert in relatively short order. The National Health Lawyers Association (NHLA) let me speak at a meeting I think in 1980, for the first time. That gave me a kind of credibility and networking that I never could have gotten otherwise. Eventually I became President of that organization. Because of the topics we work on that most lawyers don't, I've had law firms as clients for years. We back them up while they interact with the clients. Probably over the years maybe forty firms. As a result of the NHLA programs, I got connected with

others working nationally on policy issues, like the Institute of Medicine and the National Committee for Quality Assurance. And I continued to write and speak nationally and internationally. I still do. It keeps me on my toes and I learn from audiences about things I could never hear about only in my practice. I'm not bored.