Aligning Physician Decision-making with the Goals of HCOs

Edward Correia, American University Washington College of Law
Aligning Physician Decision-making with the Goals of Health Care Organizations: Are there Any Lessons from Law Firms?

By Edward Correia
Adjunct Professor, American University Washington College of Law

Abstract: In order to achieve efficiency in the delivery of health care services, it is essential to more closely align the behavior of physicians with the goals of the Health Care organization with which they are affiliated. Achieving alignment presents a number of challenges, including legal constraints, a long tradition of physician independent, a tendency for physicians to become involved in procurement decisions, and a scarcity of comparative effectiveness data that could serve as a basis for treatment protocols and purchasing decisions. The article discusses these challenges and suggests some partial solutions. In addition, it compares the incentives that affect physicians in health care organizations and partners in law firms and suggests that there member some lessons that health care organizations can learn from the lawyers.

Text of Article:

The American health care system is, to put it mildly, complex. The recent health care reform bill, The Patient Protection and Affordable Care Act (ACA), took over 2000 pages to make adjustments to the system but even these changes did not alter most of the fundamentals. There is still an incredibly diverse and fragmented system of providers, ranging from physicians who practice alone to very large Integrated Delivery Networks (IDNs), which manage dozens of hospitals and contract with or employ thousands of physicians. Although health care reform imposed significant restrictions on the private health insurance industry, there is no single payer, as is the case with some European systems, or even a “public option” for insurance coverage that

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is available to everyone. Most Americans will still have private insurance coverage, and private insurers will still determine reimbursement levels for most providers, subject to state and federal regulation. For historical and political reasons, the American health care system is destined to remain in its complex state for the foreseeable future.

This article is about one important element in promoting the efficiency of the health care system: aligning the incentives of physicians with those of the Health Care Organization (HCO) with which they are associated. This is only one aspect of increasing the efficiency of health care delivery, but it is a central one because physician decision-making drives the allocation of resources for virtually all types of medical treatment. Physicians have an extraordinary degree of discretion in decision-making, regardless of the form of HCO with which they are associated. To some extent, physicians are comparable to attorneys in law firms. Both groups are highly skilled professionals with years of professional training. Both often work with or in large organizations and have financial incentives that may conflict with the goals of these organizations. Consequently, it may be useful to compare these groups of professionals and how their organizations deal with the problem of alignment.

The article proceeds this way: Part I discusses the general idea of integration and how the benefits of integration can be undermined if the HCO fails to achieve a reasonable level of physician alignment. Part II provides some examples of the problems that may arise if physician decisions are inconsistent with the goals of an HCO. Part III compares the incentives to lawyers and physicians and discusses whether there any lessons to draw. Part IV describes different

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\(^2\) I use the term Health Care Organization (HCO) as a generic description of any organization of health care providers, ranging from very large Integrated Delivery Networks (IDNs), to independent hospitals that provide admitting privileges to physicians.
categories of decisions made by lawyers and physicians, which suggest some strategies for alignment. Part V suggests some partial solutions to the problem of physician alignment.

I. INTEGRATION OF PROVIDERS WITHIN AN HCO

A consistent theme in moving toward a more efficient health care system is integration, i.e., coordinating—by common ownership or contract—the activities of different providers in a way that minimizes costs and improve outcomes. How can integration lead to lower costs and better medical outcomes? To take a simple example, assume health care services are divided into five categories: 1) non-physician preventive care; 2) primary physician outpatient care; 3) specialty physician outpatient care; 4) acute inpatient care; and 5) post-hospitalization follow-up care. Note that the first four levels move from the least technologically complex to the most complex, while level (5) represents a return to less technical complexity. A small expenditure for services in a less technically complex category, e.g., flu vaccinations or glucose monitoring in level (1), or early detection of disease in level (2), can prevent much greater expenditures in a higher category. The same is true for services in level (5), which may reduce the number of expensive hospital readmissions. The challenge is how to allocate resources in a way that achieves the right “service mix” for patients.

In theory, integration through common ownership or contract is not essential to achieving the right mix. Coordination is the key, not a particular business arrangement. A local health department, for example, could take responsibility for promoting vaccinations, ensuring that diabetics monitor blood glucose levels, and providing post-hospitalization follow-up while an IDN serving the same community provides outpatient primary and specialty care and inpatient care. But the budgetary and service decisions of the local health department are made separately
from the HCO and it may have very different priorities. There is no structural incentive for the health department to spend $100,000 on these services even though doing so might prevent $10 million in expenditures by the HCO for inpatient care. Even in the unlikely event that the health department and the HCO agree on the right service mix, the difficulties in information-sharing and joint decision-making make consistent coordination impossible. Thus, integration of these services within a single HCO is the only way to create the economic incentives and organizational arrangements necessary for the most efficient use of resources.

Understanding the benefits of integration is one thing, and implementing them is another. Most health care providers in the U.S. operate relatively independently, for example, as solo physicians, physicians in small group practices, or independent hospitals. Some IDNs do not offer all the levels of care described above, and even very large IDNs cannot fully integrate all these levels of service. For example, in the examples above, patients must cooperate in receiving vaccinations and monitoring their own glucose levels. The most that an IDN can do is to provide information and outreach, for example, through phone calls or home health visits.3 Patients may use health care providers outside the IDN’s network that provide poor quality care, ultimately driving up the costs of care provided by the HCO. For example, a patient may have to be readmitted to an HCO’s hospital because of poor quality post-operative care by another.

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3 Because of the importance of patient behavior outside the hospital, some IDNs have begun to offer community outreach to prevent a serious illness episode and readmissions after hospitalization. See, e.g., INOVA HEALTH SYSTEM, Health Info and Classes, http://www.inova.org/health-info-and-classes/index.jsp (providing information on community classes, educational programs, events, screenings, and lectures offered in Northern Virginia by Inova Health System) (last visited July 16, 2011); SHARP: SAN DIEGO’S HEALTH CARE LEADER, SHARP HEALTHCARE COMMUNITY BENEFITS PLAN AND REPORT FY 2010 24 (2011) (reporting that Sharp spent $3,512,152 in Fiscal Year 2010 on community benefits, including health education and information, support groups, health fairs, etc.), http://www.sharp.com/about/community/upload/SHC_CommunityBenefitsPlan_FY2010.pdf.
provider. The high value placed on ensuring that a patient can choose his or her own doctor has now become widely accepted by legislators and policy-makers even though there may be significant inefficiencies involved. Despite these limitations, integration offers a significant potential to reduce health care costs.

II. THE PROBLEM OF PHYSICIAN ALIGNMENT

The challenge of achieving effective integration raises the problem of physician alignment, i.e., ensuring that the decision-making of physicians is consistent with the goals of the HCO. The problem of physician alignment has been recognized for decades, and considerable research has been done to understand the barriers to alignment. It may seem strange, given the

4 This is a weakness in the new Accountable Care Organization (ACO) program. The proposed ACO Rule provides that patients who are beneficiaries of a particular ACO cannot be required to use the services of the ACO. See Medicare Shared Savings Program: Accountable Care Organizations (Proposed Rule), 76 Fed. Reg. 19,528, 19,645, § 425.6(a)(2) (proposed Apr. 7, 2011) (to be codified at 42 C.F.R pt. 425) (“Beneficiary assignment to an ACO is for purposes of determining…whether an ACO has achieved savings…and in no way diminishes or restricts the right of beneficiaries assigned to an ACO to exercise free choice in determining where to receive health care services.”)

5 See, e.g., Jonathon D. Ketcham & Michael F. Furukawa, Hospital-Physician Gainsharing in Cardiology, 27 HEALTH AFF. 803, 803 (2008) (“A common obstacle to improving hospital quality and controlling costs is the misalignment of hospitals and their medical staffs.”) (citation omitted)); accord R.A. Barenson, P.B. Ginsburg, & J.H. May, Hospital-Physicians Relations: Cooperation, Competition, or Separation? 26 HEALTH AFF. w31 (2007); William H. Thompson, Aligning Hospital and Physician Incentives in the Era of Pay-for-Performance, 3 IND. HEALTH L.REV. 327 (2006); see also Lawton R. Burns & Ralph W. Muller, Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration, 86 MILBANK Q. 393 (2008) (“even though physicians may support the hospital’s goals, they may neither share these goals nor feel responsible for achieving them at the expense of their own future income or professional satisfaction.”) (citation omitted)); Anne Sharamitaro, Co-Management Arrangements – Aligning Physicians and Hospitals, Health Capital, July 2010, http://www.healthcapital.com/hcc/newsletter/07_10/Comanage.pdf (noting that physician
high stakes involved, that physicians still make decisions so independently. On the other hand, physicians are not unique in functioning relatively independently as professionals in large organizations. Law firms face analogous problems. Below, I discuss when these problems are similar and when they are different. First, consider two examples of the problem of alignment in the health care context.

**Example One: Ordering Catheters**

For many inpatients, decisions must be made about when to use urinary catheters. Inserting catheters could be viewed as medically appropriate by the physician, but there are also cost implications. For example, there are costs not only for the catheters themselves and staff time to insert them, but also for the inevitable high number of infections that follow. On the other hand, the use of catheters saves the time of nursing staff and, when used appropriately, can lead to better medical outcomes. Hospital administrators may have one view about the use of catheters, and the physicians, who must actually order them, may have another. Even if the physicians are employees of the hospital and, in theory, report directly to the Administrator or a Medical Director, they may still make decisions that are inconsistent with the overall goals of the HCO.

**Example Two: Purchases for the OR**

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alignment has been “an ongoing struggle, particularly since the shift from small . . . independent private practices to captive practices within larger integrated health systems . . . ”)

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6 See Department of Health and Human Services, Center for Disease Control, *Guidelines for Prevention of Catheter-Associated Urinary Tract Infections* (2009). Between 15% and 25% of hospitalized patients may receive short term urinary catheters. Id. at 23. One study found that urinary tract infections made up the highest number of infections in the hospital. Id.
A substantial portion of the costs of the health care system is made up of purchases of drugs, devices and supplies. Consequently, purchasing decisions by HCOs are very significant in determining their overall costs. For example, hospitals which offer brain tumor surgery must make decisions regarding the type of surgical devices that are available to be used by surgeons to isolate and remove brain tumor tissue. There are several devices available on the market to perform this function, and the costs for each device are substantial. These are capital cost items, i.e., they can be used many times by many physicians. The HCO absorbs the costs of purchasing these devices and bills patients and insurers for their use. However, physicians typically decide which devices they want to use and HCOs have historically deferred to their wishes. As a result, HCOs may purchase too many different devices or devices that are more expensive than alternatives that perform just as well.

IV. PROFESSIONALS IN ORGANIZATIONAL SETTINGS: COMPARING LAWYERS AND PHYSICIANS

There are many similarities between senior physicians who are affiliated with an HCO and senior lawyers who are affiliated with a law firm. Both groups are highly educated and have

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7 In 2009, the national health care supply chain itself represented $328 billion of total national health care system costs. See Centers for Medicare & Medicaid Services, NHE Web Tables tbl.2 (2011) (providing details on national health care expenditures from 1960 to 2009); see also Press Release, Dep't of Def., DOD Reports Findings from Initial Healthcare Product Data Synchronization Pilot (Nov. 15, 2007).

8 Chair’s Corner, 21 Health L. 2, 3 (2010) (“. . . absent physician/hospital integration, hospitals have no control over the decisions physicians make that drive hospital costs.”

9 See id. at 4 (stating that doctors are responsible for 80% of hospitalization costs, according to some studies, and that costs cannot be lowered without some control over physician decisions); CMS, Evaluation of the Medicare Gainsharing Demonstration: Interim Report for Quality Improvement and Savings Report to Congress 2 (2011) (noting that physicians, who control use of supplies and selection of devices, have “limited incentives” to efficiently use facilities and supplies or bargain for lower-cost devices because the costs are incurred by hospitals).
spent many years developing skills in their profession. Both groups are highly compensated compared to the rest of the workforce. Both groups have enough experience and specialized skills that they expect (with considerable justification) to have a great deal of discretion in how they handle particular cases. Both can be sued for negligence if they fail to act reasonably based on the standards of their profession. Both may resent supervision by administrators even if they are individuals in their own profession. Both groups can act inconsistently with the goals of their organization and create difficult management challenges in achieving alignment.

While there are many similarities, there are also significant differences between the two groups. The most obvious difference between senior lawyers and physicians is that senior lawyers are partners in their firms, that is, they are owners. They have a direct financial stake in the profitability of the firm. Although physicians often have an equity interest in an affiliated group practice, they usually have no ownership interest in the HCO. Consequently, physician compensation is not affected, at least in the short run, by the financial success of the HCO. The HCO purchases supplies, including very expensive equipment, at the request of the physicians, but the physicians do not share in the costs of these supplies and equipment.¹⁰ Instead, the HCO bills the patient (or their insurers) to cover the costs that are imposed on them by physician decision-making. Physicians might worry that the HCO could lose so much money that it must close its doors or that its facilities and reputation will decline. These developments could indirectly reduce the physician’s compensation or intangible benefits associated with the

¹⁰ See id. (noting that physicians may, knowingly or unknowingly, increase hospital costs through unnecessary use of supplies, use of expensive devices, inefficient use of hospital resources, etc.)
physician’s practice, but these effects are usually too far down the road or too tenuous to affect physician behavior significantly.

The incentives for salaried lawyers and salaried physicians are more similar. Junior lawyers (called associates) are salaried employees of the firm. Their bonuses are typically affected by the overall success of the firm in a particular year, but this link between individual compensation and financial success of the firm is probably too insignificant to influence their behavior. Associates work long hours because they want to become partners some day and they want to get a large bonus, not because they are trying to increase the profitability of the firm. Moreover, they are supervised by more senior attorneys. In general, if senior attorneys are acting consistently with the interests of the firm, the junior attorneys under their supervision are, too.

Like law firm associates, physicians on staff are salaried employees. They may be eligible for bonuses or salary increases based on the financial performance of the HCO. Thus, they, too, could be adversely affected if the HCO loses money. However, even though the financial success of the HCO has an indirect effect on their compensation, this effect is also too tenuous to influence behavior significantly. Their salaries and bonuses are tied to their own performance, not to the performance of the HCO. Moreover, there is not as much of an established tradition of supervision of junior physicians by senior physicians. Senior staff physicians are expected to supervise junior staff physicians (e.g., first year residents) but even

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11 Federal law places restrictions on how HCOs can compensate physicians in order to avoid reducing services to patients, distorting clinical decision-making, and causing other adverse effects. I discuss some of these laws in below. See infra notes 11, 25 and accompanying text.
supervision of residents may be limited. Moreover, there is not a tradition of senior physicians supervising non-staff physicians even if they are relatively junior.

**Implications**

One potential implication of these considerations is that HCOs should be organized so that at least their senior doctors have an equity ownership. In theory, this would encourage them to be more efficient in order to increase the financial success of the HCO. These more efficient standards of practice could then extend to junior physicians, at least to the extent that they are subject to supervision by the senior physicians. While this might sound promising in theory, at this stage in the history of the organization of medical care in the United States, it is not plausible to recapitalize ownership in HCOs to make physicians equity owners. Moreover, most hospitals and IDNs are non-profit, non-stock corporations, and no one, including physicians, can “make a profit” based on the financial success of the HCO. Consequently, financial incentives to physicians, if they are necessary to promote alignment, must be structured in some way other

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12 See Merit Buckley, *Imposing Liability in the United States Medical Residency Program: Exhaustion, Errors, and Economic Dependence*, 12 DePaul J. Health Care L. 305, 310 (2009) (“Residents are left without supervision under the theory that the stress of life and death decision-making is a significant part of the lesson in becoming a lawyer.”); Jennifer F. Whetsell, *Changing the Law, Changing the Culture: Rethinking the “Sleepy Resident “Problem*, 12 Annals Health 23, 31–32 (2003) (discussing how attending physicians are missing from most residency programs because they train their second-year residents to supervise the first-years).

13 See I.R.C. § 501(c)(3) (2006) (setting out the requirements for tax-exempt corporations). In addition, physician ownership in hospitals can implicate the Stark Law prohibitions, 42 U.S.C. § 1395nn (2006), which limit physician referrals for Medicare-covered services to entities with which the physician has a financial relationship, and the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), which prohibits persons from offering or paying providers, and providers from soliciting or receiving, something of value to induce a referral or order of goods or services covered by Medicare or Medicaid. See Thompson, *supra* note 6, at 341–44.
than equity ownership.\textsuperscript{14} Below, I discuss three approaches: Gainsharing, Pay for Performance, and Accountable Care Organizations.

Before I turn to the problem of structuring financial incentives to physicians, it is worth noting that the equity ownership of partners does not guarantee alignment with the goals of their firm. It is common for senior attorneys to act in ways that benefit their own financial interest rather than their firm. Few firms of significant size determine compensation based on a simple formula of dividing all the firm’s profits equally among partners. While this approach would tie compensation for each partner directly to the success of the firm, it would also undermine the incentive for any partner to work longer hours, bring in more business, etc. Each partner would have an incentive to take a free ride on the efforts of the other partners. Consequently, firms typically compensate partners based on formulas that take into account the overall profitability of the firm, but also consider the hours billed by the partner, the client work that is attributable to the partner from bringing in new clients, the success of the partner in particular matters, and so on.

While this more complex approach to partner compensation is understandable for purposes of creating incentives, it also means that a law firm partner might pursue his or her own financial interest at the expense of the firm. For example, a partner might accept a client that creates a conflict with matters that other attorneys might take on. The result might be that

\textsuperscript{14} One interesting possibility is for non-profit hospitals to sell bonds to members of the hospital’s staff as well as other investors. The interest paid to bondholders would depend on the financial performance of the HCO or one of the entities in its network. Thompson, \textit{supra} note 6, at 334–35. This approach might preserve the non-profit status of the hospital, but it still assumes that the financial success of the HCO is sufficiently linked to physician compensation to affect behavior. That will not necessarily be the case. \textit{See} the discussion infra at notes ___ and accompanying text.
overall profits of the firm go down, but the individual partner benefits. Similarly, a partner might try to monopolize the time of skilled associates, increasing his own billings but reducing billings for the firm overall. There are many other examples, but the point is obvious: Partners often act in their own interest, rather than the interest of the firm. For these reasons, firms spend considerable time and effort developing compensation formulas that attempt to maximize the profitability of the firm while satisfying their partners, particularly those who generate the most revenue for the firm. There is no simple solution, as firm managers will concede.  

*Insurance and the Problem of Overutilization*

Another difference between lawyers and doctors has to do with the problem of overutilization. Both law firms and HCOs have traditionally been compensated on a fee-for-service basis. Consequently, both types of organizations have an incentive to provide more services because more services mean more revenue. The result can be overutilization and increased costs. That is an extremely serious problem in health care, one of the most difficult and pressing problems faced by Congress and the Obama Administration. Clients of law firms,

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even very large corporations, routinely complain about the size of their legal bills, but there are no calls for “bending the cost curve” of legal services. Why not?

We don’t worry about overutilization of legal services for three reasons. First, compared to health care, legal services constitute a very small percentage of national income, 1.6% in 2009, compared to 7.6% for health care.\(^{16}\) Second, health care costs are generally covered by some form of insurance, private or public. Increased costs covered by private health insurance increase premiums for all policyholders. Increased costs for Medicare and Medicaid are paid by taxpayers. Costs for legal services are paid by individual clients.\(^{17}\) Third, law firm clients have much more effective tools for controlling overutilization of legal services than patients have to control overutilization of health care services.

Clients have several ways to control the costs of legal services. They can try to mitigate the effects of the fee for service system by arranging for a fixed retainer, for example, a flat monthly fee for an identified scope of work. In those cases, the lawyers’ incentive is to meet the needs of the client with the minimum number of hours possible. Second, clients have more confidence that they know what services are “really needed” than patients. Consequently, it is

\(^{16}\) Bureau of Econ. Analysis, U.S. Dep’t of Commerce, \textit{Interactive Data, GDP-by-industry & Input-Output, Value Added by Industry as a Percentage of Gross Domestic Product}, April 26, 2011, \url{http://www.bea.gov/iTable/iTable.cfm?ReqID=5&step=1}.

\(^{17}\) There are limited exceptions. First, the Government spends about $400 million on legal services for low income persons. See Department of Defense and Full-Year Continuing Appropriations Act, 2011, Pub. L. No. 112-10, § 1341, 125 Stat. 38, 123 (2011) (appropriating $405 million to the Legal Services Corporation). \textit{See generally} Legal Services Corporation, \textit{About LSC}, \url{http://www.lsc.gov/about/lsc.php}. These programs have never been adequately funded, and much of the legal services provided to low income clients is provided pro bono. Second, there is a market for insurance for legal services, but it is small compared to the overall market. If we ever lose our senses and create an entitlement for legal services, we can be sure that there soon will be a “crisis” in the cost of legal services.
far more common for clients to complain about legal bills and to negotiate reductions than for patients to do the same thing. Third, corporate clients have in-house counsel and if law firms become too expensive, they can shift some of the work to them. Finally, law firms can fire the law firm and go somewhere else if they feel they are overcharged.

None of these tools for controlling costs are as effective for patients. Patients routinely defer to their physicians to tell them what services they need. In theory, they could leave their doctor or HCO and go somewhere else if the costs are too high, but often they do not really know the full costs until the end of an episode and they may feel committed to their provider no matter what the cost. They do not have the equivalent option of shifting work to in-house lawyers, although they can use home remedies or try to do without needed care. Finally, and most importantly, most of the costs of health care are paid by insurance, private or public. Consequently, patients have less incentive to control costs for their own medical episodes, even if they have the tools to do so.

The closest equivalents to law firm clients in having tools to control health care costs are the third party payers themselves. Both private payers and public payers like CMS continue to engage in extensive efforts to control costs, but the problem is vastly more difficult than in the case of legal services. For many years, the American health care system was dominated by public and private payers, e.g., the Blues and Medicare, paying relatively unintegrated providers on a fee for service basis. The disastrous inefficiency of this system is well known. A few decades ago, the revolutionary change in health care delivery was assumed to be an integration of payers and providers in a Health Maintenance Organization (HMO), with capitation payments from consumers or a public payer, such as Medicare. The hope was that combining the insurance and provider functions would create incentives for the HMO to deliver high quality
care efficiently and to allocate more resources to preventive care. This approach would be accompanied by a high degree of integration among hospitals and primary care and specialty physicians. HMOs did not prove to be the solution many anticipated for a number of reasons, including the desire for patients to choose their own physician and the financial risks of this business model. While this model has lost much of its appeal, it would be too strong to say it “failed.” Successful examples, such as Kaiser Permanente and Geisinger Health System, are still in business.

The most recent efforts to control costs take different approaches to compensation of providers, and many of these approaches depend on creating incentives to physicians to be more efficient. Some research shows that financial incentives have the greatest potential to influence physician behavior and promote alignment. However, it is much more difficult to design

18 See Jeff Goldsmith, Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers, 30 HEALTH AFF. 132, 135 (“During the 1980s and 1990s, hundreds of hospitals and hospital-physician organizations tried to contract with insurers on the basis of capitation or to create their own health plans. Most of these efforts had inadequate resources and weak governance, lacked the clinical discipline and technology capacity to control the use of services or contain services, and failed completely.” (citations omitted)).

19 See, e.g., Peter P. Budetti, Stephen M. Shortell, Theresa M. Waters, Jeffrey A. Alexander, Lawton R. Burns, Robin R. Gillies, and Howard Zuckerman, Physician and Health System Integration, 21 HEALTH AFF. 202, 206 (2002); Bonnie Darves, Physician Compensation Models: Big Changes Ahead, NEJM CAREER CENTER, January 2011, http://www.nejmjobs.org/physician-compensation-models-big-changes-ahead.aspx (reporting that the trend toward devising bonus structures has gained “even more impetus in the past two years” as hospitals move toward tighter alignment); GAIL HEAGAN & IVAN WOOD, PHYSICIAN ALIGNMENT STRATEGIES 9 http://www.healthlawyers.org/Events/Programs/SpeakerResources/Documents/heaganwood2.pdf (maintaining that paying physicians each time they follow a protocol would have the greatest likelihood for changing physician performance); see also Margaret D. Tocknell, Healthcare Reform Pits Physicians Against Hospitals, Health Leaders Media, Apr. 21, 2011, http://www.healthleadersmedia.com/page-2/PHY-265202/Healthcare-Reform-Pits-Physicians-Against-Hospitals (reporting that physicians said that half of their compensation should be fixed
incentives to promote physician alignment than to promote lawyer alignment. In the case of lawyers, the goal is relatively easy to state: increasing the profitability of the firm, while meeting professional and ethical standards. Finding the best way to structure compensation can be challenging, as discussed above, but the need for incentives to increase billings and bring in new clients is relatively straightforward.

Designing financial incentives for physicians is considerably more complicated since the goal is often to encourage physicians to reduce services, not increase them, while maintaining high quality of care. Three prominent recent efforts illustrate the challenges: 1) Gainsharing; 2) Pay for Performance; and 3) Accountable Care Organizations (ACOs). Each approach has the potential to increase physician alignment, but each has significant limitations.

*Gainsharing*

Gainsharing occurs when an HCO shares savings with its affiliated physicians resulting from the physicians’ adoption of more efficient practices. In general, these savings are shared with a group of physicians, not with individual physicians. Savings are based on a comparison with a historical baseline. For example, a recent study of cardiology gainsharing programs showed average savings of 7.4%, most of which came from the use of lower cost devices.

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20 See Ketcham & Furukawa, *supra* note 6, at 803. See also Williams Jackson, *Shared Accountability Approach to Physician Payment: Four Options for Developing Accountable Care Organizations*, 7 Indiana Health L. Rev. 185, 210 (2010) (noting that the Medicare Advisory Committee emphasized “shared savings . . . as driving re-aligned incentives for efficiency.”)

21 Ketch & Furukawa, *supra* note 6 at 808.
An interesting example of a gainsharing program is described in a 2009 Advisory Opinion by the Office of Inspector General. An HCO proposed to share savings with three affiliated physician group practices offering cardiology services. The shared savings would be based on the adoption of practices relating to cardiac catheterization, including standardizing the types of devices and supplies they used. OIG agreed that the purpose of the program was to reduce costs and encourage alignment:

Programs like [the proposal] are designed to align incentives by offering physicians a portion of a hospital’s cost savings in exchange for implementing cost-saving strategies. Under the current reimbursement system, the burden of these costs falls on the hospitals, not physicians. Payments to physicians based on cost savings may be intended to motivate them to reduce hospital costs associated with procedures performed by physicians at hospitals.

Nevertheless, the OIG found that the proposed arrangement would likely violate the Civil Monetary Penalties statute (CMP), which prohibits hospitals from compensating physicians to reduce services to Medicare or Medicaid patients. The OIG stated that it would not pursue sanctions against the HCO if it proceeded with the arrangement because there were a number of safeguards that minimized the risk that the arrangement would harm patients. The OIG also found that the arrangement might violate the Anti-Kickback Statute because the program created incentives for the physicians to admit Medicare and Medicaid patients to the HCO in order to

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22 See DEP’T OF HEALTH & HUMAN SERVICES, OIG ADVISORY OPINION NO. 09-06 (2009).

23 Id. at 7.

increase their compensation.\(^\text{25}\) However, OIG said it would not seek sanctions under that statute either because the specific arrangement minimized the risks addressed by the statute.\(^\text{26}\)

*Pay for Performance ("P4P")*

Pay for Performance means that hospitals or physicians are paid a bonus if they achieve certain positive health care outcomes for their patients. CMS has funded a number of demonstration projects using this approach.\(^\text{27}\) For example, CMS conducted a demonstration project in which it collected data on 34 quality measures relating to five clinical conditions. According to CMS: “Hospitals scoring in the top 10% for a given set of quality measures will receive a 2% bonus payment on top of the standard DRG payment for the relevant discharges. Those scoring in the next highest 10% will receive a 1% bonus.”\(^\text{28}\) Note that the payments in this program were made to hospitals, not physicians. In addition, there was no link with using particular devices that would reduce costs as in the gainsharing program. Thus, this program did not raise questions under the CMP law discussed above. To date, P4P programs have had mixed results. Despite rapid growth and widespread adoption of P4P in the U.S. over the past five years, the long-term benefits and results remain uncertain, and few U.S. programs have


\(^{26}\) Id. The Anti-Kickback Statute prohibits persons from offering or paying providers, and providers from soliciting or receiving, something of value to induce a referral or order of goods or services covered by Medicare or Medicaid. 42 U.S.C. § 1320a-7b(b).

\(^{27}\) See Thompson, *supra* note 6, at 330.

\(^{28}\) CMS, Medicare ‘Pay for Performance (P4P)’ Initiatives (January 31, 2005).
implemented efficiency measures to demonstrate a significant financial return-on-investment (ROI).  

Accountable Care Organizations

The Affordable Care Act promotes the formation of ACOs by providing for a unique form of Medicare reimbursement to HCOs called “shared savings.” These savings are based on the difference between the costs to Medicare during a three year period for the patients assigned to the ACO and a comparable baseline. Like P4P programs (and unlike gainsharing), the savings go to the HCOs rather than physicians. HCOs then have to decide how to reward their physicians. Because this process still could violate the CMP statute, CMS provided for a waiver procedure in which HCOs could apply for a waiver from the CMP statute, the Anti-Kickback Statute, and other laws. The reaction to the CMS’s proposed regulations for the ACO program

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29 One problem is that care is dispersed among multiple providers, making it difficult to link positive outcomes with a particular physician. See Hoangmai H. Pham, M.D., M.P.H., Deborah Schrag, M.D., M.P.H., Ann S. O’Malley, M.D., M.P.H., Beny Wu, M.S., & Peter B. Bach, M.D., M.A.P.P., Care Patterns in Medicare and Their Implications for Pay for Performance, 356 New Eng. J. Med. 1130 (2007). The authors studied Medicare claims for 1.79 million beneficiaries. They found that beneficiaries saw a median of two primary care physicians and five specialists working in four different practice areas. Id. at 1130. They concluded that: “In fee-for-service Medicare, the dispersion of patients’ cares among multiple physicians will limit the effectiveness of pay-for-performance initiatives that rely on a single retrospective method of assigning responsibility for patient care.” Id.; see also Thompson, supra note 6, at 333 (“[F]or a number of reasons (a lack of aligned incentives being one of the greatest), efforts to coordinate care around improve quality, patient safety and efficiency have fallen short of their potential.”).

30 CMS also published rules for ACOs to apply for waivers from certain federal laws in order to operate effectively. Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Act, 76 Fed. Reg. 19,655 (proposed Apr. 19, 2011).
was overwhelmingly negative. In general, commenters said that the burden and costs of the program outweighed its potential financial incentives.\textsuperscript{31}

IV. Categories of Decisions

I want to suggest that the challenge of alignment, whether in an HCO or a law firm, is related to whether a decision falls into one of three categories: 1) decisions involving established knowledge in the profession; 2) discretionary professional judgments; and 3) decisions about administrative support and infrastructure. By these categories I mean the following:

1) Established knowledge means facts and principles that are widely recognized in the profession and not subject to reasonable dispute. For example, in the legal profession, there is a body of established statutory, constitutional and court-made law. These principles are often complex and hard to understand (that is why only highly educated professionals apply them), but experts would fundamentally agree about them. Similarly, there are rules of procedure that have the force of law in both federal and state courts. The Federal Rules of Civil Procedure provide that a complaint filed in federal court must be answered within a certain time, or some other response must be filed, such as a motion to dismiss.\textsuperscript{32} The Federal Rules of Evidence provide for the admissibility of certain types of evidence and the exclusion of other types.\textsuperscript{33} There are

\textsuperscript{31} See, e.g., Comments of the Cleveland Clinic, Letter from Delos M. Cosgrove, M.D., to Donald Berwick, M.D., p.5 (May 26, 2011) (“Cleveland Clinic Comment”); comments of the American Hospital Association, Letter from Rick Pollack to Donald M. Berwick, M.D., p. 15 (June 1, 2011) (“AHA Comment”); comments of the American Medical Association, Letter from Michael D. Maves, M.D., to Donald Berwick, p. 12 (June 3, 2011) (“AMA Comment”); comments of America’s Health Insurance Plans, Letter from Carmello Bocchino and Joni Hong to Donald Berwick, M.D., June 6, 2011, pp. 7-8 (“AHIP Comment”).

\textsuperscript{32} Fed. R. Civ. P. 12

\textsuperscript{33} See, e.g., Fed. R. Evid. 401–15.
judgment calls that must be made within the constraints of these rules, but the basic principles are well understood and must be followed. In medicine, thousands of principles of medical science are well-established: a lack of oxygen to the heart will cause cardiac failure, liver failure will lead to death if not reversed, and so on. Similarly, there are standards of medical practice, for example, the circumstances when general anesthesia can be used, essential laboratory tests for patients who present with certain symptoms, and so on.

It is reasonable for a law firm or an HCO to insist that professionals associated with their organization comply with these principles. If they do not, the professionals themselves, as well as the organizations with which they are affiliated, are subject to severe sanctions such as malpractice liability and license revocation. Although it would likely be viewed as intrusive and unnecessary, a law firm or HCO could reduce these basic principles to a written compliance manual.

2) Discretionary judgments include decisions where there are no clearly established principles for guidance. Instead, senior lawyers must use their discretion in a particular case. In the legal profession, for example, broad legal principles established by the Supreme Court may be reasonably clear, but how they apply in a new set of circumstances is not. The Federal Rules of Civil Procedure (and the Constitution) are clear in providing a right to a jury trial, but when it is in the interest of a party to demand a jury is not. A defendant has a right to testify in a criminal case, but when it makes sense for defense counsel to put a defendant on the stand is a complex strategic decision that requires a number of considerations, including whether the

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defendant can be impeached, whether calling the defendant might breach ethical considerations, and so on.\textsuperscript{35}

Similarly, in the medical profession, when a patient is experiencing significantly impaired blood flow through the cardiac arteries, the physician must do something. But which therapeutic approach makes sense—using only drugs, inserting a stent, performing cardiac bypass surgery, or doing something else—may not be clear at all. Women who have cancerous cells in their uterus have a high risk for more widespread cancer in their uterus, ovaries, and other organs. Again, something must be done, but the best approach—removing the uterus, removing the uterus and ovaries, using chemotherapy, or some combination—is a complex decision that requires expert analysis of the particular case. Decisions in this category, in both professions, are not made by administrators or managers, even ones who are lawyers or doctors themselves.\textsuperscript{36} The senior lawyers or doctors who are dealing with the particular case have to make them.

3) Finally, decisions about administrative support and infrastructure include decisions about how the organization functions and what purchases it makes to support its professionals. For law firms, that means decisions about purchasing everything from telephone systems to computers; developing rules about hours and compensation; decisions about hiring junior attorneys and non-legal staff, devising policies for paying for travel, and so on. For HCOs, this

\textsuperscript{35} See Model Rules of Prof’l Conduct R. 1.2, 1.2 cmts. (2010).

\textsuperscript{36} There are some exceptions. Junior physicians, e.g., junior residents, are supervised by more senior physicians. Sometimes, an administrator or a committee may overrule the decision of the attending doctor, even a senior physician, after an extensive review of the facts. However, the overwhelming majority of decisions are made by the attending physician and other specialists he or she consults.
category includes decisions about purchasing supplies and equipment, hiring and firing hospital staff, building new facilities, making administrative and financial decisions, etc.

Within law firms, by and large, these kinds of decisions are made by administrators based on broad policies approved by the law firm partners. While the partners may serve on a committee dealing with a major purchase, administrators are usually responsible for making these kinds of decisions in particular cases. Individual partners can make a request, but they typically have little or no say in a particular purchasing decision. This is so because administrators have the expertise to make such decisions without relying on the professional judgment of the lawyers, and involving lawyers in individual decisions would take time away from the practice of law. It is true that sometimes individual law partners have a strong preference for a particular decision, and it may be uncomfortable for the administrators to stand up to senior partners. However, the general assumption is that it is in the interest of the firm for administrators to make decisions in individual cases.

Below I suggest how dividing decisions into these categories can be useful in thinking about solutions to the problem of physician alignment.

IV. SOLUTIONS TO THE PROBLEM OF ALIGNMENT

What lessons can we learn from our comparison of lawyers and physicians and our discussion of structuring financial incentives to physicians? I want to suggest four:

1) *Repeal or narrow the Civil Monetary Penalties law.* Law firms can reward partners who increase the firm’s profits, whether they do it by bringing in more revenue, reducing costs, or both. The OIG opinion discussed above shows how the Civil Monetary Penalties law can prevent HCOs from rewarding physicians who reduce costs, and how the Anti-Kickback Statute
can prevent HCOs from rewarding physicians who increase revenues. While OIG has written a number of advisory opinions allowing gainsharing programs to proceed, HCOs should not have to live with the uncertainty of the statute and the burden of having to seek an advisory opinion in every case. Congress should consider repealing or narrowing the CMP and the OIG should consider interpreting the Anti-Kickback Statute so that it does not prevent constructive financial incentives for physicians.

2) *Increase the level of financial incentives.* Law firms provide very substantial financial incentives to their attorneys. Bonuses for associates are routinely in the tens of thousands of dollars and very successful partners receive hundreds of thousands of dollars (or more) for making the firm more profitable. Some research suggests that financial incentives are the most effective way to encourage physician alignment. The magnitude of incentives for physicians is not likely to equal those for very successful partners, but, assuming financial incentives can be appropriately targeted, they must be significant. The lack of meaningful financial incentives is clearly a weakness in CMS’s proposed regulations for ACOs. CMS estimates the total net savings to the federal government in the first three years of the ACO program to be $510 million based on the assumption that there will be between 75 and 150 ACOs. Assuming ACOs are rewarded with the same amount (it could be a little more), an average ACO would be rewarded

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37 The potential constraints of both statutes led CMS to propose a waiver procedure for them in connection with the ACO program. *See supra* note 25.

38 *See supra* note 20 and accompanying text.

39 One gainsharing program reported payouts to physicians averaging $17,000, ranging from $0 to $59,000. *See* Ketcham & Furukawa, *supra* note 6, at 804. The high end of this range is presumably significant in influencing behavior, and perhaps the average level is, too, but that seems less certain.

with about $4.5 million over three years, or $1.5 million per year. Based on these figures, a reasonable estimate of the ultimate savings to be shared with physicians is less than $100 per physician per patient. The same problem may exist in pay for performance programs, too.

3) Reduce physician discretion where there is reliable comparative effectiveness data. In the categorization of decisions discussed above, Category 2 decisions must be made by the treating physician or the lawyer handling the case. However, if the HCO has reliable and specific comparative effectiveness data clearly showing the desirability of a particular treatment protocol, the same level of professional discretion is not required. The decision then belongs in Category 1, and administrators can insist that that a particular protocol should be followed. Moreover, if other HCOs have the same data, the physician cannot credibly threaten to move to another HCO in order to achieve a different outcome.

These data will not available for all medical conditions or for all patients. Many situations will present unique circumstances or the comparative effectiveness data will be ambiguous. In addition, even if the data seem to suggest one approach, there may be an alternative that is only slightly inferior. The HCO may not feel it is worth insisting on one approach when the potential savings in resources or the likely differences in outcomes are slight.

41 For example, an ACO with 10,000 beneficiaries would get $150 per patient. Assume that the ACO decides to allocate 50% of this amount to physicians and three physicians qualify for a reward for an average patient. Each physician would receive $25 per patient. See Edward W. Correia, Accountable Care Organizations: The Proposed Regulations and Prospects for Success, 17 AMERICAN JOURNAL OF MANAGED CARE 31, 39 (August 2011).


43 A possible example of a treatment protocol involving use of urinary catheters is the CDC publication cited supra at note 7.
However, when the data are clear and the stakes are significant, the HCO is in a strong position to require that a particular protocol should be followed.

The problem with this solution, of course, is that the American health care system is only just now taking seriously the need for comparative effectiveness data. It may be many years before an HCO can insist on treatment protocols for a large number of medical decisions. Congress and CMS should place even more emphasis on the collection and analysis of this kind of information.

4) Reduce physician involvement in purchasing decisions. In general, individual lawyers do not make administrative decisions, Category 3 above. However, there continues to be a tradition within HCOs for individual physicians to be extensively involved in these decisions, particularly with regard to the purchase of “physician preference” items. Arguably, there is more medical expertise required in deciding what capital equipment should be purchased for the surgical suite than the level of legal expertise required to purchase, say, computers for the law firm. Nevertheless, it is widely believed by HCO managers that physicians are too involved in making these kinds of decisions at the expense of the HCO.44

Some large IDNs have developed decision-making procedures for purchasing that reduce the role of the physician.45 Physicians may serve on advisory committees, but they do not have the final say, and they do not have a veto over a particular decision. Not only can these

44 See CMS Report, supra note 10, at 8 (claiming that gaining control of hospitals’ supply chains—the flow of products and associated services to meet the needs of the hospital and its providers—is difficult because “the most expensive materials—up to 60% of the total supply expenditures—are for items about which physicians have strong preference.” (citation omitted).

45 See Johns Hopkins Medicine, Mission Statement, http://www.hopkinsmedicine.org/purchasing/geninfo/mission.html;
procedures reduce costs, for example, by enabling the HCO to limit the number of different types of capital equipment it must buy, they can reduce potential legal problems that can arise if physicians are suspected of distorting their decision-making because of a financial relationship with manufacturers.

Consider the gainsharing program involving cardiac catheterization procedures discussed above. The HCO that wanted to implement this program wanted to share savings with physician groups if they ordered particular lower cost devices. If the HCO had data showing that these devices work just as well or better, and they cost less, why shouldn’t the HCO be able to require all physicians using its facilities order those devices? After all, the HCO has to pay for them. Under that approach, there is no need for shared savings and the CMP law should not be implicated.

Physicians should be able to have some input in purchasing decisions where there are complex medical or technical questions involved in the decision. However, the days of unquestioned “physician preference items” should end. The argument for reducing physician discretion about purchases is even stronger than for expanding the use of treatment protocols discussed above. Limiting the role of physicians in purchasing can have multiple benefits. First, the HCO can reduce costs by choosing the most cost-effective supplies and equipment. Second, minimizing physician involvement reduces the risk that a manufacturer-physician relationship will offend the Anti-Kickback Statute. As in the case of treatment protocols, administrators are in a much stronger position to limit physician discretion if they can point to reliable comparative effectiveness data.

V. CONCLUSION
If the American health care system is ever to be reasonably “efficient,” as that word is understood in other industries, the decision-making of American physicians must become more closely aligned with the goals of the organizations with which they work. It seems clear that some changes in the system can increase alignment: 1) providing more significant financial incentives for physicians that are tied to efficient use of resources; 2) developing the use of comparative effectiveness data to enable HCOs to establish treatment protocols; 3) reducing the role of physicians in purchasing decisions; and 4) amending or reinterpreting certain federal laws that inhibit the development of programs to reward efficiency. The American legal system, despite its excesses and waste, has within it a number of structural incentives to keep costs down and encourage lawyers to act more or less consistently the goals of their law firms. We surely don’t want large health care organizations to resemble large law firms in all respects, but there may be some lessons that the doctors can learn from the lawyers.