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ALIGNING PHYSICIAN DECISION-MAKING WITH THE GOALS OF HEALTH CARE ORGANIZATIONS: ARE THERE ANY LESSONS FROM LAW FIRMS?

Edward Correia[*]

ABSTRACT: *In order to achieve efficiency in the delivery of health care services, it is essential to align more closely 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 independence, 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 may be some lessons that health care organizations can learn from the firms.*

I. INTRODUCTION

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"),[1] took over 2000 pages to make adjustments to the system that did not alter its fundamental structure of the American health care system. Even though the Supreme Court has agreed to review a challenge to the ACA,[2] we assume that much of the statute will remain in place for the long term.[3] The

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010) (codified as amended at scattered sections of the Internal Revenue Code and 42 U.S.C.) [hereinafter ACA].

2. *See* Florida v. Dep't Health & Human Servs., 648 F. 3d 1235, *cert. granted*, 80 U.S.L.W. 648 (U.S. Nov. 14, 2011); Nat'l Fed'n Indep. Bus. v. Sebelius, No. 11-393; Dep't Health & Human Servs. v. Florida, No. 11-398; Florida v. Dep't Health & Human Servs., No. 11-400.

3. This assumption is supported by the bulk of the U.S. Courts of Appeals decisions addressing the ACA's constitutionality. Five Circuits have addressed the

most controversial question is whether Congress has the power under the Commerce Clause to require individuals to purchase health insurance.[4] 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 and other health care providers and staff.[5] Although health care reform imposed significant

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constitutionality of the ACA. The Eleventh Circuit declared 26 U.S.C. §5000A unconstitutional, but also found it severable from the rest of the bill (meaning the vast majority of the provisions relevant to this discussion would remain intact). *Florida*, 648 F. 3d at 1235. The Sixth and D.C. Circuits both upheld the bill in its entirety. Thomas More Law Ctr. v. Obama, 651 F. 3d 529 (6th Cir. 2011) (2-1 with dissenting judge dissenting from merits); Seven-sky v. Holder, 661 F. 3d 1 (D.C. Cir. 2011) (2-1 with dissenting judge arguing for no jurisdiction). The Third and Fourth Circuits declined to reach the merits, dismissing the challenges for jurisdictional reasons. New Jersey Physician, Inc. v. President of the United States, 653 F. 3d 234 (3d Cir. 2011) (lack of standing); Commonwealth of Virginia ex rel. Cucinelli v. Sebelius, 656 F.3d 253 (4th Cir. 2011) (lack of standing); Liberty Univ., Inc. v. Geithner, 671 F. 3d 391 (4th Cir. 2011), (lack of subject matter jurisdiction). In one of two cases, the Fourth Circuit concurrence and dissent each argued that if the court had jurisdiction, those judges would have upheld the ACA in its entirety, though for differing reasons. *Liberty Univ.*, 671 F. 3d at 415, 422 (concurrence based on Tax and Spend power, dissent based on Commerce power).

4. The Supreme Court heard arguments on March 27, 2012, regarding the individual mandate and heard arguments on March 28, 2012, regarding severability. It was widely reported that many Justices expressed skepticism about whether the Commerce Clause can be interpreted broadly enough so support the mandate. *See, e.g.*, Robert Barnes & N. C. Aizenman, *Supreme Court Expresses Doubts on Key Constitutional Issue in Health-care Law*, WASH. POST, Mar. 27, 2012, at A1.

5. *See Healthcare, GLG Industry Dictionary, Integrated Delivery Network (IDN)*, GLG RESEARCH, http://www.glgresearch.com/Dictionary/HC-Integrated-Delivery-Network-(IDN).html (last visited Jan. 9, 2012) (stating "IDNs include many types of associations across the continuum of care and one network may include a short- and long-term hospital, HMO, PHO, PPO, Home Health agency, and hospice services, for example. Multi-hospital systems and mergers may be considered limited IDNs in that different entities join forces to provide care."); *see also About Us, Centers, All Fee-For-Service Providers*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/center/provider.asp (last modified Dec. 9, 2011) (listing different types of providers); *Statistics and Studies, Fast Facts on US Hospitals*, AM. HOSP. ASS'N, http://www.aha.org/research/rc/stat-studies/fast-facts.shtml (relaying that 1,508 community hospitals are in a network, while 2,941 community hospitals are in a system).

restrictions on the private health insurance industry, the reform did not create a single payer system, as is the case with some European systems, or even a "public option" for insurance coverage that is available to everyone.[6] Most Americans will still have private insurance coverage[7] and private insurers will still determine reimbursement levels for most providers, subject to state and federal regulation.[8] For historical and political reasons, the American health care system is destined to remain in its complex state for the foreseeable future.

This article addresses one important element in promoting the efficiency of the health care system: aligning the incentives of physicians and the health care organization ("HCO") with which they are associated.[9] 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 clinical 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 might 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 as follows: Part II 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 III

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6. *See* Miles Mogulescu, *Obama, Durbin and Pelosi All Point Fingers at Someone Else for Killing Public Option*, HUFFINGTON POST (Mar. 12, 2010), http://www.huffingtonpost.com/miles-mogulescu/obama-durbin-and-pelosi-a_b_497359.html.

7. *Compare* CTRS. FOR DISEASE CONTROL & PREVENTION, PUBLICATION AND INFORMATION PRODUCTS, HEALTH, UNITED STATES, 2010, HEALTH INSURANCE 8, *available at* http://www.cdc.gov/nchs/hus/healthinsurance.htm *with* THE HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM, SUMMARY OF NEW HEALTH REFORM LAW (2012), http://www.kff.org/healthreform/upload/8061.pdf.

8. THE HENRY J. KAISER FAMILY FOUND., *supra* note 7.

9. 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.

provides some examples of the problems that may arise if physician decisions are inconsistent with the goals of an HCO. Part IV compares the incentives to lawyers and physicians and discusses whether there are any lessons to draw. Part V describes different categories of decisions made by lawyers and physicians, which suggest some strategies for alignment. Part VI suggests some partial solutions to the problem of physician alignment.

II. 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 improves outcomes.[10] How can integration lead to lower costs and better medical outcomes? For a simple example, assume health care services are divided into five categories: (1) non-physician preventive care;[11] (2) primary physician out-patient care;[12] (3) specialty physician outpatient care;[13] (4) acute inpatient care;[14] and (5) post-hospitalization follow-up care.[15] Note

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10. *See Accountable Care Organizations: Improving Care Coordination for People with Medicare,* HEALTHCARE.GOV (Mar. 31, 2011), http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html [hereinafter HEALTHCARE.GOV: ACO] (explaining that the Accountable Care Act (ACA) reforms create incentives for coordination that will improve the patients' and community health, increase the quality of health care provided, and lower costs). *See also* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 11-49, HEALTH CARE DELIVERY: FEATURES OF INTEGRATED SYSTEMS SUPPORT PATIENT CARE STRATEGIES AND ACCESS TO CARE, BUT SYSTEM FACES CHALLENGES 1 (2010) (discussing how fragmentation in health care can lead to lower quality of care, inefficiencies, and higher costs, and that one way providers are dealing with the problems of fragmentation is by forming integrated delivery systems).

11. *See Preventive Medicine: A Student Resource*, JOHNS HOPKINS BLOOMBERG SCH. PUB. HEALTH, http://www.jhsph.edu/PrevMed_student_resource (last visited Jan. 6, 2012) (defining preventive medicine).

12. *See John Hopkins Primary Care Policy Center, Definitions*, JOHNS HOPKINS BLOOMBERG SCH. PUB. HEALTH, http://www.jhsph.edu/pcpc/definitions.html (last visited Jan. 6, 2012) (defining primary care).

13. *See Tertiary Care Definition,* JOHNS HOPKINS MED., http://www.hopkinsmedicine.org/patient_care/pay_bill/insurance_footnotes.html (last visited Jan. 6, 2012) (defining specialty care).

14. Acute inpatient care is "a pattern of health care in which a patient is treated for a brief but severe episode of illness, for the sequelae of an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital [i.e. inpatient] by

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.[16] The same is true for services in level (5), which may reduce the number of expensive hospital readmissions.[17] The challenge is

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specialized personnel using complex and sophisticated technical equipment and materials, and it may involve intensive or emergency care. This pattern of care is often necessary for only a short time, unlike chronic care." MOSBY'S MED. DICTIONARY (8th ed. 2009). By contrast, outpatient care is given outside a medical facility (i.e., at a person's home). *See id.*

15. *See, About the H2H National Quality Improvement Initiative*, H2H: HOSPITAL TO HOME, http://h2hquality.org/WhatisH2H/AboutH2H/tabid/168/Default.aspx (last visited Jan. 6, 2012) (focusing on medication management post-discharge, early follow-up, and symptom management in order to reduce cardiovascular-related hospital readmissions). *See also Alicare Medical Management Expands Patient Transition Coaching Program to Reduce Readmissions*, PATIENT SAFETY & QUALITY HEALTHCARE (June 29, 2010) http://www.psqh.com/product-news/560-alicare-medical-management-expands-patient-transition-coaching-program-to-reduce-readmissions.html (reporting that one of the nation's leading care management solution providers is having health coaches ensure that patients are informed about post-discharge follow-up care and self-management services in order to reduce readmissions).

16. *See* Lorian E. Hardcastle et al., *Improving the Population's Health: The Affordable Care Act and the Importance of Integration*, 39 J. L. MED. & ETHICS 317, 317–327 (2011) (arguing that billions are unnecessarily spent on conditions that might have been prevented or lessened in severity, or the costs for which could have been decreased, if there was earlier, preventive care); *see id.* at 318 (explaining that evidence indicates that preventive interventions account for 80% of the reduction in morbidity and mortality). *See also* MOLLY FRENCH, AM. PUB. HEALTH ASS'N, SHIFTING THE COURSE OF OUR NATION'S HEALTH: PREVENTION AND WELLNESS AS A POLICY (2009), http://www.apha.org/NR/rdonlyres/0867A2FF-88EE-41CF-97C3-21E79D8C8896/0/FINALPreventionPolicy.pdf (arguing that the key to sustainable cost containment in health care is implementing reforms in clinical preventive services); U.S. PREVENTIVE SERVICES TASK FORCE, FIRST ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES (2011), http://www.uspreventiveservicestaskforce.org/annlrpt/tfannrpt2011.pdf.

17. *See* Margaret A. Kuehl, *Hospital to Home National Quality Initiative*, STAT BULLETIN (April-May 2010). *See also* Stephen F. Jencks et al., *Rehospitalizations Among Patients in the Medicare Fee-for-Service Program*, 360 NEW ENG. J. MED. 1418, 1428 (2009) (finding that the costs to Medicare of unplanned rehospitalizations in 2004

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. The key to achieving efficiency is coordination, not any particular business arrangement.[18] 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.[19] But the budgetary and service decisions of the local health department are made separately from the HCO and they may have very different priorities from each other.[20] 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 HCO expenditures for inpatient care.[21] Even in

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was $17.4 billion); C. Clancy, *Re-Engineered Hospital Discharge Process Lowers Re-Admissions, Reduces Costs*, 6 PATIENT SAFETY & QUALITY HEALTHCARE 8, 9 (2009); Peter Orszag, *New Study on Hospital Readmissions*, OFFICE OF MGMT. & BUDGET (Apr. 8, 2009), http://www.whitehouse.gov/omb/blog/09/04/08/NewStudyonHospital Readmissions/.

18. A similar consideration arises in the antitrust context when the antitrust agencies consider whether competitors are genuinely "integrated" in order to determine whether a "rule of reason" or "per se" rule applies. *See* HEALTHCARE.GOV: ACO, *supra* note 10 (emphasizing the need for coordination under the ACA). *See also* DEP'T OF HEALTH & HUMAN SERVS., NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE 11 (2011), http://www.healthcare.gov/law/resources/reports/nationalqualitystrategy 032011.pdf [hereinafter DHHS NATIONAL STRATEGY] (reporting that models show that coordination between providers, from small physician practice settings to larger hospital center settings, can decrease costs and increase quality).

19. *See, e.g.*, Michael McRobbie, *The Academy's Pivotal Role in Supporting Public-Private Partnerships to Prevent Chronic Diseases*, 6 PREVENTING CHRONIC DISEASE 1, 1-4 (2009), *available at* http://www.cdc.gov/pcd/issues/2009/apr/08_0218.htm (concluding from an Indiana University study that private-public cooperative partnerships acieve balanced division of labor and resources, and can be characterized as collaborations continuums).

20. *Id.*

21. PHILIP D. SLOANE ET AL., AM. MED. ASS'N, EFFECTIVE CLINICAL PARTNERSHIPS BETWEEN PRIMARY CARE MEDICAL PRACTICES AND PUBLIC HEALTH AGENCIES 10 (2011), http://www.ama-assn.org/ama1/pub/upload/mm/433/clinical-partnerships.pdf (listing factors upon which successful coordination depends).

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 render consistent coordination problematic.[22] Thus, integration of these services within a single HCO is a potentially superior 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, while implementing them is another. Most health care providers in the U.S. operate relatively independently, for example, solo physicians, physicians in small group practices, or independent hospitals.[23] 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.[24] In the examples above, patients must cooperate in receiving vaccinations and monitoring their own glucose levels. The most that an IDN can do is provide information and outreach, for example, through phone calls or home health visits.[25] Patients may use health care

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22. *Id.*

23. *See, e.g.*, *HSCdataOnline*, CTRS. FOR STUDYING HEALTH SYS. CHANGE, http://hscdataonline.s-3.com/psurvey_r5.asp (last visited Apr. 23, 2012) (relaying that about 32% of physicians are in solo or two physicians practice, 14.5% are part of group practice of three to five physicians, 19.4% are part of a group practice of six to fifty physicians, 6.1% are part of a group practice of more than fifty physicians, 3.5% are part of an HMO, and 13.1% practice in hospitals).

24. *See* James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 IND. HEALTH L. REV. 211, 218, 231 (2007) (noting that IDNs come in "many sizes, shapes, and structures," and further noting that, generally, IDNs have not yet achieved the level of integration needed to lead to cost efficiencies and higher quality care). *See also Hospital-Physician Relationships & Accountable Care Organizations, 50 Integrated Delivery Systems to Know,* BECKER'S HOSP. REV., (Oct. 14, 2010), http://www.beckershospitalreview.com/hospital-physician-relationships/50-integrated-delivery-systems-to-know.html (listing and providing detailed information on some of the nation's integrated health systems).

25. 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.*, *Health Info and Classes*, INOVA HEALTH SYS., http://www.inova.org/health-info-and-classes/index.jsp (last visited July 16, 2011) (providing information on community classes, educational programs, events, screenings, and lectures offered in Northern Virginia by Inova Health System). *See also* SHARP, SAN DIEGO'S HEALTH CARE LEADER, SHARP HEALTHCARE COMMUNITY BENEFITS PLAN AND REPORT FY 2011 46 (2011), http://www.sharp.com/about/community/upload/SHC_

providers outside the IDN that provide poor quality care, ultimately driving up the costs of care provided by the HCO.[26] For example, a patient may have to be readmitted to an HCO's hospital because of poor quality post-operative care by another provider.[27] 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.[28] Despite these limitations, integration offers a significant potential to reduce health care costs.[29]

CommunityBenefitsPlan_FY2010.pdf (reporting that Sharp spent $3,125,051 in Fiscal Year 2010 on community benefits, including health education and information, support groups, health fairs, etc.).

26. *Cf. PPOs v. HMOs, Health, Insurance, Health Care Plans*, CONSUMERREPORTS.ORG (Oct. 2011), http://www.consumerreports.org/health/insurance/health-insurance/how-to-pick-health-insurance/hmo-vs-ppo.htm (referencing the distinction between Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs) as PPOs providing easier access to out-of-network providers but resulting in higher costs, while HMOs make access to out-of-network providers more difficult but usually cost less).

27. This is a weakness in the new Accountable Care Organization (ACO) program. The proposed ACO Rule provided 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."). CMS made some adjustments to the beneficiary assignment formulas in the final rule but it retained the principle that an ACO's beneficiaries have the freedom to obtain care from any provider they choose. *See* Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,851-70 (Nov. 11, 2011).

28. *See* Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,804 ("We have also been vigilant in protecting the rights and benefits of FFS beneficiaries under traditional Medicare to maintain the same access to care and freedom of choice that existed prior to the implementation of this program.").

29. *See PPOs v. HMOs*, *supra* note 26.

III. 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.[30] The problem of physician alignment has been recognized for decades, and considerable research has been done to understand the barriers to alignment.[31] It may seem strange, given the 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.

A. Example One: Ordering Catheters

For many inpatients, decisions must be made about when to use urinary catheters.[32] Inserting catheters are medically necessary under some

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30. *See* William H. Thompson, *Aligning Hospital and Physician Incentives in the Era of Pay-for-Performance*, 3 IND. HEALTH L. REV. 327, 334 (2006) (summarizing that one of the goals of physician alignment is "to align clinical, operational, and financial incentives among the physicians, the hospitals, and other caregivers."). *See also* Steven H. Pratt, *Hospital-Physician Joint Venture Relationships: A Useful Tool to Improve Hospital Services*, 4 IND. HEALTH L. REV. 241, 243 (2007).

31. *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."). *See also* R.A. Barenson et al., *Hospital-Physicians Relations: Cooperation, Competition, or Separation?*, 26 HEALTH AFF. 31, 31 (2007); Lawton R. Burns & Ralph W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 MILBANK Q. 393, 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."); Anne Sharamitaro, *Co-Management Arrangements—Aligning Physicians and Hospitals*, HEALTH CAP. TOPICS (Health Capital Consultants, St. Louis, Mo.) (July 2010), http://www.healthcapital.com/hcc/newsletter/07_10/Comanage.pdf (noting that physician alignment has been "an ongoing struggle, particularly since the shift from small . . . independent private practices to captive practices within larger integrated health systems.").

32. *See* DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR DISEASE CONTROL & PREVENTION, GUIDELINES FOR PREVENTION OF CATHETER-ASSOCIATED URINARY TRACT

circumstances, but there are also cost and safety implications.[33] For example, there are costs not only associated with the catheters themselves and staff time to insert them, but also for the inevitable high number of infections that follow.[34] On the other hand, the use of catheters saves the time of nursing staff and, when used appropriately, can lead to better medical outcomes.[35] Hospital administrators may have one view about the use of catheters, while 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.

B. *Example Two: Purchases for the OR*

A substantial portion of the costs of the health care system is made up of purchases of drugs, devices, and supplies.[36] Consequently, purchasing decisions by HCOs are very significant in determining their overall costs.[37]

INFECTIONS 23 (2009) [hereinafter CDC GUIDELINES FOR PREVENTION] (stating that between 15% and 25% of hospitalized patients may receive short term urinary catheters).

33. *Id.* *See also* RUTH M. KLEINPELL ET AL., PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES, Ch. 42 (2008), http://www.ahrq.gov/qual/nurseshdbk/docs/KleinpellR_THCAI.pdf [hereinafter HANDBOOK FOR NURSES] (specifying that UTIs account for 40% of hospital-associated infections, and that approximately 80% of those are associated with urinary catheters).

34. One study found that urinary tract infections made up the highest number of infections in the hospital. CDC GUIDELINES FOR PREVENTION, *supra* note 32, at 23. *See* also HANDBOOK FOR NURSES, *supra* note 33.

35. HANDBOOK FOR NURSES, *supra* note 33.

36. In 2009, the national health care supply chain itself represented $328 billion of total national health care system costs. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., 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) (on file with author).

37. Hospitals are spending approximately $140 billion on supplies, which is approximately 20 percent of their operating costs and second only to labor costs. LISA DEITZ, THE CURE FOR AILING HOSPITAL SUPPLY CHAIN METRICS 1 (2010), http://www.medassets.com/servicelineanalytics/Documents/MedAssets-Whitepaper-SIM.PDF.

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.[38] There are several devices available on the market to perform this function, and the costs for each device are substantial.[39] These are capital cost items, i.e., they can be used many times by many physicians.[40] 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.[41] As a result, HCOs may purchase too many different devices or devices that are more expensive than alternatives that perform just as well.[42]

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 spent many years developing skills in

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38. For examples of the types of devices that are needed in these types of procedures, *see generally* AM. BRAIN TUMOR ASS'N, SURGERY (2004), http://www.abta.org/sitefiles/sitepages/abc3a809dea9e6f5b1a2e4c935ed6188.pdf.

39. For an example of new, non-invasive technology that targets brain cancer cells for removal, *see* Press Release, Food and Drug Admin., FDA Approves New Medical Device for Form of Brain Cancer (Apr. 15, 2011), http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm251669.htm.

40. *See Capital*, MERRIAM-WEBSTER, http://www.merriam-webster.com/dictionary/capital%5B3%5D?show=0&t=1325921568 (last visited Jan. 6, 2012).

41. Bill Asyltene et al., *Accountable Care Organizations—Physician/Hospital Integration*, 21 THE HEALTH LAWYER 3 (2009) (". . . absent physician/hospital integration, hospitals have no control over the decisions physicians make that drive hospital costs.").

42. *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). *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., EVALUATION OF THE MEDICARE GAINSHARING DEMONSTRATION: INTERIM REPORT FOR QUALITY IMPROVEMENT AND SAVINGS REPORT TO CONGRESS 2 (2011) [hereinafter CMS GAINSHARING] (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).

their profession.[43] Both groups are highly compensated compared to the rest of the workforce.[44] Both groups have enough experience and specialized skills that they likely expect 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.[45] Both groups can act inconsistently with the goals of their organization and create difficult management challenges in achieving alignment.

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.[46] They have a direct financial stake in the profitability of the firm.[47] Although physicians often have an equity interest in an affiliated group practice, they usually have no ownership interest in the HCO.[48] Consequently, physician compensation is not affected, at least in the short run, by the financial success of the HCO.[49] The HCO purchases supplies, including very

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43. *See Occupational Outlook Handbook, 2012-2013 Edition*, BUREAU OF LABOR STATISTICS (Mar. 29, 2012), http://www.bls.gov/oco/oco1002.htm.

44. As of May 2011, the average annual wage for physicians and surgeons was $184,650, and the mean annual wage for lawyers was $130,490. *See Occupational Employment Statistics*, BUREAU OF LABOR STATISTICS, http://www.bls.gov/oes/current/oes_stru.htm#23-0000 (last modified Mar. 27, 2012).

45. *See Professional Liability, 50 State Survey of Legal Malpractice Law*, AM. BAR ASS'N, http://apps.americanbar.org/litigation/committees/professional/malpractice_survey.html (last visited Jan. 6, 2012). *See also* FED'N OF STATE MED. BDS., 2008 LEGISLATIVE SERVICE UPDATE (2008), http://www.fsmb.org/annualmeetingsessions/thursday/regional_board_forums/legislativeupdate_crockett_c_and_d/crockett_c_and_d.pdf.

46. The American Bar Association has conducted a survey of how law firms are organized. *See* AM. BAR ASS'N, LAWYER DEMOGRAPHICS (2011), http://www.americanbar.org/content/dam/aba/migrated/marketresearch/PublicDocuments/lawyer_demographics_2011.authcheckdam.pdf.

47. *Id.*

48. *See* ACA, Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684–89 (2010) (codified as amended at scattered sections of the Internal Revenue Code and 42 U.S.C.). *See also* 42 C.F.R. pts. 411.354–56, 362–59 (2012).

49. *Cf.* ACA § 6001; 42 C.F.R. pts. 411.354–56, 362–59.

expensive equipment, at the request of the physicians, but the physicians do not share in the costs of these supplies and equipment.[50] Instead, the HCO bills the patients (or their insurers) to cover the costs that are imposed on them by physician decision-making.[51] 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. While such developments could indirectly reduce the physician's compensation or intangible benefits associated with the physician's practice, these effects are usually too far down the road or too tenuous to affect short-term physician decision-making behavior significantly.

The incentives for salaried lawyers and salaried physicians are more similar. Junior lawyers (called associates) are salaried employees of the firm.[52] 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 decision-making behavior.[53] Associates work long hours because they want to become partners some day and they want to get large bonuses, not because they are trying to increase the profitability of the firm.[54] Moreover, associates are usually supervised by more senior attorneys.[55] In general, if

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50. *See* CMS GAINSHARING, *supra* note 42, at 2 (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.).

51. *See id.*

52. *See America's Largest 250 Law* Firms, ILRG.COM, http://www.ilrg.com/nlj250 (last updated Jan. 2011) (providing data on number of associates and partners in the top 250 law firms).

53. *See* Marc Galanter & William Henderson, *The Elastic Tournament: A Second Transformation of the Big Law Firm*, 60 STAN. L. REV. 1867, 1913 (2008) (observing that the financial interests of associates, partners, and firm management are not necessarily aligned).

54. *See id.* ("Associates have an interest in receiving the training and work assignments necessary to ensure that their skill set keeps pace with heir hourly rate, which, in turn, fuels demand for their services . . . .").

55. *See generally* LAURA EMPSON, MANAGING THE MODERN LAW FIRM: NEW CHALLENGES, NEW PERSPECTIVES (2007).

senior attorneys are acting consistently with the interests of the firm, the junior attorneys under their supervision are too.[56]

Like law firm associates, physicians on staff are salaried employees.[57] They may be eligible for bonuses or salary increases based on the financial performance of the HCO.[58] Thus, they could be adversely affected if the HCO loses money. However, even though the overall financial success of the HCO has an indirect effect on their compensation, this effect is also too tenuous to influence decision-making behavior significantly.[59] Their salaries and bonuses are tied to their own performance, not to the performance of the HCO.[60] Moreover, there is not as much of an established tradition of supervision of junior physicians by senior physicians.[61] Senior staff physicians are expected to supervise junior staff physicians (e.g., first year residents) but even supervision of residents may be limited.[62] Moreover,

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56. *Id.*

57. John Carroll, *How Doctors Are Paid Now, And Why It Has to Change*, MANAGED CARE (Dec. 2007), http://www.managedcaremag.com/archives/0712/0712.docpay.html.

58. 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 below. *See infra* Part IV.C-E.

59. *See, e.g.*, *Top 10 Lessons Learned from "Mature" Co-Management Arrangements*, CAMDEN GROUP, http://www.thecamdengroup.com/blog/2011/10/top-10-lessons-learned-from-mature-co-management-arrangements/ (last visited Jan. 6, 2012) ("Many physicians confused co-management with gain-sharing and were surprised to learn that the hospital savings are not shared with physicians. . . . Inadequate attention to (and dollars in) the 'incentive' payment portion of the fees deflated physician enthusiasm.").

60. *Id.*

61. 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).

62. *See id.* ("Residents are left without adequate supervision under the theory that the stress of life and death decision-making is a significant part of the lesson in becoming a doctor."). *See also* Jennifer F. Whetsell, *Changing the Law, Changing the Culture: Rethinking the "Sleepy Resident "Problem*, 12 ANNALS HEALTH L. 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); Carolyne Krupa,

there is not a tradition of senior physicians supervising non-staff physicians even if they are relatively junior.

A. Organizational Implications

One potential implication of these considerations is that HCOs should be organized so that their senior doctors have an equity ownership. Based on conventional economic 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 approach might sound promising, 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.[63] 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.[64] Finally, physician ownership of hospitals can implicate federal laws, such as the Anti-Kickback Statute and the Stark Law prohibitions.[65] Consequently, financial incentives to physicians, if they are necessary to promote alignment, must be structured in some way other than

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Resident Work Hours, Supervision Face New Round of Restrictions, AMEDNEWS.COM (July 5, 2010), http://www.ama-assn.org/amednews/2010/07/05/prl10705.htm (discussing how the Accreditation Council for Graduate Medical Educate proposed changes to increase supervision of resident physicians, but only first-year students would have direct supervision at all times).

63. *See generally* SARAH GUNTHER LANE, ET AL., A COMMUNITY LEADER'S GUIDE TO HOSPITAL FINANCE: EVALUATING HOW A HOSPITAL GETS AND SPENDS ITS MONEY 2 (2001), http://www.accessproject.org/downloads/Hospital_Finance.pdf

64. *Id.* I.R.C. § 501(c)(3) (2006). Various state laws regarding non-profit organizations generally prohibit making distributions and thus would prevent shareholders from owning equity in an HCO. *Id.*

65. The Stark Law prohibitions limit physician referrals for Medicare-covered services to entities with which the physician has a financial relationship. *See* 42 U.S.C. § 1395nn (2006). 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. *See* 42 U.S.C. § 1320a-7b(b). *See also* Thompson, *supra* note 30, at 341–44.

equity ownership.[66] Below, I discuss three approaches: Gainsharing, Pay for Performance, and Accountable Care Organizations.[67]

Before I turn to the problem of structuring financial incentives to physicians, it is worth noting that the equity ownership of partners may not guarantee alignment with the goals of their firm. It is common for senior attorneys to act in ways that benefit their own financial interests rather than their firm's interests.[68] Few firms of significant size determine compensation based on a simple formula of dividing all the firm's profits equally among partners.[69] 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 may 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.[70]

While this more complex approach to partner compensation is understandable for purposes of creating incentives, it also means that a law

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66. 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, *supra* note 30, 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.

67. *See infra* Part IV.C-E.

68. *See, e.g.*, LARRY E. RIBSTEIN, REGULATING THE EVOLVING LAW FIRM 2, 5 (2008), http://www.americanbar.org/content/dam/aba/migrated/cpr/regulation/lawfirm.pdf ("Lawyers face a tradeoff between developing their own clientele and building the firm's value. In order to remain viable business entities, law firms must align lawyers' incentives with their firms' interests.").

69. *Id.*

70. *See* Joel A. Rose, *How to Compensate Law Firm Managers*, LEGAL INTELLIGENCER (May 17, 2011), http://www.law.com/jsp/pa/PubArticlePA.jsp?id=1202494167945# (discussing various compensation formulas and noting that "[t]he ultimate goal of a compensation system is to have the amount of money a partner takes off the table bear a relationship to what the partner contributes.").

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.[71] The result might be that 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 can 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.[72] There is no simple solution, as firm managers will concede.[73]

B. 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.[74] 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

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71. *See* MODEL RULES OF PROF'L CONDUCT R. 1.8 (2010).

72. *See* Elizabeth Chambliss, *New Sources of Managerial Authority in Large Law Firms*, 22 GEO. J. LEGAL ETHICS 63, 64 (2009) ("a position of managerial authority in the firm, whether it be membership on the governing committee, a position at the head of a department, or managing partner, will always be subordinate to the power of the lawyers controlling the largest block of clients.").

73. *See* Rose, *supra* note 70; *see also* Ed Poll, *Hang Together or be Hung Separately: The Collective Compensation Dynamic*, LAW.COM (Feb. 08, 2008), http://www.law.com/jsp/article.jsp?id=900005560068# (discussing incentive problems created by individual compensation formulas, proposing, instead, a collective compensation formula to increase firm profits); Joel A. Rose, *Dealing with Tensions Surround Partner Compensation*, N.Y. STATE BAR (June 22, 2009), http://nysbar.com/blogs/Tipoftheweek/2009/06/dealing_with_tensions_surround.html (opining that there is no ultimate partner compensation formula, and explaining the factors that must be considered).

74. *See Glossary*, U.S. OFFICE OF PERS. MGMT., http://www.opm.gov/insure/glossary/index.asp#f (last visited Oct. 29, 2010) (defining fee-for-service and detailing that providers receive fees for office visits, tests, procedures, and other health care services). *See also* Cleland Consulting Group Inc., *A Seven-Step Process for Fixed-Fee Billing*, 35 L. PRAC. 50 (2009).

costs.[75] That is an extremely serious problem in health care, one of the most difficult and pressing problems faced by Congress and the Obama Administration.[76] Clients of law firms, 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 the gross domestic product, 1.5% in 2010, compared to 7.6% for health care.[77] Second, health care costs are generally covered by some form of insurance, private or public.[78] Increased costs covered by private health insurance increase premiums for all policyholders.[79] Increased costs for Medicare and Medicaid are paid by taxpayers.[80] Costs for legal services

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75. *See* Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. POL'Y 1, 13–16 (2005–2006). *See also* David M. Eddy, *Balancing Cost and Quality in Fee-for-Services Versus Managed Care*, 16 HEALTH AFF. 16262–73 (1997).

76. *See CMS Home, Research, Statistics, Data and Systems, National Health Expenditure Data, NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp (last visited Jan. 6, 2012) [hereinafter *CMS NHE Fact Sheet*] (showing that health expenditures increased to $2.5 trillion in 2009, and is expected to increase by an average of 6.1% per year from 2009 to 2019). DHHS NATIONAL STRATEGY, *supra* note 18, at 5 (noting that a comparable study found that the costs of health care are "far higher in the United States" compared to the costs in its five largest trading partners).

77. *Interactive Data, GDP-by-industry & Input-Output, Value Added by Industry as a Percentage of Gross Domestic Product*, BUREAU OF ECON. ANALYSIS, U.S. DEP'T OF COMMERCE (Apr. 26, 2011), http://www.bea.gov/iTable/print.cfm?fid=974175A7AA7FAC14C0992D2C1C283E09EB3A1E862683AD2AAA4CC0225E4C86662000761E5B0FB6E564FF5ED1C6AAF619DFEECEE1A10D22920E9CA6D590DBE968.http://www.bea.gov/iTable/iTable.cfm?ReqID=5&step=1.

78. Frank Newport & Elizabeth Mendes, *About One in Six U.S. Adults Are Without Health Insurance*, GALLUP WELLBEING (July 22, 2009), http://www.gallup.com/poll/121820/one-six-adults-without-health-insurance.aspx.

79. *See* ACA, Pub. L. No. 111-148, § 2602(c)(7), 124 Stat. 119 (2010) (codified as amended at scattered sections of the Internal Revenue Code and 42 U.S.C.) (the preamble to the law lists among its "Goals," "Eliminating Cost-shifting").

80. *See CMS NHE Fact Sheet*, *supra* note 76 (providing that $876.2 billion was spent on Medicare and Medicaid services in 2009).

are paid by individual clients.[81] Third, as discussed below, 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.[82] In those cases, the lawyers' incentive is to meet the needs of the client with the minimum number of hours possible.[83] Second, at least when clients are senior executives or lawyers themselves, they have more confidence that they know what services are "really needed" than patients. Consequently, it is far more common for clients to complain about legal bills and to negotiate reductions than for patients to do the same thing.[84] Third, corporate clients have in-house counsel and if law firms become too

81. 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, Pub. L. No. 112-10, § 1341, 125 Stat. 38, 123 (2011) (appropriating $405 million to the Legal Services Corporation). *See generally About LSC*, LEGAL SERVS. CORP., http://www.lsc.gov/about/lsc.php (last visited May 15, 2012). 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.

82. *See* Larry Bodine, *New Research on Law Firms Fees and Profitability*, LAWMARKETING CHANNEL (June 30, 2008), http://www.lawmarketing.com/pages/articles.asp?Action=Article&ArticleCategoryID=58&ArticleID=783 (finding that 88% of firms use a going rates strategy, 83% of firms use an hourly or daily fees strategy, 87% of firms use a fixed fee strategy, and 8% of firms use a value-based pricing strategy).

83. *Cf. id.*

84. *See Newsroom, Fact Sheets, Consumer Assistance Program Grants: How States Are Using New Resource to Give Consumers Greater Control of their Health Care*, HEALTHCARE.GOV (Oct. 19, 2010), http://www.healthcare.gov/news/factsheets/2010/10/capgrants-states.html (listing dispute resolutions as one of the purposes towards which states and communities will use their new Consumer Assistance Program grants, granted to them under the ACA); *see also* Elisabeth Leamy, *Save Big: Negotiate with Your Doctor*, ABC NEWS.COM (June 14, 2010), http://abcnews.go.com/Business/save-big-negotiate-doctor/story?id=10888443#.Twh3uDW6bO4 (reporting that, although 61% of people surveyed who negotiated with a doctor were successful in getting a lower fee, only 12% of people surveyed ever tried negotiating).

expensive, they can shift some of the work to them. Finally, clients 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.[85] 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.[86] 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.[87] Finally, and most importantly, private or public insurance pays most health care costs.[88] 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,[89] but the problem is vastly more difficult than in the case of legal

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85. *See* Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 54–55 (1994) ("[N]o matter what degree of autonomy a patient may want . . . the patient is dependent on the physician's disclosure of diagnosis, prognosis, treatment options, side effects, effectiveness, outcomes, etc.").

86. *See* Ha T. Tu & Johanna Lauer, *Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice*, CTR. FOR STUDYING HEALTH SYS. CHANGE (Dec. 2008), http://hschange.org/CONTENT/1028/ (reporting that in 2007 only 11% of adults were looking for a new primary care physician).

87. *See Disparities/Minority Health: Americans, Especially Blacks, Spend Substantial Periods of Time Uninsured*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (Jul. 2011), http://www.ahrq.gov/research/jul11/0711RA3.htm; *see also*, *Health Coverage & Uninsured*, STATEHEALTHFACTS.ORG, http://statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1 (last visited May 15, 2012) (reporting that about 16% of the U.S. population is uninsured).

88. CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 76 (finding that private health insurance spending was $801.2 billion, and government health expenditures were $675 billion in 2009).

89. An extensive effort to do so is reflected in the ACA's creation of the Center for Medicare and Medicaid Innovation (CMMI), a new subdivision of CMS dedicated to studying new means of controlling costs. *See* CTR. FOR MEDICARE AND MEDICAID INNOVATION, http://innovations.cms.gov/ (last visited May 3, 2012); *see also* ACA, Pub.

services. For many years, the American health care system was dominated by public and private payers, e.g., the Blues and Medicare, paying relatively segregated providers on a fee-for-service basis.[90] The disastrous inefficiency of this system is well known.[91] 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.[92] 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.[93] This approach would be accompanied by a high degree of integration among hospitals and primary care and specialty physicians.[94] 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.[95] While this model has lost much of its appeal, it

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L. No. 111-148, § 3021, 124 Stat. 119 (2010) (codified as amended at scattered sections of the Internal Revenue Code and 42 U.S.C.).

90. *See* Susan Bartlett Foote, *Impact of the Medicare Modernization Act's Contracts Reform on Fee-for-Service Medicare*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 67 (2007).

91. Michael Ramlet & Carey Lafferty, *Moving Beyond Fee-for-Service: The Case for Managed Care in Medicaid*, AM. ACTION FORUM (June 14, 2011) (arguing that the decline of the Medicaid program "has been driven by an inefficient fee-for-service"). *See also* ALAN M. GARBER & JONATHAN SKINNER, NAT'L BUREAU OF ECON. RESEARCH, IS AMERICAN HEALTHCARE UNIQUELY INEFFICIENT? (2008), http://www.nber.org/papers/w14257.pdf (discussing, among other inefficiencies in the American health care system, the inefficiencies related to fee-for-service program).

92. Karen Visocan, *Recent Changes in Medicare Managed Care: A Step Backwards for Consumers*, 6 ELDER L. J. 31, 38 (giving the history of HMOs).

93. *See id. See also* ROBERT KANE, ET AL., MANAGED CARE: HANDBOOK FOR THE AGING NETWORK, Ch. 2 (1996).

94. *See HMOs*, ILL. DEP'T OF INS., http://insurance.illinois.gov/healthinsurance/HMOs.asp (last visited May 15, 2012).

95. *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

would be too strong to say it "failed." Successful examples, such as Kaiser Permanente and Geisinger Health System, are still in business.[96]

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.[97] However, it is much more difficult to design 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.[98] Finding the best way to structure compensation can be

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discipline and technology capacity to control the use of services or contain services, and failed completely.").

96. KAISER PERMANENTE, ANNUAL REPORT (2010), http://xnet.kp.org/newscenter/annualreport/docs/kpreport_2010.pdf (reporting a $1.2 billion operating net income for 2010, as well as leading the nation with Top National Committee Quality Assurance Quality Compass marks in 23 quality measures); *see also*, GEISINGER HEALTH SYSTEM, SYSTEM REPORT 4 (2010), http://www.geisinger.org/about/ar_2010_2.pdf ("Richard J. Umbdenstock, president of the American Hospital Association adds a national perspective. 'Geisinger Health System is particularly well positioned to be a national leader in creating the healthcare delivery system of the future. They have steadily built the components and culture that is the backbone of accountable care that we all hope will result in the highest quality, safest, and most efficient care for every patient served.'").

97. *See, e.g*, Peter P. Budetti, et al., *Physician and Health System Integration*, 21 HEALTH AFF. 202, 206 (2002); *see also* Bonnie Darves, *Physician Compensation Models: Big Changes Ahead*, NEJM CAREER CTR. (Jan. 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 (2006), 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); 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 salary, while the other half should be based on meeting "productivity, quality, patient satisfaction, and cost-of-care goals, with upside earning potential for performance.").

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 because 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;[99] (2) Pay for Performance;[100] and (3) Accountable Care Organizations ("ACOs").[101] Each approach has the potential to increase physician alignment, but each has significant limitations.

C. *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.[102] Savings are based on a comparison with an historical baseline.[103] For example, a recent study of cardiology

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98. *See* RIBSTEIN, *supra* note 68 (discussing profits and ethical standards associated with various law firm models).

99. *See* OFFICE INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., GAINSHARING ARRANGEMENTS AND CMPS FOR HOSPITAL PAYMENTS TO PHYSICIANS TO REDUCE OR LIMIT SERVICES TO BENEFICIARIES (1999) (defining gainsharing as "an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts.").

100. *See Quality & Patient Safety, Quality Information & Improvement, Pay for Performance (P4P): AHRQ Resource*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, http://www.ahrq.gov/qual/pay4per.htm (last updated Mar. 2012) (defining pay-for-performance programs as "financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payer, and improved quality and patient safety.").

101. ACOs are groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries. ACA, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010) (codified as amended at scattered sections of the Internal Revenue Code and 42 U.S.C.).

102. *See* CTR. FOR MEDICARE & MEDICAID SERVS., CMS REPORT TO CONGRESS: MEDICARE GAINSHARING DEMONSTRATION: REPORT TO CONGRESS ON QUALITY IMPROVEMENT AND SAVINGS 4 (2011), https://www.cms.gov/reports/downloads/Buczko_Gain_Sharing_Final_Report_May_2011.pdf [hereinafter CMS REPORT].

gainsharing programs showed average savings of 7.4%, most of which came from the use of lower cost devices.[104]

An interesting example of a gainsharing program is described in a 2009 Advisory Opinion by the Office of Inspector General.[105] An HCO proposed to share savings with three affiliated physician group practices offering cardiology services.[106] 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.[107] 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.[108]

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.[109] 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

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103. *See* Ketcham & Furukawa, *supra* note 31, at 803. *See also* Williams Jackson, *Shared Accountability Approach to Physician Payment: Four Options for Developing Accountable Care Organizations*, 7 IND. HEALTH L. REV. 185, 210 (2010) (noting that the Medicare Advisory Committee emphasized "shared savings . . . as driving re-aligned incentives for efficiency.").

104. Ketcham & Furukawa, *supra* note 31, at 808.

105. *See* DEP'T OF HEALTH & HUMAN SERVS., OIG ADVISORY OPINION NO. 09-06 (2009) [hereinafter 2009 OIG OPINION].

106. *Id.*

107. *See id.* at 4.

108. *Id.* at 7.

109. 42 U.S.C. § 1395nn (2006).

harm patients.[110] 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 increase their compensation.[111] However, OIG said it would not seek sanctions under that statute either because the specific arrangement minimized the risks addressed by the statute.[112]

D. 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.[113] CMS has funded a number of demonstration projects using this approach.[114] For example, CMS conducted a demonstration project in which it collected data on 34 quality measures relating to five clinical conditions.[115] 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."[116] Note that the payments in this program were made to hospitals, not physicians.[117] In addition, there was no link with using

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110. *See* 2009 OIG OPINION, *supra* note 105, at 9-10.

111. *See id.* at 12–13.

112. *See 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) (2006).

113. Pay for performance programs are incentive programs that provide monetary bonuses or non-financial benefits to physician practices that make progress in achieving or attaining specific quality and/or efficiency (cost of care) benchmarks or standards that are established by the program. *See Health Information Technology, Resources, Health IT Glossary*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/health-information-technology/resources/glossary.page (last visited Jan. 7, 2012).

114. *See* Thompson, *supra* note 30, at 330.

115. *Medicare "Pay for Performance (P4P)" Initiatives*, CTRS. FOR MEDICAID AND MEDICARE SERVS. (Jan. 31, 2005), http://www.cms.gov/apps/media/press/release.asp?Counter=1343.

116. *Id.*

particular devices that would reduce costs as in the gainsharing program.[118] 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 implemented efficiency measures to demonstrate a significant financial return-on-investment ("ROI").[119]

E. 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."[120] 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.[121] Like P4P programs (and unlike gainsharing), the savings go to the HCOs rather than physicians.[122] HCOs then decide how to reward their physicians.[123] Because this process still could violate

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117. *See id.*

118. *See id.*

119. 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, et al., *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 30, 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.").

120. *See* ACA, Pub. L. No. 111–148, § 3022, 124 Stat. 119, 395 (2010) (codified as amended at scattered sections of the Internal Revenue Code and 42 U.S.C.).

121. § 3022, 124 Stat. at 398.

122. *Id.*

123. *See id.* ("[I]f an ACO meets the requirements . . . a percent . . . of the difference . . . may be paid to the ACO as shared savings . . . ."). *See also* Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg.

the CMP statute, CMS provided a waiver procedure in which HCOs could apply for a waiver from the CMP statute, the Anti-Kickback Statute, and other laws.[124] The reaction to the CMS's proposed regulations for the ACO program was overwhelmingly negative.[125] In general, commentators said the burden and costs of the program outweighed its potential financial incentives.[126] CMS has now issued its final rule, which responds to many of the criticisms it received in response to the proposed rule.[127] The final rule makes a number of important changes, but it remains to be seen whether the revised program will interest a significant number of participants.[128]

V. CATEGORIES OF DECISIONS

I want to suggest that the challenge of alignment, either 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)

67,802, 67,814 (Nov. 11, 2011) (effective Jan. 3, 2012) ("Operationally, an ACO's legal structure must provide both the basis for its shared governance as well as the mechanism for it to receive and distribute shared savings payments to ACO participants and providers/suppliers.").

124. 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).

125. *See* Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,804–972.

126. *See, e.g.*, Comments of the Cleveland Clinic, Letter from Delos M. Cosgrove, M.D., to Donald Berwick, M.D. 5 (May 26, 2011) (on file with author). Comments of the American Hospital Association, Letter from Rick Pollack to Donald M. Berwick, M.D. 15 (June 1, 2011) (on file with author). Comments of the American Medical Association, Letter from Michael D. Maves, M.D., to Donald Berwick, M.D. 12 (June 3, 2011) (on file with author). Comments of America's Health Insurance Plans, Letter from Carmello Bocchino and Joni Hong to Donald Berwick, M.D. 7-8 (June 6, 2011) (on file with author).

127. *See* Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. at 67,804-67,972.

128. *See* Edward Correia, *Afterword: The Final ACO Rule*, 28 J. CONTEMP. HEALTH L. & POL'Y 260 (2012).

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.[129] The Federal Rules of Evidence provide for the admissibility of certain types of evidence and the exclusion of other types.[130] There are judgment calls that must be made within the constraints of these rules, but the basic principles are well understood and must be followed if the lawyer is to avoid sanctions, adverse outcomes, or malpractice suits. 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, standards of medical practice include the circumstances when general anesthesia can be used, the essential laboratory tests for patients who present certain symptoms, and so forth.[131] These treatment standards can be identified in treatment protocols or statements by medical authorities.[132] In

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129. FED. R. CIV. P. 12

130. *See, e.g.*, FED. R. EVID. 401–15.

131. *See, e.g.*, Julie A. Muroff, *Policing Willpower: Obesity as a Test Case for State Empowerment of Integrated Health Care*, 11 HOUS. J. HEALTH L. & POL'Y 47, 71–72 (2011) (discussing integrated treatment protocols and how studying them can help better serve public health and individual needs); *see also* Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 139, 151 (2006) (arguing how increased information exchange "allows traditional public health to be merged with health care delivery; a physician with ten diabetic patients using the same treatment protocols can obtain information about diabetes treatments, and share all this internally, as well as with other institutions."); David R. Johnson, *Mandatory HIV Testing Issues in State Newborn Screening Programs*, 7 J. L. & HEALTH 55, 62 (1992) (explaining how treatment protocols for HIV infections were gaining acceptance in the medical community).

132. *See* Muroff, *supra* note 131, at 71–72 (discussing integrated treatment protocols and how studying them can help better serve public health and individual needs); *see also* Trubek, *supra* note 131, at 151 (arguing how increased information exchange "allows

addition, these treatment standards are cited in medical malpractice cases by experts.[133]

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, as well as the organizations with which they are affiliated, are subject to severe sanctions such as malpractice liability and license revocation.[134] 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 it is not clear when it is in the interest of a party to demand a jury.[135] A defendant has a right to testify in a criminal case,[136] but when it

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traditional public health to be merged with health care delivery; a physician with ten diabetic patients using the same treatment protocols can obtain information about diabetes treatments, and share all this internally, as well as with other institutions."); Johnson, *supra* note 131, at 62 (explaining how treatment protocols for HIV infections were gaining acceptance in the medical community).

133. *See* Horsley v. Richland Corr. Inst., No. 2004-03454, 2005 WL 1020918, at *1, *2 (Ohio Ct. Cl. Apr. 18, 2005) (finding that the "defendant established a protocol for the treatment of chronic Hepatitis C and that plaintiff admitted that the protocol was followed with regard to his care."). *See also* Lewis v. Tulane Univ. Hosp. & Clinic, 855 So. 2d 383, 385 (La. Ct. App. 2003) (affirming the finding that all aspects of a treatment protocol during hospitalization were in compliance with the appropriate standard of care by the defendant-physician); David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1133 (2006) (arguing that physicians who adhere to standards and treatment protocols should be immune from malpractice suits).

134. *See, e.g.*, *State Law Summaries: Medical Malpractice and Reform*, FINDLAW, http://injury.findlaw.com/medical-malpractice/state-medical-malpractice-and-reform.html (last visited Jan. 7, 2012) (listing each state's malpractice process and procedures).

135. *See* U.S. CONST. amend. VII. *See also* FED. R. CIV. P. 38–39.

136. *See* U.S. CONST. amend. XIV.

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 defendant can be impeached, whether calling the defendant might breach ethical considerations, and so on.[137]

Similarly, in the medical profession, when a patient is experiencing significantly impaired blood flow through the cardiac arteries, the physician must do something.[138] But which therapeutic approach makes sense—using only drugs, inserting a stent, performing cardiac bypass surgery, etc.—may not be clear at all.[139] Women who have cancerous cells in their uterus have a high risk for more widespread cancer in their uterus, ovaries, and other organs. Consequently, there must be some medical intervention, but the best approach—removing the uterus, removing the ovaries, using chemotherapy, or a combination of these procedures—is a complex decision that requires expert analysis of the particular case.[140] Decisions in this category, in both professions, are not made by administrators or managers,[141] instead, 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;

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137. *See* MODEL RULES OF PROF'L CONDUCT R. 1.2 cmts. (2010).

138. *See AMA Code of Ethics: Principle of Medical Ethics*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page? (last visited Jan. 7, 2012).

139. *See* Kevin B. O'Reilly, *Physician-Ethicist Explains "Ashley Treatment" Decision*, AMDEDNEWS.COM (Mar. 12, 2007), http://www.ama-assn.org/amednews/2007/03/12/prse0312.htm. *See also* Susan J. Landers, *Lyme Disease Debate Provokes Treatment Divide, Legal Action*, AMEDNEWS.COM (Dec. 25, 2006), http://www.ama-assn.org/amednews/2006/12/25/hlsa1225.htm.

140. *Ovarian Cancer, Treatment*, MAYO CLINIC, http://www.mayoclinic.org/ovarian-cancer/treatment.html (last visited May 3, 2012) (listing treatment options for ovarian cancer).

141. 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.

developing rules about hours and compensation; decisions about hiring junior attorneys and non-legal staff; and devising policies for paying for travel.[142] For HCOs, this process 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.[143] 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.[144]

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

VI. 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 lessons learned:

(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.[145] Moreover, according to OIG, "whether the current

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142. Carroll, *supra* note 57.

143. *Id.*

144. *Id.*

145. For example, the OIG Opinion discussed above concluded that all of the recommendations included in the requestor's letter implicated the CMP: "Simply put, with respect to the recommendations under the Arrangement regarding standardization of

medical practice reflects necessity or prudence is irrelevant for purposes of the CMP."[146] The barriers caused by the Civil Monetary Penalties law in HCO efforts to reduce costs led CMS to include a waiver procedure in the ACO regulations.[147] 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.[148]

(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.[149] While financial incentives can influence physician behavior, structuring those incentives is a complex task.[150] 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.[151] The lack of meaningful financial incentives is clearly a weakness in CMS's proposed regulations for ACOs.

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devices and supplies, the Arrangement might induce physicians to reduce or limit the then-current medical practices at the Hospital." 2009 OIG OPINION, *supra* note 105, at 9.

146. *Id.*

147. Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,840 (Nov. 11, 2011) (effective Jan. 3, 2012).

148. For example, Congress could authorize a waiver procedure, administered by OIG or some other agency, for all health care organizations, similar to the one proposed by CMS for ACOs. Alternatively, Congress could review the experience in granting waivers under the ACO program to develop safe harbors to include in both the CMP and the Anti-kickback Statute.

149. *See Law Firm Profits are Up, but Bonuses Don't Follow Suit*, RUETERS (Dec. 8, 2011), http://newsandinsight.thomsonreuters.com/Legal/News/2011/12_-_December/Law_firm_profits_are_up,_but_bonuses_don_t_follow_suit/ (reporting that 2011 law firm bonuses ranged from $7,500 to $200,000).

150. *See supra* Part IV.C-E.

151. One gainsharing program reported payouts to physicians averaging $17,000, ranging from $0 to $59,000. *See* Ketcham & Furukawa, *supra* note 31, at 804. The high

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.[152] Assuming ACOs are rewarded with the same amount (it could be a little more), an average ACO would be rewarded 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.[153] The same problem may exist in pay for performance programs, too.[154] The revised final rule mitigates this problem by increasing the financial incentives to ACOs.[155] It is unlikely that these modifications will solve a fundamental problem: The dollar amounts available to individual physicians are too small to change behavior significantly.

(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.[156] 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.

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end of this range is presumably significant in influencing behavior, and perhaps the average level is, too, but that seems less certain.

152. Medicare Shared Savings Program: Accountable Care Organizations (Proposed Rule), 76 Fed. Reg. 19,528, 19,638–39.

153. 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 AM. J. OF MANAGED CARE 560, 568 (2011).

154. GEOFFREY BAKER, PAY FOR PERFORMANCE INCENTIVE PROGRAMS IN HEALTHCARE: MARKET DYNAMICS AND BUSINESS PROCESS 6 (2003), http://www.leapfroggroup.org/media/file/Leapfrog-Pay_for_Performance_Briefing.pdf.

155. *See* Correia, *supra* note 128.

156. *See* CDC GUIDELINES FOR PREVENTION, *supra* note 32 (providing a possible example of a treatment protocol involving use of urinary catheters).

Comparative effectiveness data will not be 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. 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.[157] 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, for example, 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.[158]

Some large IDNs have developed decision-making procedures for purchasing that reduce the role of the physician.[159] Physicians may serve on

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157. *See* Eleanor D. Kinney, *For Profit Enterprise in Health Care: Can it Contribute to Health Reform?*, 36 AM. J. L. & MED. 405, 433 (2010) (arguing that one of the reforms needed to make health care more efficient is "a revision of the entrepreneurial spirit in medicine that encourages some doctors to order unnecessary goods and services."). *But see id.* (noting physicians' defense that they order goods and services out of fear of medical malpractice).

158. *See* CMS REPORT, *supra* note 102, 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)).

159. *See* *Mission Statement,* JOHNS HOPKINS MED., http://www.hopkinsmedicine.org/purchasing/geninfo/mission.html (last visited May 3, 2012).

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 procedures reduce costs, for example, by enabling the HCO to limit the number of different types of capital equipment it must buy, they can also 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.[160] 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 to 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.[161]

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.

VII. 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

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160. *See* 2009 OIG OPINION, *supra* note 105, at 4 ("To develop the Arrangement, the Program Administrator conducted a study of the historical practices of the Groups with respect to cardiac catheterization procedures performed at the Hospital and identified twenty-one specific cost-savings opportunities.").

161. *See* 42 U.S.C. §§ 1320a-7b(b) (2006) (imposing penalties on those who knowingly and willfully: (1) offering or paying remuneration to induce the referral of Federal health care program business; or (2) soliciting or receiving remuneration in return for the referral of Federal health care program business).

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 with 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.