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THE MEDICARE Rx: PROSPECTIVE PRICING TO EFFECT COST CONTAINMENT

In 1983, Congress amended the Social Security Act, establishing a prospective payment system for Medicare hospital inpatient services.[1] This change was designed to slow the phenomenal rate of Medicare expenditures growth[2] and to streamline the delivery of health care.[3] The amendments dramatically changed Medicare reimbursement to hospitals from retrospective reimbursement—on the basis of costs incurred, to prospective reimbursement—on the basis of patient diagnosis.

Government expenditures for Medicare had been rising at a rate disproportionate to the increase in gross national product, from $3.2 billion for hospital services in fiscal year 1967, to over $37 billion for fiscal year 1983.[4] The increasing number of eld-

1. Pub. L. No. 98-21, 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395(f) (Supp. I 1983)). Title VI of Pub. L. No. 98-21 provides for Medicare payment of hospital services under a prospective payment system. Under prospective payment, hospital reimbursement is at a predetermined, specific rate for each discharge. All discharges are classified according to a list of 470 categories of diagnosis related groups (DRGs). 48 Fed. Reg. 39,754 (1983). Capital related costs, such as depreciation and taxes, and direct medical education costs continue to be reimbursed on the basis of reasonable cost. *Id. See infra* note 14. "Prospective payment" will be used interchangeably with "prospective payment system" where applicable.

2. Between its inception in 1965 and 1981, Medicare outlays rose at a rate of 27.9% per year. Gibson & Waldo, *National Health Care Expenditures, 1981*, 4 HEALTH CARE FINANCING REV. 1, 1 (1982), *cited in* Zuckerman, Becker, Adams, Musacchio & Sreckovich, *Physician Practice Patterns Under Hospital Rate-Setting Programs*, 252 J. A.M.A. 2589 (1984) [hereinafter cited as Zuckerman].

3. The Secretary of Health and Human Services reported to Congress regarding the impact of prospective payment: "The Department believes that the prospective payment system proposed here will provide hospitals an incentive to improve efficiency, will establish Medicare as a prudent buyer of hospital services, will reduce the administrative burden on hospitals, and will assure beneficiary access to quality care." 374 MEDICARE & MEDICAID GUIDE (CCH) at i (Jan. 5, 1983) (reprinting U.S. DEP'T OF HEALTH AND HUMAN SERVICES, REPORT TO CONGRESS: HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE (1982)) [hereinafter cited as HOSPITAL PROSPECTIVE PAYMENT].

4. *Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess. 5 (1983). R. Schweiker stated that Medicare expenditures for hospital care had increased at the rate of 19% per year from 1979 to 1983. *Id.*

erly patients[5] makes the control of governmental expenditures for Medicare recipients a primary concern, especially because of the impact on the federal budget.

The 1983 amendments, however, did not alter physician compensation under Medicare. For services provided to Medicare patients, physicians are still compensated on a retrospective reimbursement basis, based on their "customary, reasonable, prevailing charges."[6] This Note analyzes the impact of changing hospital reimbursement while maintaining charge-based reimbursement for physicians on hospital-physician relationships and on cost and quality of care. This Note contends that if the stated goals of redirecting incentives and containing costs are to be realized, physicians must be drawn into the revised reimbursement scheme. An indirect, aggregate approach is advocated to maintain the integrity of the physician-patient relationship and to avoid a direct financial impact upon the physician regarding patient care decisions. Part I will briefly examine the reasons for changing hospital reimbursement from retrospective cost-based reimbursement to prospective fixed rates. Part II of this Note will demonstrate that to realize the stated goals of hospital prospective payment, physicians must be drawn into the incentive structure. The necessity of incorporating physicians into this structure, however, is moderated by the desirability, indeed, necessity, of insulating the physician-patient relationship from any direct financial impact. Thus, Part III of this Note will conclude by advocating a mandatory Medicare incentive plan, administered jointly by the hospital and medical staff, that encourages physicians to share jointly in reduced cost care while forcing them to absorb any losses.

I. REASONS FOR PROSPECTIVE PRICING OF HOSPITAL SERVICES

Prospective payment rates were implemented to address "the dynamic growth in health care spending . . . particularly the rapid increase in Medicare program and hospital costs"[7] and increased hospital utilization.[8] Hospital services, as the largest sin-

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5. *Health Care Cost: Defining the Issues, 1983: Hearings Before the Senate Comm. on Labor and Human Resources*, 98th Cong., 1st Sess. 9, 10 (1983) (Health Care Costs: A Discussion Paper, submitted by Sen. O. Hatch).

6. 42 C.F.R. § 405.551 (1985); *id.* § 405.502(a)(3).

7. 48 Fed. Reg. 39,804 (1983) (to be codified at 42 C.F.R. pts. 405, 409, 489).

8. *Id.*

gle component of medical care expenditures,[9] are the natural target for a program designed to contain expenditures. Before the advent of prospective pricing, hospitals had no incentive to curtail costs: reimbursement was determined retrospectively, compensating hospitals for all "reasonable costs" incurred.[10] Under this system, Medicare expenditures for hospitals increased nineteen percent per year between 1979 and 1982, and in 1982, hospital sector inflation rose three times faster than the overall rate of inflation.[11]

Prospective payment marks a fundamental and radical departure from cost-based reimbursement. The goal is to restructure incentives by putting the hospital at financial risk if inpatient treatment is not delivered efficiently.[12]

The prospective payment system developed by the Department of Health and Human Services is said to provide "hospitals an incentive to improve efficiency, . . . establish Medicare as a prudent buyer of hospital services, . . . reduce the administrative burden on hospitals, and . . . assure beneficiary access to quality care."[13] Under the prospective payment[14] system adopted, the Medicare patient's diagnosis determines the hospital's reimbursement. All Medicare patients are classified into a diagnosis related group (DRG) and each group is assigned a corresponding dollar value. Thus, as opposed to the former retrospective cost-based reimbursement system, the hospital "knows" the amount it will be reimbursed for each patient, and this fig-

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9. A. DONABEDIAN, S. AXELROD & L. WYSZEWIANSKI, MEDICAL CARE CHARTBOOK 115 (7th ed. 1980) [hereinafter cited as CHARTBOOK].

10. The Department of Health and Human Services defines "retrospective cost-based reimbursement" as a "[m]ethod of paying hospitals . . . in which 1) payment is made to the hospital for covered services rendered to beneficiaries during the preceding year(s), and 2) hospitals are reimbursed for the 'reasonable costs' incurred in providing such services." HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at xii.

11. *Id.* at i.

12. Efficiency is judged by the predetermined amount established for the patient's diagnosis. The hospital's compensation is derived from the use of diagnosis related groups (DRGs), a patient classification system developed by Yale University since 1969. The value the hospital receives for each patient is the predetermined "average" cost of treating the given diagnosis, modified to some extent to account for factors such as local wages and whether the location is urban or rural. 48 Fed. Reg. 39,805 (1983).

13. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at i.

14. The Department of Health and Human Services defines "prospective payment" as a "[m]ethod of paying hospitals in which 1) full amounts or rates of payment are established in advance for the coming year, and 2) hospitals are paid these amounts or rates regardless of the costs they actually incur." HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at xii. All inpatient operating costs are included in the prospective payment to provide financial incentives for hospital managers to plan and allocate resources efficiently so that "the most effective use of health care funds can be achieved." 48 Fed. Reg. 39,761-62 (1983).

ure does not vary regardless of the resources the hospital devotes to treating the patient. The hospital cannot recover any additional amounts from the Medicare patient.[15] Thus, according to the Department of Health and Human Services, "The prospective payment system promotes efficiency in a simple effective way. Hospitals will be allowed to retain any surplus they can earn by operating efficiently. Likewise, they must absorb any losses."[16]

Under the retrospective cost-based reimbursement system, hospital administrators and trustees had little incentive to interfere in or curtail physician practice; in fact, hospital revenues rose as physicians ordered additional tests and procedures. Furthermore, the hospital's reputation and attractiveness to physicians was enhanced as the hospital acquired expensive, state-of-the-art technology to facilitate thorough and innovative medical practice.[17] Prospective payment, however, requires hospital management to ensure that institutional performance patterns are compatible with overall cost-control strategies.[18] The role and involvement of the physician becomes crucial in determining how effective the hospital is at containing costs and—critically—whether the hospital makes or loses money in treating Medicare patients.[19]

II. PHYSICIANS: THE KEY TO SUCCESSFUL COST CONTAINMENT

While the hospital's risks and incentives are clearly established through prospective payment, the key determinant of the institution's ability to realize these goals, the physician, is spe-

15. Coinsurance and deductible provisions contained in the Medicare legislation as previously enacted remain in effect, but the Medicare patient cannot be held responsible for costs in excess of the DRG amount. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at v. Section 1886(d)(5)(A) of the Social Security Act, 42 U.S.C. § 1395ww (Supp. II 1984), requires that additional amounts be paid for atypical cases known as "outliers." Outliers either have an extremely long length of stay or extraordinarily high cost when compared to most discharges classified in the DRG. 48 Fed. Reg. 39,776 (1983). Additional reimbursement may be available where the patient's length of stay exceeds the average length of stay for discharges in the DRG by a fixed number of days or a fixed number of standard deviations. 42 U.S.C. § 1395ww(d)(5)(A) (Supp. II 1984).

16. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at vi.

17. *See infra* notes 52-53, 70 and accompanying text.

18. Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. LEGAL MED. 157, 173 (1985).

19. This concern becomes even more vital to hospital survival because Blue Cross and other private insurers are expected to adopt DRGs or a similar payment strategy in the near future. *See, e.g.*, Jessee & Suver, *Physicians and DRGs: Survival Under PPS*, HOSP. MED. STAFF, Apr. 1984, at 2, 3.

cifically excluded from the system. The physician, responsible for as much as seventy-five or eighty percent of the total cost of services provided in hospitals,[20] continues to be reimbursed on the basis of reasonable, customary, and prevailing charges.[21] Because the physician drives hospital costs by triggering patients' demand for services and by determining the length of stay, a key to hospital efficiency lies in physician behavior.[22]

The Health Care Financing Administration has recognized the crucial role of physicians in determining the cost of medical care[23] yet relies on the ability of hospital administrators to influence medical practice patterns[24] instead of imposing financial incentives on physicians.[25] If the goals of the prospective pricing system are cost and utilization reduction,[26] streamlining the Medicare program, and preserving the integrity of the trust funds,[27] then the impact and advisability of an incentive system

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20. *Id.*; Lowenstein, Iezzoni & Moskowitz, *Prospective Payment for Physician Services*, 254 J. A.M.A. 2632, 2632 (1985) [hereinafter cited as *Physician Services*].

21. 42 C.F.R. § 405.551 (1985); *id.* § 405.502(a)(3).

22. The Department of Health and Human Services recognized the vital role of physicians: "Physicians are the key figure in the hospital care process. They are responsible for identifying the patient's problems, defining the alternative treatment strategies and ordering the necessary hospital services." HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at 8.

23.

> We believe that hospitals can also temper any impact they experience resulting from this [prospective] payment system. . . . [E]xamples of management strategies that could be used by a hospital include:
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> . . . .
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> Examining the present relation of hospital management and attending physicians to determine the appropriate extent of physician involvement in the management control process. This is necessary because of the direct authority attending physicians have over inputs per case, which are key components of any hospital's costs.

48 Fed. Reg. 39,805-06 (1983)(emphasis omitted).

24. *Id.*

25. Commentators have suggested that physicians were excluded from the prospective payment system for largely political reasons. *See, e.g.*, Goldsmith, *MDs and Hospitals: Conflict or Partnership*, HOSP. MED. STAFF, May 1983, at 3, 4 ("[S]ince Congress lacked the power or the will directly to reduce the income of physicians, they delegated this thoroughly unwelcome task to hospital boards of trustees and administrators . . . ."); Comment, *Reagan Administration Health Legislation: The Emergence of a Hidden Agenda*, 20 HARV. J. ON LEGIS. 575, 584 (1983)("[B]ecause of a deliberate strategy to accomplish meaningful change without arousing controversy and opposition, the Reagan health initiatives have been disguised.").

26. *See supra* notes 7-8 and accompanying text. "Currently, cost comes ahead of anything else by a very wide margin. In the case of DRGs, cost control was the foremost objective." J. Griffith, in DRGs—What's Next? Two Views 17 (text of seminar sponsored by the Mount Sinai School of Medicine, Dep't of Health Care Management (1984)) (copy on file with U. MICH. J.L. REF.).

27. 42 U.S.C. § 1395(i) (1982) establishes and describes the administration of the "Federal Hospital Insurance Trust Fund," and provides for tax contributions to the

that specifically excludes physicians, the key actors, requires closer examination.

A. *Physicians Must Be Incorporated into a Financial Incentive System for Effective Cost Containment*

The physician, not the patient or the hospital, determines whether there is an admission and the date of discharge.[28] Every service provided to the patient, beyond routine nursing and "hotel" services such as meals and laundry, is delivered upon the doctor's orders.[29] Even the level of nursing care and the corresponding level of cost are dictated by physicians. Thus, the physician, as the party responsible for making all treatment decisions, is best able to realize the reduction in cost and utilization that prospective pricing was implemented to achieve.

Medicare prospective pricing directs financial incentives at hospitals rather than physicians. There is at least some statistical evidence that suggests that such a system does serve to contain hospital costs[30] and physician fees.[31] This evidence, however, is tempered by several factors. The target income hypothesis,[32] grounded in empirical evidence, indicates that physicians can manipulate the amount of services they provide to achieve a target level of income. Also, the physician's ability to stimulate demand,[33] supported by further empirical evidence, militates against the effectiveness of a cost-containment strategy

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fund.

The Social Security Amendments Act of 1983 states that it is "An Act [t]o assure the solvency of the Social Security Trust Funds, to reform the medicare reimbursement of hospitals." Pub. L. No. 98-21, 97 Stat. 65 (1983).

28. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at 17 ("The decision to admit an individual, and any decisions regarding services provided during the inpatient stay, are made by the attending physician.").

29. *Id.*

30. *See, e.g.*, Biles, Schramm & Atkinson, *Hospital Cost Inflation Under State Rate-Setting Programs*, 303 NEW ENG. J. MED. 664 (1980)(finding an average annual rate of increase in hospital costs of 11.2% in states with rate-setting programs compared to 14.3% annual increase in states without such programs between 1970 and 1978) [hereinafter cited as Biles]; Sloan, *Regulation and the Rising Cost of Hospital Care*, 63 REV. ECON. & STATISTICS 479 (1981)(studying the impact of regulations controlling the expansion of facilities and services and of limitations on allowable revenues and costs); Worthington & Piro, *The Effects of Hospital Rate-Setting Programs on Volumes of Hospital Services: A Preliminary Analysis*, HEALTH CARE FINANCING REV., Dec. 1982, at 47 (reviewing the effects of various states' attempts to control costs and utilization).

31. *See, e.g.*, Biles, *supra* note 30; Sloan, *supra* note 30; Worthington & Piro, *supra* note 30; *see also infra* note 83 and accompanying text.

32. *See infra* note 81 and accompanying text.

33. *See infra* note 82 and accompanying text.

that does not affect physicians. Furthermore, the physician's role in determining the nature and cost of hospital services rendered,[34] together with these other factors, indicates the advisability—and, in fact, necessity—of incorporating physicians into a prospective payment system.

From admission to discharge, the physician makes all treatment decisions affecting the patient.[35] The current Medicare reimbursement system compensates physicians separately and independently from hospitals.[36] The current method of reimbursing physicians, according to their usual, customary, and reasonable fees, tends to reinforce inflationary trends in physicians' fees; this reimbursement scheme has a greater inflationary effect than fixed fee schedules would have on health care costs.[37] Physicians are not limited to receiving an established maximum compensation, as hospitals are under DRGs. Thus, longer or more intensive hospital stays may provide physicians with additional revenue earning opportunities.[38]

Physicians' reimbursement incentives are in direct opposition to hospitals' incentives if physician reimbursement is not modified. The physician is now able to commit hospital resources, which the hospital may never recoup, yet the physician bears no financial risk and can only gain income for additional prescribed services. Conflict between physicians and hospital administrators and trustees seems likely because administrators and trustees are cast in the "inappropriate and ultimately impossible role of trying to regulate or at least modify physician behavior."[39] For prospective pricing to be effective and realize its full cost-savings potential, the onus of failure to conserve resources must fall directly on physicians as well as hospitals.

The physician's cost-based reimbursement further conflicts with hospitals' concern for cost containment under prospective payment due to practice patterns that have developed in response to increasing medical malpractice litigation. Fear of malpractice litigation has caused many physicians to abuse and

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34. *See supra* note 28 and accompanying text.

35. *See supra* note 28 and accompanying text. As noted earlier, the physician is responsible for as much as 75-80% of the total cost of services provided in hospitals. Jessee & Suver, *supra* note 19; *Physician Services, supra* note 20.

36. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at 8.

37. Rosenthal, *Controlling the Cost of Health Care,* in HOSPITAL COST CONTAINMENT 33 (1978) (summarizing findings of Sloan & Steinwald study, *The Role of Insurance in the Physicians' Services Market,* INQUIRY, Dec. 1975, at 275).

38. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at 9.

39. Spivey, *The Relation Between Hospital Management and Medical Staff Under a Prospective Payment System,* 310 NEW ENG. J. MED. 984, 984-85 (1984).

overuse diagnostic and therapeutic services.[40] This incentive to be overly cautious through excessive and repetitive tests may be exacerbated under current physician reimbursement practices where physicians' income generally increases as more services are provided.[41] Thus physicians, responsible for triggering hospital costs, are now paid independently and increasingly for additional services provided. Motivated to practice "defensive medicine," overtreating to avoid malpractice exposure, physicians could contribute to the financial demise of hospitals under prospective payment.

Physicians must be drawn into the prospective payment system to reduce their financial incentives to "overtreat" and to counter medically unnecessary or redundant practices developed out of fear of malpractice. The fear of malpractice exposure, shared by many hospitals and physicians,[42] is in many ways also a key to successfully extending prospective pricing to physicians. The Department of Health and Human Services relies upon "the constant threat of malpractice suits"[43] as a deterrent force to assure that hospitals provide sufficient care despite incentives to minimize treatment costs under prospective payment. This deterrent force is equally applicable to physicians.

Physicians subject to reimbursement constraints will be prompted to seek and apply the least cost treatment alternatives.[44] This should contribute to lower cost-per-case treatments, and hence lower overall health care expenditures.[45] Physicians

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40. *See, e.g.*, Comment, *supra* note 25, at 578.
41. *See supra* note 38 and accompanying text.
42. Jessee & Suver, *supra* note 19, at 6.
43. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at 74, *cited in* Comment, *supra* note 25, at 594. The Comment raises a relevant skepticism regarding the force of such a deterrent.
44. A prospective pricing system would be most cost effective in situations where medical judgments may differ as to the appropriate course of treatment. There are many such instances, *see* J. Griffith, in DRGs—What's Next? Two Views, *supra* note 26, at 20 ("There are widely differing opinions on when to hospitalize, what tests and treatments to use, and how long the patient should stay."); Gold, *Wiser than the Laws?: Legal Accountability of the Medical Profession,* 7 AM. J.L. & MED. 145, 167 (1981), and where conservative, non-invasive techniques are available as alternatives to radical, invasive procedures the dollar savings at stake can be substantial.
45. Hospital costs may, however, increase as a result of such physician practices. If a comprehensive physician reimbursement scheme were developed, providing physicians with an incentive to utilize always the least cost treatment available, only the most complicated and critical cases would be hospitalized. Other patients would be treated in less capital intensive, lower cost outpatient facilities. Hospitals' patient mix would reflect, overall, a more severely ill patient population, and correspondingly, the resources and hence costs devoted to treating these patients would rise. Overall expenditures for health would, however, decline, as treatment would be geared toward the appropriate lowest cost setting.

would seek to maximize their efficiency and thus would more fully integrate the skills of nonphysician health professionals, such as nurse practitioners and physician assistants, into their practice. When these other health care professionals are used appropriately, lower cost quality care will result.

For prospective pricing to realize its cost-savings potential, the reimbursement system must incorporate and affect the party most responsible for affecting hospital costs: the physician. Once physicians are economically motivated to reduce health care costs, the wasteful and repetitive practices associated with "defensive" medicine can be eliminated. Physicians will actively seek to apply the most cost-effective treatment modalities and personnel.

The sanctity of the physician-patient relationship should be preserved in any compensation system which more closely aligns hospitals' and physicians' interests. The patient's interest in the quality and appropriateness of treatment are of paramount concern. Efforts to motivate physicians should preserve the direct relationship between doctor and patient to avoid adversely affecting the patient's interests in the quality and outcome of treatment. Thus, to achieve the cost-savings goals of the prospective payment system, physicians must be forced to share cost-savings incentives. To avoid any undesirable impact on the physician-patient relationship, incentives must be structured to affect physicans in the aggregate rather than as individuals.

B. Financial Incentives Should Not Impinge Directly upon the Individual Physician-Patient Relationship

While physicians must be incorporated into a prospective reimbursement system to achieve the goals of the Medicare amendments—to contain hospital costs and utilization—the system must be designed so as to leave undisturbed the physician-patient relationship. The patient's interest in quality, appropriate care is of paramount concern, and the physician's interest in achieving this outcome should not be diverted by economic factors. Thus, to preserve the physician's role in advancing the patient's interest, to guard against physicians actively avoiding Medicare patients, and to continue providing these patients with necessary and appropriate physician services, physician compensation should not be directly tied to an individual patient's care.

1. The physician as protector of patient interests— The physician and patient stand in a fiduciary relationship.[46] The physician has a duty to provide the patient with reasonable and ordinary care, skill, and diligence.[47] The treatment the physician provides is generally measured against the effort exercised by his peers in good standing in the same locality and line of practice.[48] This standard of care will protect the patient by discouraging his physician from "skimping" under a prospective pricing system.[49] A malpractice action will lie where the doctor fails to exercise at least the skill and judgment of the "average" physician or specialist in good standing. The standard against which the physician will be evaluated is "good medical practice" defined by what is customary and usual.[50] If this standard falls below what the patient's best interests minimally require, a court might, under compelling circumstances, redefine and upgrade the requisite standard of care.[51]

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46. *See, e.g.*, Adams v. Ison, 249 S.W.2d 791, 793-94 (Ky. 1952) (physician-patient relationship requires the doctor to act with utmost good faith and to speak fairly and truthfully; physician-patient relationship begets confidence and reliance so a liberal attitude should be taken on patient's behalf); Tvedt v. Haugan, 70 N.D. 338, 294 N.W. 183 (1940)(physician is in a position of trust and confidence toward his patient and has a duty to act with the utmost good faith).

47. A. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 115 (1978); *see* Hirschberg v. State, 91 Misc. 2d 590, 593-94, 398 N.Y.S.2d 470, 472 (1977).

48. A. SOUTHWICK, *supra* note 47, at 115. The "locality" requirement has been abandoned by some courts as too narrow, and a general national standard applied in its place. *See* W. PROSSER, THE LAW OF TORTS § 32, at 188 (W. Keeton 5th ed. 1984); *see also* Sullivan v. Henry, 160 Ga. App. 791, 800, 287 S.E.2d 652, 659 (1982); Blair v. Eblen, 461 S.W.2d 370, 372-73 (Ky. 1970); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Hirschberg v. State, 91 Misc. 2d 590, 595-98, 398 N.Y.S.2d 470, 474-75 (1977).

49. Because the appropriate standard of care is generally derived from physicians' practice patterns, there may be some danger of physicians "redefining" or downgrading treatment protocols to keep costs within those established by prospective pricing limitations. Marsh argues that a small group of practitioners could arguably redefine the standard of treatment protocols in their community to conform with cost-containment guidelines and offer such a standard as a defense in a malpractice suit. Marsh, *supra* note 18, at 169. He finds the possibility of this defense actually materializing unlikely, however, because of the current malpractice climate. *Id.* If this defense were raised, it would likely receive strict judicial scrutiny upon challenge, and a court might be willing to find the professionally established standard of care legally insufficient. *See* Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974); *see also infra* note 51 and accompanying text. Furthermore, the regulations providing for prospective payment of hospitals "anticipate that quality of care for beneficiaries will be maintained or improved." 48 Fed. Reg. 39,806 (1983).

50. W. PROSSER, *supra* note 48, at 189. It is also acceptable to follow the tenets of an established but differing school of medical thought. *Id.* at 187. *See also* Marsh, *supra* note 18, at 169 (discussing the possibility of the physicians of a community establishing a standard of care designed to comply with cost-containment guidelines).

51. Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974). In *Helling*, the Washington Supreme Court found ophthalmologists negligent as a matter of law for failure to

Even with these protective standards of care, however, the sanctity of the physician-patient relationship is essential. The doctor's fiduciary role in relation to his patient takes on heightened significance under prospective pricing: as hospitals strive to streamline health care delivery and cut expenses to bolster their financial bottom lines, many see physicians assuming the role of champion of patients' rights to quality care.[52] This includes more than simply advancing the interests of the individual patient: the physician stimulates rapid adoption of technological innovations.[53] Physicians currently consider the availability of technological advances an important criterion in deciding where to practice and admit patients.[54]

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expert testimony that the universal practice was not to administer glaucoma tests to patients under forty because of the small incidence of glaucoma at younger ages.

> Where [glaucoma's] presence can be detected by a simple, well-known, harmless test, where the results of the test are definitive, where the disease can be successfully arrested by early detection and where its effects are irreversible if undetected over a substantial period of time, liability should be imposed upon defendants even though they did not violate the standard existing within the profession of ophthalmology.

Id. at 522, 519 P.2d at 985. *Helling* was reaffirmed in part after attempted legislative repeal in Gates v. Jensen, 92 Wash. 2d 246, 252-54, 595 P.2d 919, 923-24 (1979) (The doctrine of reasonable prudence may require a standard of practice which is higher than that exercised by the relevant professional community. This doctrine was held not to be abrogated by a statute requiring a physician to exercise the skill, care, and learning possessed by others in the same profession.).

Under prospective payment systems, the courts may be delegated the task of scrutinizing health care delivery to assure the existence of a "safety net," providing essential treatment and services. While some might argue that this is an inappropriate role for courts, standards would still be derived from the medical profession. The court's role seems to follow from the role of health care providers becoming *de facto* rationers of "scarce" health care resources under the cost-control mechanism of prospective pricing. *See, e.g.*, Mariner, *Diagnosis Related Groups: Evading Social Responsibility?*, 12 LAW MED. & HEALTH CARE 243, 243 (1985): "The DRG system represents a social mechanism for rationing supposedly scarce resources. It does so by converting health care professionals and hospitals from providers of care into agents for rationing health services." The editorial goes on to argue this is an inappropriate burden to put on clinicians, and explicit national criteria for allocating resources should be developed.

52. *See, e.g.*, R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26, at 8; Spivey, *supra* note 39, at 985.

53. Victor Fuchs and Paul Feldstein have described the technologic imperative: "[M]edicine will prescribe the best care that is technically possible." P. FELDSTEIN, HEALTH CARE ECONOMICS 84 (1979); Fuchs, *The Growing Demand for Medical Care*, 279 NEW ENG. J. MED. 190, 192 (1968). The Feldstein analysis has been summarized: "The physician, aware that third-party payment is guaranteed and that providing additional care to the patient normally results in additional income to the provider, has little or no incentive to withhold medically justifiable care." Comment, *supra* note 25, at 578.

54. HOSPITAL PROSPECTIVE PAYMENT, *supra* note 3, at 9. While this practice promotes rapid, widespread incorporation of technological advances, it also has contributed to the dramatic rise of hospital costs. Technology found in hospital settings is generally quite expensive; if it were not, physicians would incorporate it into their office practices. Because the availability of state-of-the-art technology is known to be crucial to physician

2. *Limitations on establishing a physician-patient relationship: physician discretion*— While physicians are seen as the protectors of patients' rights under a prospective pricing system, no duty arises until the physician-patient relationship is established.[55] This relationship is established through an express or implied contract, which gives rise to a duty to treat.[56] Should the physician turn away a patient who has come to his office seeking treatment, the physician has rejected this implied offer to contract and no duty to the individual is established.[57]

The combined effects of a physician's ability to "select" those patients with whom a contractual relationship is voluntarily established and a Medicare prospective pricing system directly applicable to physicians would decrease physicians' willingness to contract with Medicare patients.[58] Physicians seem to have greater opportunity than hospitals to "select" their patients for two reasons. First, most hospitals are nonprofit, charitable organizations, entitled to tax-exempt status.[59] To enjoy charitable status, a nonprofit hospital must confer a real benefit on the community[60] and must not refuse to treat emergency patients on the basis of an inability to pay.[61] Physicians, however, generally

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attraction and retention, hospitals strive to provide innovations on their premises. This often results in medically unnecessary and costly duplication. While the availability of technology is likely to remain important to physicians under prospective pricing, once physicians have a financial risk in health care delivery, they will be more likely to approach the technology acquisition process as a rational buyer, pressing for the purchase of only those facilities for which there is a sufficient need to justify acquisition.

55. For a more exhaustive discussion of physician discretion in establishing a physician-patient relationship, see Marsh, *supra* note 18.

56. Seidel, *The Physician-Patient Relationship—Professional Liability,* in A. SOUTHWICK, *supra* note 47, at 92.

57. Once undertaken, however, the physician has an obligation to use his best skill, judgment, and effort, and will be held to the standard of reasonable and ordinary care, skill, and diligence as a peer in good standing. *See supra* notes 47-48 and accompanying text. Also, the physician-patient relationship will remain in effect until the patient is cured or dies, both parties agree to termination, the patient dismisses the physician, or the physician withdraws. Seidel, *supra* note 56, at 97-98. A physician who withdraws prematurely may be liable on a claim of abandonment. *Id.*

58. This is true assuming the prospective pricing system is not universally adopted, and a primary goal of prospective pricing is to contain health care expenditures. If other insurers or private pay patients are willing to pay more than the Medicare rate, then physicians, wherever possible, could be expected to shift their patient loads away from Medicare patients in favor of those paying more for similar services.

59. I.R.C. § 501(c)(3) (1982).

60. A. SOUTHWICK, *supra* note 47, at 63; Bromberg, *The Charitable Hospital,* 20 CATH. U.L. REV. 237, 248-51 (1970).

61. A. SOUTHWICK, *supra* note 47, at 63. *See, e.g.,* City of Natchez v. Natchez Sanatorium Benevolent Ass'n, 191 Miss. 91, 96, 2 So. 2d 798, 799 (1941):

> [I]t is important in the public interest that persons so injured or taken suddenly and seriously ill shall be immediately treated and cared for at the nearest hospi-

do not structure their practices as charitable and nonprofit in organization and thus have no duty to treat absent a contractual arrangement.[62] Thus, absent the community benefit obligation of a nonprofit, charitable hospital, limiting physician compensation to prospectively determined pricing would cause many physicians to exercise their greater ability to control the patients they treat.[63] Second, physicians can further manipulate patient load because of their greater geographic mobility. A prospective payment system applied directly to physicians would decrease the likelihood of physicians locating in areas with a high concentration of elderly and poor, where their services are most needed. This tendency would exacerbate the empirically verifiable pattern of physicians locating in the most "affluent" communities.[64] It would not only limit accessibility to medical care for these populations, but would also cause an increase in the amount of "unidentified" and untreated "need" for medical care.[65] While hospitals also have the ability to relocate, the task is much more arduous and costly because of long term community ties, the numbers of people and jobs involved, and the great capital commitment necessary to build a facility and transfer or replace equipment.

The individual physician's ability to select his patients through location, scheduling, and choice indicates that a prospectively determined compensation scheme applied directly to the physician could, in effect, serve to polarize a dual system of medical care based on ability to pay. A prospective pricing system applied to physicians as a group to influence patterns of

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tal which may be reached, and that this treatment . . . shall have no such delay . . . as would be consequent upon inquiry . . . whether the injured is able to pay . . . .

62. *See supra* notes 56-57 and accompanying text. This may also be true because hospitals must rely on physicians to admit patients, except those admitted through the emergency room. These patients are often assigned a physician or group, usually on a rotating basis. Even in this instance, however, a physician decides whether to admit an emergency room patient. *See supra* note 28 and accompanying text.

63. *See, e.g.*, Hirsh, *Health Care as a Business*, 27 MED. TRIAL TECH. Q. 412, 412 (1981) (editor's note).

64. CHARTBOOK, *supra* note 9, at 146-49.

65. A. DONABEDIAN, BENEFITS IN MEDICAL CARE PROGRAMS 9-38, 99-100 (1976) (discussing underreporting of illness among the poor and uninsured); Donabedian, *Effects of Medicare and Medicaid on Access to and Quality of Health Care*, 91 PUB. HEALTH REP. 322, 330 (1976) ("[D]ifferences persist in the range of choices available as sources of care, in the amenities these sources offer, and most probably, in the technical quality of the care that they provide."); *see also* Penchansky & Thomas, *The Concept of Access: Definition and Relationship to Consumer Satisfaction*, 19 MED. CARE 127 (1981)(studying the five dimensions of access: availability, accessibility, accommodation, affordability, and acceptability).

practice, yet divorced from the individual physician-patient relationship, would minimize the impact on the individual while maintaining incentives for physicians to practice cost-effective medicine.

3. *The nonfungible physician*— The most compelling reason for not compensating individual physicians on a prospectively determined scale for each patient is that the basic premise underlying the DRG approach applied to hospitals—that case mix will average out—does not seem to be true for physicians.[66] The Medicare prospective pricing system as designed for hospitals presumes that, over the course of a year, the full gamut of patients seen by each hospital will *average* out to the rough equivalent of those treated in every other hospital.[67] While some patients may be more severely ill and require treatments of greater resource intensity, other patients will balance the total costs.

A physician, however, generally treats fewer patients per year than a hospital. The physician will be more limited in practice than the typical community hospital. Thus, over the course of a year, it is less likely that the random pairings of patients and physicians will yield uniform results.[68] Furthermore, physicians, individually, may not be as homogeneous as community general hospitals.[69] They may also differ as to their education, postgraduate training, professional status, experience, and reputation among peers and with patients. A prospective payment system that does not factor in such differences for individuals could tarnish a doctor's incentive to strive for quality and continuing education if the individual doctor must bear the associated costs. This result could impair hospitals by making it more difficult to find and attract "more qualified" physicians, thus having an adverse impact on the hospital's reputation and on patients' treatments and satisfaction.[70]

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66. R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26, at 5.

67. The Health Care Financing Administration (HCFA) calculates DRG rates on the basis of average cost per diagnosis. 42 U.S.C. § 1395ww(d)(2)-(4) (Supp. II 1984) (outlining factors to be considered in determining DRG rates). Hospitals are, on the average, expected to break even on the costs of caring for Medicare patients, based on the values assigned to DRG groupings. Medicare Program: Prospective Payment for Medicare Inpatient Services: Interim Final Rule with Comment Period, 48 Fed. Reg. 39,752, 39,752-888 (1983) (to be codified at 42 C.F.R. pts. 405, 409, 489).

68. R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26, at 5.

69. *Id.*

70. Physician education and reputation are important to patients and play a determinative role in hospital selection. According to a national survey conducted by F.E.C. Marketing Service Corporation, for most people the most important factor in selecting a hospital is the medical staff's reputation. HOSP. MED. STAFF, Apr. 1983, at 31.

A prospective pricing system directed at aggregations of physicians—such as through hospital medical staff affiliations—resolves many of the problems that an individual physician compensation scheme creates. While individual physicians are not homogeneous, those comprising a hospital's medical staff, taken together, should be as homogeneous as the institutions in which they practice. Thus, a prospective pricing scheme, applied to the hospital medical staff as a whole, offers a means of fairly motivating physicians to provide cost-conscious medical practice while minimizing any adverse impact on individual Medicare patients' treatment.

C. An Aggregate Approach Is Necessary for Cost-Effective Medicine and to Minimize Interference with the Physician-Patient Relationship

The physician's crucial role in dictating treatments and corresponding costs[71] makes the ability to influence physicians' behavior essential to the impact of a prospective pricing program. Physicians' roles in protecting patients,[72] their opportunities to determine which patients they treat,[73] and their limited scope of practice coupled with widely divergent individual qualifications,[74] indicate that a prospective pricing system must be designed to mitigate a direct impact on the individual physician-patient relationship while still encouraging cost-conscious medical practice. A program structured to coordinate and address these concerns must therefore be addressed to aggregations of physicians, for example, through their hospital medical staff affiliations.

Physicians can be drawn into cost and utilization reduction efforts and motivated through their hospital medical staff capacities to provide only reasonably necessary medical services in the most cost-effective manner. Health maintenance organizations (HMOs)[75] provide an example of how structured financial incen-

71. *See supra* notes 28-29 and accompanying text.

72. *See supra* notes 46-54 and accompanying text.

73. *See supra* notes 55-65 and accompanying text.

74. *See supra* notes 68-70 and accompanying text.

75. Health maintenance organizations (HMOs) offer health insurance plans in which beneficiaries prepay their premiums and are provided comprehensive medical care. P. FELDSTEIN, *supra* note 53. There are two major physician incentives in HMOs: (1) they are placed at financial risk regarding the delivery of care, in a proprietary or profit sharing situation, so that it is to their advantage to decrease expenses; and (2) they are reimbursed on a salary system rather than on a fee-for-service basis. Wolinsky, *The Perform-*

tives can successfully encourage physicians to minimize health care delivery costs[76] while enhancing quality.[77] Although the HMO is not the approach advanced in this Note, the nature and experience of HMO physicians offers a useful analogy to the aggregate approach that will be advocated here. HMO strategy focuses on physician behavior, "recogniz[ing] that if physicians are properly organized and motivated, they will control not only the cost of physician care, but, more importantly, the cost of hospital care."[78] A hospital's success under DRG reimbursement and the Medicare prospective pricing system's effectiveness are inexorably dependent upon physician cooperation.[79] The HMO focus on physician behavior and success in overall cost reduction[80] provides valuable insight and evidence that targeting incentives to organized groups of physicians—such as those comprising a hospital's medical staff—can help to reduce costs while maintaining quality.

Focusing incentives on the hospital medical staff as a group minimizes physicians' incentives to manipulate health care de-

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ance of Health Maintenance Organizations: An Analytic Review, 58 Milbank Memorial Fund Q. 537, 550-51 (1980).

76. Roemer & Shonick, *HMO Performance: The Recent Evidence*, 51 Milbank Memorial Fund Q. 271 (1973) (finding that prepaid group practice model HMOs yield lower hospital use, relatively more ambulatory and preventive service, and lower overall costs than fee-for-service patterns).

77. Cunningham & Williamson, *How Does the Quality of Health Care in HMOs Compare to That in Other Settings?*, Group Health J., Winter 1980, at 4, 13:

> Of a total of 27 separate studies . . . , 19 found that the general quality of health care, as indicated by the measures applied, was superior in the HMOs studied to that in general fee-for-service or other settings. . . . None of these studies reported HMO care to be inferior overall.
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> . . . .
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> Of particular significance . . . is the persistent finding that quality of care, as measured by a range of indicators, is better for the poor and those with apparent high need in the facility-based HMO setting compared with that delivered to comparable populations in the non-HMO setting.
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> . . . [F]acility-based HMO care is at least comparable to care in other health care facilities, if not superior.

See also Roemer & Shonick, *supra* note 76, at 291-93 (based on analysis of medical records and increased use of preventive and screening services).

78. Carpenter, *Finding the Shoe that Fits*, Hosp. F., Sept.-Oct. 1984, at 14, 15.

79. *See, e.g.*, Goldsmith, *supra* note 25, at 10 ("How physicians respond to the changing role of the hospital will be critical to the future of the health care system."); Jessee & Suver, *supra* note 19, at 6 ("Hospitals in which the medical staff recognizes the profundity of the changes and the enormity of the challenges and works in a cooperative fashion with the institution will be those that survive and continue to provide services to their communities.").

80. Luft, *Assessing the Evidence on HMO Performance*, 58 Milbank Memorial Fund Q. 501, 508 (1980)("In all instances, the total cost of medical care (premium plus out-of-pocket costs) for HMO enrollees is lower than for comparable people with conventional insurance coverage . . . ."); Roemer & Shonick, *supra* note 76 (same).

livery to their own advantage while imposing greater costs on society. Studies have empirically shown that physicians have the ability to adjust the demand for their own services in light of pricing constraints to achieve a certain target level of income.[81] Thus, although hospital-focused regulatory programs may decelerate the rate of growth of physicians' fees, they may also lead to a corresponding increase in the number of both hospital and physicians' office visits.[82]

The physicians' interests and benefits in so manipulating the medical care system are lower under an aggregate approach to reimbursement than they would be if the individual physician's income were prospectively capped and directly tied to patient treatment.[83] Moreover, at the hospital medical staff level, utilization review will serve to monitor the necessity and appropriateness of Medicare admissions, to minimize the impact of such improper physician behavior. Changes in Medicare authorizing prospective payment also established peer review organizations (PROs)[84] comprised of groups of local physicians. PROs review medical care decisions to determine that care provided was reasonable and necessary, that services provided conform with professional standards of quality, and that the care provided in the

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81. *See generally* P. FELDSTEIN, *supra* note 53, at 165-67. For examples of studies lending support to this theory, see Feldstein, *The Rising Price of Physicians' Services*, 52 REV. ECON. & STATISTICS 121, 132 (1970) ("[P]hysicians have discretionary power to vary both their prices and the quantity of services which they supply. There appears to be a tendency to increase prices when patients' ability to pay improves through higher income or more complete insurance coverage. . . . [P]hysicians reduce the quantity of services provided when fees rise."); Evans, *Supplier Induced Demand: Some Empirical Evidence and Implications*, in THE ECONOMICS OF HEALTH AND MEDICAL CARE 162-73 (M. Perlman ed. 1974).

82. Zuckerman, *supra* note 2, at 2589-90.

83. As the population continues to age, true cost savings become essential to Medicare's continued financial viability. A *comprehensive* health care insurance plan should replace current insurance schemes, which focus on hospital coverage, to maximize efficiency and economical health care delivery. The hospital is the most resource intensive component of our health care system, both in terms of capital and labor. It must be prepared to handle emergencies, trauma, and disaster, and it generally must house the intensive, highly technological health care services. In addition, the hospital must provide "hotel" services and nursing care 24 hours each day and must have the capability to perform all tests and procedures on short notice. Consequently, in order to reduce the total cost of health care delivery, insurers' and providers' financial incentives must be structured to shift treatment, as much as possible, to prevention, early detection, and outpatient treatment. *See generally* P. FELDSTEIN, *supra* note 53, at 279-302; Carpenter, *supra* note 78, at 15; Donabedian, *An Evaluation of Prepaid Group Practice*, INQUIRY, Sept. 1969, at 12; Goldsmith, *supra* note 25, at 7; Comment, *supra* note 25, at 595. The comprehensive insurance system is similar in theory and approach to health maintenance organizations. *See* P. FELDSTEIN, *supra* note 53, at 279-83 and accompanying notes at 301-02.

84. 42 U.S.C. § 1320c-1 (1982).

hospital could not have been more appropriately and economically delivered in another setting.[85]

A physician cost-incentive program directed at the medical staff as a group rather than each individual physician may also prove to realize greater total cost savings. The cost of administering and enforcing an accurate prospective pricing program applied to physicians would impose a far greater burden than the cost of a program applied solely to hospitals.[86] The extensive data collection and associated administrative obligations necessary to implement an individual physician reimbursement system might not yield any significant savings. The ability to implement effectively such a physician compensation system is further limited by lack of information: until the present, Medicare has only collected information related to physicians' *charges,* which may bear little or no relation to the *cost* of physician services.[87] Medicare thus has little or no relevant information upon which a prospective pricing system could be predicated.[88] A hospital medical staff approach would eliminate the need for extensive individual physician cost information. Administrative processing for a hospital staff should be no more burdensome than for a hospital, because the number of hospital medical staffs is identical to the number of hospitals.

Thus, while physician cooperation and integration is essential to achieving cost savings under prospective pricing,[89] an aggregate approach directed towards physicians is the most appropriate method to achieve this goal. Tying physicians' financial incentives directly to the physician-patient relationship may result in access impairment and perhaps decreased quality for Medicare patients. A medical staff approach, however, would minimize any negative impact on access and, as HMO experience has demonstrated, quality should be maintained if not enhanced.[90] An aggregate approach will minimize the direct effect on physicians' income, thus diminishing the likelihood that physicians will engage in system-manipulating practices. Furthermore, an

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85. 42 U.S.C. § 1320c-3(a)(1) (1982). Payment can be denied for inappropriate or unnecessary treatment and for instances where the patient is unnecessarily discharged and readmitted. 42 U.S.C. § 1395ww(f)(2) (Supp. II 1984).

86. R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26, at 5; Zuckerman, *supra* note 2, at 2592.

87. R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26, at 5. Another author has claimed, however, that traditional hospital cost accounting systems provide little insight into what a hospital service really costs. *See* Spivey, *supra* note 39, at 985.

88. R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26, at 5.

89. *See supra* note 79 and accompanying text.

90. *See supra* note 77 and accompanying text.

aggregate, medical staff approach presents the least administrative costs and burdens.

III. STRUCTURED PHYSICIAN FINANCIAL INCENTIVES: A MEDICAL STAFF APPROACH

Physicians, as the party responsible for determining the nature and costs of medical treatments, must have a commitment to cost-efficient medical care. A prospective pricing system applied to hospitals, excluding physicians, does not provide the commitment or the impetus for physicians to practice cost-efficient medicine. "The third-party payers behind the DRG carving knife are taking a chance in assuming doctors and hospitals will collaborate successfully."[91] Should the collaboration fail, the hospital's economic viability and, ultimately, patient access to health care are threatened. Such high stakes warrant more than the "chance" for success that the current system provides.

The Medicare prospective pricing system must mandate physician participation in cost-containment efforts. A number of factors militate against successful voluntary cooperation between many hospitals and physicians. Too many hospitals face tense relationships between administrators and physicians, which are manifested through mutual distrust[92] and apathy.[93] Hospitals with such poor medical staff relations and communications will not be able to persuade their medical staffs to enlist in a united campaign to flourish amidst cost constraints.[94] Furthermore, not all hospital medical staffs will be interested or inclined as a group or through their governing bodies to cooperate with

91. Ellwood, *When MDs Meet DRGs*, HOSP. MED. STAFF, Dec. 1983, at 2, 3.

92. Goldsmith, *supra* note 25, at 10.

93. Jessee & Suver, *supra* note 19, at 6.

94. The hospital's leverage vis-à-vis the physician is at its pinnacle when it chooses to grant or renew a physician's privileges. Currently, there are no parameters establishing the extent to which hospitals may consider an individual doctor's "economic" performance—demonstrated ability to practice within dollar limitations proscribed by the DRG rate—as a criterion for granting or renewing medical staff privileges. A hospital may require a physician seeking privileges to document his education, training, experience, demonstrated competence, ethical practice, good reputation, and ability to work with others. Huffaker v. Bailey, 273 Or. 223, 540 P.2d 1398 (1975), *cited in* Hirsh, *supra* note 63, at 415.

There seems to be consensus, however, that hospitals are not powerless against "wasteful" physicians. Utilization review committees can attempt to educate such physicians to avoid unnecessary treatment. Zaslow, *The Physician and DRGs*, LEGAL ASP. MED. PRAC., Aug. 1984, at 4, 5. Perhaps in the future hospitals will be able to ask physicians with consistent overutilization patterns to leave. *See, e.g.*, Jessee & Suver, *supra* note 19, at 5.

hospitals by making a structured commitment to efficiency and cost reduction[95]—especially because many physicians fear a greater malpractice liability potential under such cost constraints. These factors and the physicians' key role in driving health care costs indicate the necessity for a mandatory program extending the cost-containment goals of prospective pricing to physicians. The need to mandate physician inclusion becomes even more pressing as private insurers contemplate adopting prospective reimbursement,[96] thereby inhibiting a hospital's ability to engage in cost shifting.[97]

A. *A Proposed Mandatory Medical Staff Incentive Plan*

Public perception[98] and the need to curtail health care inflation make physicians' fees the next likely target for Medicare cost-savings efforts.[99] The hospital medical staff provides an ag-

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95. The *threat* of regulation, by extending prospective payment to physicians may, however, provide a sufficient impetus to physicians to produce real cost savings. In the early 1970's, for example, the threat of strict regulation of the health care industry caused hospitals to strive together to reduce health care inflation through the so-called "Voluntary Effort." *See* McMahon & Drake, *The American Hospital Association Perspective*, in HOSPITAL COST CONTAINMENT, *supra* note 37, at 76; *see also* Biles, *supra* note 30, at 667 ("[T]he introduction of the Carter administration's hospital-cost-containment proposal in early 1977 and the subsequent consideration of that proposal by Congress may have increased the states' interest and the regulators' ability to restrain cost increases.").

96. *See, e.g.*, Jessee & Suver, *supra* note 19, at 3 (discussing the inevitability of such an extension). *But see* J. Griffith, in DRGs—What's Next? Two Views, *supra* note 26, at 22.

97.

> [V]irtually all hospitals participate in the Federal Medicare and state Medicaid programs and, if they are to be believed (the evidence supports them), they lose money on every patient treated . . . .
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> . . . [They] believe that they lose money in treating these patients and that they must recover those losses elsewhere in order to keep their doors open. They thus create the phenomenon known in the industry as "cost shifting," which is no more than segregating purchasers according to their ability to pay. Those who have private health coverage are deemed able to pay more and are charged more than are patients whose coverage comes through a government-sponsored system.

Colton, *Hospital Involvement in Health Care Coalitions*, 14 N.C. CENT. L.J. 33, 36 (1983).

98. A survey conducted for the AMA reported that 57% of those questioned did not agree that physicians' fees are usually reasonable. In addition, 52% did not agree that physicians spend enough time with a patient. Finally, 60% felt that physicians are too concerned with making money. HOSP. MED. STAFF, Apr. 1983, at 31.

99. As of this writing, the Health Care Financing Administration is studying the possibility of alternative methods for Medicare to reimburse physicians for treatment of Medicare patients.

gregation appropriate in size,[100] already organized, operating vital governance and utilization review functions.[101] The proposed mandatory plan focuses cost-containment incentives on the hospital medical staff level, retaining the integrity of the individual physician-patient relationship.

To maintain access and quality, the individual physician should be directly compensated for services provided to Medicare patients. The "reasonable charge"[102] directly provided to physicians, however, should grow at a slower rate than overall charges. The difference will be absorbed by a "physician risk" amount, by which the hospital's DRG payment is enhanced. A "risk pool" will be established and overseen by a committee representing the hospital board, administration, and medical staff. This fund will contain monies contributed from the hospital's DRG receipts, for which the hospital and the medical staff will be at risk; periodically the hospital and members of the medical staff will share in the profits or losses that result from patient care.[103] This proposal requires participation by all members, per-

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100. Goldsmith, *supra* note 25, at 9.

101. *Id.*

102. A "relative value scale," as advocated by the AMA for physician payment, could be substituted as the direct compensation component of this scheme. A relative value scale is a set of numerical values associated with physicians' services; more complex procedures have a greater scale value than simpler procedures. Juba & Hadley, *Relative Value Scales for Physicians' Services*, HEALTH CARE FINANCING REV., Summer 1985, at 93, 93. Juba and Hadley developed and compared relative value scales based on alternative data sources and construction methods. They conclude that the issues of how to construct a relative value scale and whether different scales are required need not be primary concerns in developing physicians' fee schedules. *Id.* at 99.

103. The AMA is strongly opposed to any arrangement that puts a physician at financial risk in treating patients. The AMA's position is

> that physicians are not entitled to derive a profit which results directly or indirectly from services delivered by other health care providers who are not their employees or agents. Thus, the physician is not entitled to derive a profit which results from services provided by the hospital under DRG payments.

Judicial Council, AMA, 38th Interim Meeting, Report D—Ethical Implications of Hospital-Physician Risk-Sharing Arrangements Under DRGs (Dec. 2-5, 1984). It seems, however, a bit naive for the AMA to assert that the revenues physicians receive directly from Medicare are not "derived" from services provided by the hospital. Risk incentives here are being distributed to physicians as an aggregate and do not impose the potential threats discussed in Part II, *supra*. Furthermore, physicians and hospitals share a symbiotic relationship in treating hospitalized patients. "Hospitals need physicians, but physicians also need financially healthy hospitals. Perhaps more importantly, the community and patient need both." Jessee & Suver, *supra* note 19, at 6. Acknowledging this relationship openly and economically will help to rationalize health care delivery by transforming the relationship between doctors and hospitals to one of parity.

This proposal does not distinguish between admitting physicians and those later drawn into a case as consultants or surgeons. (For a proposal adopting this approach, see Carpenter, *supra* note 78, at 16-17.) Nor are disbursements segregated by diagnosis in this proposal.

haps, like a union shop, within thirty days of joining the staff.[104] Payments from the risk pool fund to physicians can be distributed according to the *number* of patients seen by each doctor,[105] but should not be further disaggregated.[106] The committee administering the risk pool fund will also have managerial responsibility for the hospital's quality assurance and utilization review functions[107] as well as risk management.[108] This organizational structure will thus combine the activities devoted to quality and appropriateness of hospital utilization with the incentive-payment administration to ensure that these concerns are concurrently and consistently monitored.

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104. The arrangement proposed here differs in a few significant ways from that developed by Paul Ellwood with Interstudy, Minn., known as MeSH plans. (MeSH is the acronym for *Me*dical *S*taff-*H*ospital.) MeSH plans are voluntary contractual arrangements which do not involve all members of the medical staff; a portion of the profits earned from the treatment of Medicare patients is siphoned off and shared with the participating physicians. Ellwood, *supra* note 91, at 4.

The proposal advocated in this Note calls upon the Health Care Financing Administration to provide the financial impetus to cause hospitals and physicians to strive together in achieving efficiency, then share in its rewards. Because the direct payment to the physician would be presumably lower under this plan, physicians would feel a direct pressure to be enthusiastic contributors in achieving the goals of such a plan. *See supra* notes 81-82 and accompanying text (discussing the target income hypothesis).

105. The plan is designed to stimulate continued physician productivity by tying physician compensation from the risk pool fund to patient activity. Standards, perhaps derived from relative value units, may need to be established to accommodate the differing practices and procedures among the medical specialties. Implementation of such a program may involve structuring the amounts allocated from the risk pool fund to the medical staff aggregation and hospital on an established percentage basis. The percentage could be varied with the experience of the program to provide one or the other group with a greater portion.

106. MeSH plans contemplate the development of subplans for each payor to segregate physicians treating patients of different insurers. The MeSH plans also contemplate hospital and physician members of the plan engaging in diversification and ambulatory care networking—that is, branching out into activities beyond the delivery of inpatient hospital and physician services. Ellwood, *supra* note 91, at 7-8. This proposal only contemplates incentive payment schemes. Once physicians and hospitals begin to work together in this vein, however, the advantages and expertise they can garner from one another should become apparent to all. It is quite likely that voluntary, cooperative "joint ventures" will accelerate beyond those already being undertaken.

107. Along with managerial responsibility, the personnel and staff currently devoted to quality assurance and utilization review responsibilities within the institution will also be transferred to the committee.

108. "Risk management" is used to describe the reporting, investigation, analysis, and recommendations concerning "incidents" which have potential liability exposure for the hospital or personnel. The activity is dedicated to examining and correcting or eliminating behaviors and procedures which give rise to such incidents.

B. *Benefits of a Medical Staff Incentive System*

Structuring the incentive relationship at the medical staff-hospital level will leave the integrity of the physician-patient relationship intact. Physicians will have the same incentive to practice "defensive medicine" as prior to restructured reimbursement. Thus, continued quality will be preserved. Because physicians will continue to receive a direct "reasonable" charge, there will be little incentive for physicians to curtail access by Medicare patients.

Hospital-physician incentive plans may arguably raise questions concerning the applicability of the Medicare Fraud and Abuse provisions.[109] The Fraud and Abuse provisions were designed to eliminate waste and misdirection of government monies paid out for Medicare.[110] Hospital-physician incentive

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109. The Fraud and Abuse provisions provide:

(b) Illegal remunerations

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1395nn(b)(1)-(2) (1982). *See* Note, *Abusing the Patient: Medicare Fraud and Abuse and Hospital-Physician Incentive Plans*, 20 U. MICH. J.L. REF. (forthcoming 1986) (arguing that the Fraud and Abuse Amendments properly prohibit hospital-physician incentive plans).

110. *See* H.R. REP. No. 393, Pt. II, 95th Cong., 1st Sess. 1, *reprinted in* 1977 U.S. CODE CONG. & AD. NEWS 3039, 3047-50 (discussing the need to eliminate the fraud associated with unlicensed "medicaid mills," billing for unnecessary treatment and/or services not provided, and clinical lab referrals garnered through kickbacks) [hereinafter cited as H.R. REP. No. 393]; *Medicare and Medicaid Fraud: Hearing Before the Subcomm. on Health and Long-Term Care of the Select Comm. on Aging*, 96th Cong., 2d

plans were not, however, contemplated for inclusion by Congress within the Fraud and Abuse provisions.[111] Hospital-physician incentive programs promote cost savings and efficient health care delivery by offering the physician an opportunity to participate in the savings realized. Physician incentive plans further the goals of prospective payment and the Fraud and Abuse provisions by streamlining health care delivery, eliminating waste, and ensuring that only necessary health care expenditures are incurred. These plans do not fall within the definition or scope of fraud, abuse, or program abuse relevant to and designed to be eliminated by the Fraud and Abuse provisions.[112] Efficiency is openly encouraged by hospital-physician incentive plans—there is no deception or waste involved.[113] While referral networks and allegiances between hospitals and physicians may be bolstered by incentive plans, these tangential results should not be construed as violations of the Fraud and Abuse provisions. These plans and relationships are outside the scope and purpose of the Fraud and Abuse provisions. Furthermore, they promote the goals of the prospective payment system and original Medicare legislation by providing Medicare patients with access to quality, cost-effective care.[114]

Sess. 3 (1980) (purpose of Fraud and Abuse Amendments was to eliminate wasted and diverted resources) [hereinafter cited as *Hearing*]; *Medicare and Medicaid Frauds: Joint Hearing Before the Subcomm. on Long-Term Care and the Subcomm. on Health of the Elderly of the Senate Special Comm. on Aging,* 94th Cong., 1st Sess. 4 (1975) [hereinafter cited as *Joint Hearing*]; *see also* Note, *supra* note 109.

111. *See* H.R. REP. No. 393, *supra* note 110; *Hearing, supra* note 110; *Joint Hearing, supra* note 110; *see also* Note, *supra* note 109.

112. H.R. REP. No. 393, *supra* note 110; *Medicare-Medicaid Fraud Act: Hearings Before the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce,* 94th Cong., 2d Sess. 81-82 (1976)(statement of Beverlee A. Myers, Lecturer, University of Michigan, School of Public Health, citing the *Discursive Dictionary of Health Care*):

> [A]buse is defined as "improper or excessive use of program benefits, resources or services by either providers or consumers. Abuse can occur intentionally or unintentionally, when services are used which are excessive or unnecessary; which are not the appropriate treatment for the patient's condition . . . . It should be distinguished from fraud, in which deliberate deceit is used by providers or consumers . . . ."

113. The clarification of the Fraud and Abuse Amendments in 1977, through the addition of the phrase "any remuneration," did not add new types of activity designed to be deterred through the Fraud and Abuse provisions. Note, *supra* note 109. The addition of this clarifying phrase does not, therefore, necessitate a finding that the hospital-physician incentive plans contemplated within this Note violate the Fraud and Abuse provisions.

114. If the courts show the slightest hesitation or doubt that these incentive plans—whether required by the HCFA, as advocated here, or initiated voluntarily by hospitals and groups of physicians—are clearly outside the scope of the Fraud and Abuse provisions, Congress should act swiftly to specifically exempt bona fide hospital-physi-

In addition to maintaining access to quality physician and hospital services, several other benefits would result from the adoption of joint hospital-physician incentive plans as proposed within this Note.

1. *Improved peer review*— Physicians as well as hospitals will have a stake in the efficiency of both their own practice and the practice of their peers.[115] While many hospitals have had numerous problems with physicians' untimely completion of records, medical records documentation will be completed more thoroughly and more timely under this system because accurate completion is the basis of payments to the hospital and the risk pool fund. Peer review and any corresponding disciplinary actions or enforcements are likely to be more rigorously applied because of the mutual economic impact. These efforts will promote and facilitate the effective functioning of the PROs, which rely upon the timely completion of the medical record and its contents for assessment purposes.[116]

As cost-containment pressures are brought to bear upon physicians, the need for protocols and the development of national standards may be perceived. The protocols could be developed by national specialty boards,[117] with perhaps some institutional

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cian incentive programs to enable the goals of streamlining and reducing the cost of health care to the elderly to become a reality.

115. This proposal may be somewhat counter to the traditional style of the physician as the fiercely independent practitioner. This style must be moderated, however, in the interests of cost containment; the strategy proposed is designed to reduce costs while retaining maximum integrity for the physician-patient relationship.

While the danger of a "free-rider" problem might potentially exist, the likelihood of this being substantial is minimized by two factors. First, incentive payments will be doled out on the basis of the *number* of patients treated from which there was a contribution to the fund. The party distributing fund monies is also overseeing the quality and appropriateness of care. *See supra* notes 107-08 and accompanying text.

Second, the medical staff and hospital will have incentive to grant and renew staff privileges to only those physicians who make an active, ongoing contribution to the viability of an effective and efficient medical practice. All physicians with such active, efficient practices will be welcome additions to the staff because they will help to increase the size of the risk pool fund in which all physicians will share.

116. *See supra* notes 84-85 and accompanying text.

117.

> Protocols and standards for care may take on a new meaning under the DRG system and may become more rigid and detailed. Traditionally, physicians have regarded such protocols with suspicion, concerned that they would result in the practice of "cookbook" medicine, which would not be sensitive to the special circumstances of each case. However, with the payment for DRGs dependent on norms for each group, establishment of agreed-on norms, protocols, or standards is likely to become critical. Physicians will probably turn to the national specialty societies for the development of such standards or guidelines, perhaps to be applied with regional or local modifications.

Spivey, *supra* note 39, at 985-86.

or locally developed variations.[118] In addition, "quality" may ultimately need to be defined.[119] These developments, however, may enhance the overall practice of medicine by focusing physicians on dual concerns that need not be contradictory: cost and quality.[120]

2. *Cost savings*— Once the physician, the discerning consumer of health care, is provided an incentive to deliver economical patient care and bears a financial risk, the most cost-effective treatments are likely to be selected and true cost savings should be realized.[121]

3. *Improved hospital-medical staff relationships*— If hospitals and physicians are united in the goals of streamlining delivery costs while retaining quality, and are teamed together in management of the risk pool fund and utilization review functions, communications and cooperation should be enhanced. When physicians, administrators, and trustees begin to work together toward these goals, the hospital and, more importantly, its community and patients will benefit. Increased cooperation will facilitate the achievement of one of the perceived benefits of the Medicare prospective pricing system: "[p]roviders being able to identify, in terms of revenue to the institution, what services they deliver well and what services they do not provide efficiently."[122] Such evaluations require the active participation and cooperation of all three key hospital constituents, trustees, administrators, and physicians, in order to be properly and credibly conducted. Decisions regarding the reduction or elimination of "inefficient" services can then be realistically made and implemented by a tripartite panel.

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118. *Id.*

119. Comment, *supra* note 25, at 594. The concern for cost-conscious health care delivery has been viewed as indicative of a new era in the financing of health care: the emphasis has shifted from providing all people with as much care as they desire to providing, instead, a minimal, or adequate level, to those dependent upon public financing. *See, e.g.*, Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, LAW MED. & HEALTH CARE, Dec. 1984, at 245; *see also* Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost Cutting*, 98 HARV. L. REV. 1004 (1985).

120. Contrary to what some might argue, *see, e.g.*, Note, *supra* note 109, discharging patients earlier than they had been under cost-based reimbursement may not be inappropriate. The hospital is a very expensive setting for treatment, and thus should be reserved only for acute care. Patients should, rationally, be discharged as soon as possible to a less resource intensive setting (such as a nursing home or home with home-health services provided as appropriate).

121. *See supra* notes 75-80 and accompanying text (discussing cost savings resulting from HMOs' focus on physicians).

122. 48 Fed. Reg. 39,807 (1983).

4. *Impact on physicians' privileges*— In conjunction with such a reimbursement system, hospitals should be explicitly encouraged to consider a physician's economic performance in evaluating candidates for medical staff privileges. Particularly in light of the anticipated physician glut,[123] scarce privilege spots should be allocated to physicians who have demonstrated they have the commitment and capability of practicing cost-efficient, quality medicine. Physicians are less likely to oppose economic factors in the decision to grant privileges[124] when they share in the risk of each other's inefficient practice.

Physicians make decisions that directly affect the resources used and costs incurred in hospital treatment. Their decisions, furthermore, affect individual patients and the commitment of resources, both through direct expense and opportunity costs. Because the impact of physicians' decisions can be so pervasive, a financial incentive program that operates on physician behavior, without disturbing the physician-patient relationship, seems to provide a solution to the cost/quality dilemma.

CONCLUSION

Medicare prospective pricing was imposed to "restructure the economic incentives facing the health care system to establish market like forces,"[125] and to "[restrain] hospital cost increases which will preserve the integrity of the Medicare trust funds."[126] The focus of efforts to curb the health cost crisis has been on hospitals, the largest single component of medical care expenditures.[127] To provide "optimal" health care in the most cost-effective manner, a more comprehensive health care insurance system is necessary, one that focuses treatment on prevention, early diagnosis, and outpatient treatment.[128] Presuming current efforts continue to concentrate on the hospital as the most heavily insured setting, and the hospital is the focus of efforts to reduce

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123. *See, e.g.*, GRADUATE MED. EDUC. NAT'L ADVISORY COMM., SUMMARY REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES 20-25 (1980); THE COMING PHYSICIAN SURPLUS: IN SEARCH OF A POLICY (E. Ginzberg & M. Ostow eds. 1984); M. MILLMAN, POLITICS AND THE EXPANDING PHYSICIAN SUPPLY (1980).

124. Gold, *supra* note 44, at 164.

125. 48 Fed. Reg. 39,807 (1983).

126. *Id.*

127. *See supra* note 9.

128. As this occurs, however, the patient population treated in hospitals will be a sicker and costlier group to treat. *See, e.g.*, Goldsmith, *supra* note 25, at 7; *see also supra* note 45.

health care delivery costs, then physicians must be drawn into the cost-reduction plan. Physicians must share in the risk if a financial incentive plan is to achieve its objective of enhancing efficiency. Because access to quality care remains a valued goal of American society,[129] an incentive system that would inhibit access for Medicare patients, already an undesirable group to many physicians, is unacceptable. The reimbursement system advocated in this Note requires risk and incentive sharing by the hospital medical staff as a whole, leaving undisturbed the physician-patient relationship and the emphasis on quality and access which Medicare, since its inception, has strived to provide its beneficiaries.

—H. Lynda Kugel

129. R. Rubin, in DRGs—What's Next? Two Views, *supra* note 26.