

Virtual Mentor

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THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinions on Cost Containment, Payment Structures, and Financial Incentives

Opinion 8.054 - Financial Incentives and the Practice of Medicine

In order to achieve the necessary goals of patient care and to protect the role of physicians as advocates for individual patients, the following statement is offered for the guidance of physicians:

(1) Although physicians have an obligation to consider the needs of broader patient populations within the context of the patient-physician relationship, their first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice.

(2) Physicians, individually or through their representatives, should evaluate the financial incentives associated with participation in a health plan before contracting with that plan. The purpose of the evaluation is to ensure that the quality of patient care is not compromised by unrealistic expectations for utilization or by placing that physician's payments for care at excessive risk. In the process of making judgments about the ethical propriety of such reimbursement systems, physicians should refer to the following general guidelines:

(a) Monetary incentives may be judged in part on the basis of their size. Large incentives may create conflicts of interest that can in turn compromise clinical objectivity. While an obligation has been established to resolve financial conflicts of interest to the benefit of patients, it is important to recognize that sufficiently large incentives can create an untenable position for physicians,

(b) The proximity of large financial incentives to individual treatment decisions should be limited in order to prevent physicians' personal financial concerns from creating a conflict with their role as individual patient advocates. When the proximity of incentives cannot be mitigated, as in the case of fee-for-service payments, physicians must behave in accordance with prior Council recommendations limiting the potential for abuse. This includes the Council's prohibitions on fee-splitting arrangements, the provision of unnecessary services, unreasonable fees, and self-referral. For incentives that can be distanced from clinical decisions, physicians should consider the following factors in order to evaluate the correlation between individual act and monetary reward or penalty:

(i) In general, physicians should favor incentives that are applied across broad physician groups. This dilutes the effect any one physician can have on his or her financial situation through clinical recommendations, thus allowing physicians to provide those services they feel are necessary in each case. Simultaneously, however, physicians are encouraged by the incentive to practice efficiently.

(ii) The size of the patient pool considered in calculations of incentive payments will affect the proximity of financial motivations to individual treatment decisions. The laws of probability dictate that in large populations of patients, the overall level of utilization remains relatively stable and predictable. Physicians practicing in plans with large numbers of patients in a risk pool therefore have greater freedom to provide the care they feel is necessary based on the likelihood that the needs of other plan patients will balance out decisions to provide extensive care.

(iii) Physicians should advocate for the time period over which incentives are determined to be long enough to accommodate fluctuations in utilization resulting from the random distribution of patients and illnesses. For example, basing incentive payments on an annual analysis of resource utilization is preferable to basing them on monthly review.

(iv) Financial rewards or penalties that are triggered by specific points of utilization may create enormous incentives as a physician's practice approaches the established level. Therefore, physicians should advocate that incentives be calculated on a continuum of utilization rather than a bracketed system with tiers of widely varied bonuses or penalties.

(v) Physicians should ascertain that a stop-loss plan is in place to prevent the costs associated with unusual outliers from significantly impacting the reward or penalty offered to a physician.

(3) Physicians also should advocate for incentives that promote efficient practice, but are not be designed to realize cost savings beyond those attainable through efficiency. As a counterbalance to the focus on utilization reduction, physicians also should advocate for incentives based on quality of care and patient satisfaction.

(4) Patients must be informed of financial incentives that could impact the level or type of care they receive. Although this responsibility should be assumed by the health plan, physicians, individually or through their representatives, must be prepared to discuss with patients any financial arrangements that could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the patient-physician relationship.

Issued June 1998 based on the report "[Financial Incentives and the Practice of Medicine](#)," adopted December 1997; updated June 2002.

Opinion 8.13 - Managed Care

The expansion of managed care has brought a variety of changes to medicine including new and different reimbursement systems for physicians with complex referral restrictions and benefits packages for patients. Some of these changes have raised concerns that a physician's ability to practice ethical medicine will be adversely affected by the modifications in the system. In response to these concerns, the following points were developed to provide physicians with general guidelines that will assist them in fulfilling their ethical responsibilities to patients given the changes heralded by managed care.

(1) The duty of patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the system of health care delivery. Physicians must continue to place the interests of their patients first.

(2) When health care plans place restrictions on the care that physicians in the plan may provide to their patients, physicians should insist that the following principles be followed:

(a) Any broad allocation guidelines that restrict care and choices--which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities--should be established at a policy-making level so that individual physicians are not asked to engage in bedside rationing.

(b) Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.

(c) Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Health care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.

(d) Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operations. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the

guideline. Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests.

(e) Health care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that health care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.

(f) Physicians also should continue to promote full disclosure to patients enrolled in health care plans. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's health care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the health care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

(g) Physicians should not participate in any plan that encourages or requires care below minimum professional standards.

(3) When physicians are employed or reimbursed by health care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, physicians should accept only those financial incentives that promote the cost-effective delivery of health care and not the withholding of medically necessary care.

(a) Physicians should insist that any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter.

(b) Physicians should advocate that limits be placed on the magnitude of fee withholds, bonuses, and other financial incentives to limit care and that incentive payments be calculated according to the performance of a sizable group of physicians rather than on an individual basis.

(c) Physicians should advocate that health care plans or other groups develop financial incentives based on quality of care. Such incentives should complement those based on the quantity of services used.

(4) Physicians should encourage both that patients be aware of the benefits and limitations of their health care coverage and that they exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs.

Issued June 1996 based on the report "[Ethical Issues in Managed Care](#)," adopted June 1994; updated June 2002.

Opinion 8.051 - Conflicts of Interest under Capitation

The application of capitation to physicians' practices can result in the provision of cost-effective, quality medical care. It is important to note, however, that the potential for conflict exists under such systems. Physicians who contract with health care plans should attempt to minimize these conflicts and to ensure that capitation is applied in a manner consistent patients' interests.

(1) Physicians have an obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation. Physicians should advocate that capitation payments be calculated primarily on the basis of relevant medical factors, available outcomes data, the costs associated with involved providers, and consensus-oriented standards of necessary care. Furthermore, the predictable costs resulting from existing conditions of enrolled patients should be considered when determining the rate of capitation. Different populations of patients have different medical needs and the costs associated with those needs should be reflected in the per member per month payment. Physicians should seek agreements with plans that provide sufficient financial resources for all care that is the physician's obligations to deliver and should refuse to sign agreements that fail in this regard.

(2) Physicians must not assume inordinate levels of financial risk and should therefore consider a number of factors when deciding whether or not to sign a provider agreement. The size of the plan and the time period over which the rate is figured should be considered by physicians evaluating a plan as well as in determinations of the per member per month payment. The capitation rate for large plans can be calculated more accurately than for smaller plans because of the mitigating influence of probability and the behavior of large systems. Similarly, length of time will influence the predictability of the cost of care. Therefore, physicians should advocate for capitation rates calculated for large plans over an extended period of time.

(3) Stop-loss plans can prevent the potential of catastrophic expenses from influencing physician behavior. Physicians should ensure that such arrangements are finalized prior to signing an agreement to provide services in a health plan.

(4) Physicians must be prepared to discuss with patients any financial arrangements which could impact patient care. Physicians should avoid reimbursement systems that, if disclosed to patients, could negatively affect the patient-physician relationship.

Issued December 1997 based on the report [“The Ethical Implications of Capitation,”](#) adopted June 1997; updated June 2002.

Opinion 8.056 - Physician Pay-for-Performance Programs

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:

(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;

(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;

(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;

(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:

(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;

(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;

(c) be aware of evidence-based practice guidelines and the findings upon which they are based;

(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;

(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.

Issued June 2006 based on the report "Physician Pay-for-Performance Programs," adopted November 2005.

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[Health Reform and the Future of Medical Practice](#), November 2011

[How Medicare and Hospitals Have Shaped American Health Care](#), November 2011

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