# Virtual Mentor
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**THE CODE SAYS**
**AMA *Code of Medical Ethics'* Opinions on Financial Incentives and Conflicts under Various Models of Payment for Care**

**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 with 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 8.054 - 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,
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> (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:
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> > (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 8.055 - Retainer Practices**

Individuals are free to select and supplement insurance for their health care on the basis of what appears to them to be an acceptable tradeoff between quality and cost. Retainer contracts, whereby physicians offer special services and amenities (such as longer visits, guaranteed availability by phone or pager, counseling for healthy lifestyles, and various other customized services) to patients who pay additional fees distinct from the cost of medical care, are consistent with pluralism in the delivery and financing of health care. However, they also raise ethical concerns that warrant careful attention, particularly if retainer practices become so widespread as to threaten access to care.

(1) When entering into a retainer contract, both parties must be clear about the terms of the relationship and must agree to them. Physicians must present the terms of the contract in an honest manner, and must not exert undue pressure on patients to agree to the arrangement. If a physician has knowledge that the patient's health care insurance coverage will be compromised by the retainer contract, the information must be discussed with the patient before reaching an agreement on the terms of the retainer contract. Also, patients must be able to opt out of a retainer contract without undue inconveniences or financial penalties.

(2) Concern for quality of care the patient receives should be the physician's first consideration. However, it is important that a retainer contract not be promoted as a promise for more or better diagnostic and therapeutic services. Physicians must always ensure that medical care is provided only on the basis of scientific evidence, sound medical judgment, relevant professional guidelines, and concern for economic prudence. Physicians who engage in mixed practices, in which some patients have contracted for special services and amenities and others have not, must be particularly diligent to offer the same standard of diagnostic and therapeutic services to both categories of patients. All patients are entitled to courtesy, respect, dignity, responsiveness, and timely attention to their needs.

(3) In accord with medicine's ethical mandate to provide for continuity of care and the ethical imperative that physicians not abandon their patients, physicians converting their traditional practices into retainer practices must facilitate the transfer of their non-participating patients, particularly their sickest and most vulnerable ones, to other physicians. If no other physicians are available to care for non-retainer patients in the local community, the physician may be ethically obligated to continue caring for such patients.

(4) Physicians who enter into retainer contracts will usually receive reimbursement from their patients' health care plans for medical services. Physicians are ethically required to be honest in billing for reimbursement, and must observe relevant laws, rules, and contracts. It is desirable that retainer contracts separate clearly special services and amenities from reimbursable medical services. In the absence of such clarification, identification of reimbursable services should be determined on a case-by-case basis.

(5) Physicians have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care. Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation.

Issued December 2003 based on the report "Retainer Practices," adopted June 2003.

**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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