Competing in the Marketplace:

How physicians can improve quality and increase their value in the health care market through medical practice integration

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American Medical Association
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Table of contents

Introduction 1

The purpose of this Guidance 1

New reasons driving physician practice integration 2

Tools already exist that can greatly facilitate medical practice and the integration process 3

Additional reasons to integrate 3

The necessity of strategic and business planning 4

The structure of this Guidance 4

I. The Merger Model 4

A. Introduction 4

B. General requirements for fully-integrated physician practice mergers 5

II. Collaborative integration models 8

A. Financial integration 8

B. Clinical Integration 9

III. Antitrust issues 17

A. The Sherman and Clayton Acts: A general overview 17

B. Physician collaborative arrangements 19

Conclusion 24

Exhibit A: Evaluating affiliation options 25

Exhibit B: Community physician organization: Business plan outline 26

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Introduction

The American Medical Association (AMA) has developed this guidance (Guidance) to apprise its members of the lawful ways in which they may integrate with other independent, and sometimes competing, physician practices in order to respond proactively to the changing practice environment and bargain collectively with health insurers and other third-party payers. This Guidance covers options approved by the federal agencies that enforce the antitrust laws: (1) mergers of previously separate physician practices and (2) financial and clinical collaborative arrangements. This Guidance does not address options involving non-physicians, e.g., physician hospital organizations. The AMA will address physician/ non-physician integration in a separate guidance. This separate guidance will discuss how physicians may integrate with non-physicians without forfeiting the practice autonomy that is essential to quality medical care and professional satisfaction. Although this Guidance confines its focus to physician integration and how, in some cases, that integration may legally and appropriately necessitate joint negotiation of fees, the AMA continues to strenuously advocate through all legally appropriate channels to effect changes in both the antitrust laws and antitrust enforcement policy as a means of empowering physicians in their relationships with dominant health insurers[1]. For further information regarding this Guidance, please contact Wes Cleveland or Henry Allen, American Medical Association, at (312) 464-5000 or via email at *wes.cleveland@ama-assn.org* or *henry.allen@ama-assn.org*.

The purpose of this Guidance

The market and regulatory environment within which physicians practice is undergoing rapid and dramatic change. This change is motivating many physicians to explore the potential benefits of practice integration. Perhaps the strongest motivations driving physicians towards greater integration and mutual interdependence are the growing expectation for physicians to adopt expensive automated medical record and pharmacy order entry systems and the emergence of pay-for-performance bonus systems by governmental agencies and health insurance companies. Electronic record systems and pay-for-performance initiatives require sophisticated care delivery and data reporting systems.

Physicians in solo or small group practice may find it prohibitively expensive and time consuming to participate in and take advantage of these market and reimbursement changes. Physicians may be compelled to explore ways to integrate their activities with their colleagues to acquire or develop these tools in an interdependent fashion without violating legal and regulatory requirements.

Physicians may be unaware of the flexibility permitted by the numerous lawful collaboration options available to them. In many cases, physicians will be able to: (1) remain in their local practice settings, (2) oversee many day-to-day practice operations, and (3) be rewarded based on individual productivity while still achieving the level of integration necessary both to amass the capital required for health information technology (HIT) and other technological investments and to bargain collectively with health insurers and other third-party payers for the payment required to support a state-of-the-art medical practice. Physicians will also likely be able to continue to work with primary care physicians (PCPs) and the medical specialists with whom they have established professional relationships—indeed, most successful physician practice integrations involve

[1]AMA Policy H-380.987, which was reaffirmed in June 2006, states: "Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association." The AMA continually seeks to make the reform expressed in H-380.987 a reality. In 2007 the AMA undertook a number of high-profile and proactive efforts to achieve antitrust reform and expects to do the same in 2008.

increased collaboration among physicians who already have cooperative call, consultation and referral relationships.

The AMA has developed this Guidance describing medical practice integration options as one means of helping physicians successfully adapt to a changing practice environment.

New reasons driving physician practice integration

Recent groundbreaking changes in health care policy and reimbursement methodologies are providing new, and often compelling, reasons for physicians to work in much closer collaboration than in the past. In his 2004 State of the Union Address, President George W. Bush announced a federal policy to ensure that most Americans have an electronic health record by 2014. The potential benefits of widespread HIT implementation are enormous—a 90 percent adoption of HIT in inpatient and outpatient settings is projected to result in average annual savings of $77 billion.[2] In a December 2007 report, the Commonwealth Fund indicated that accelerated provider adoption of HIT could result in net health system savings reaching $88 billion over the next ten years[3]. Accordingly, several major federal agencies significantly altered their enforcement policies to facilitate physician adoption of HIT. However, for physicians to acquire, implement, and maintain an HIT system, they need extensive financial resources that in turn may require that they form a fully merged firm or integrated joint venture.

Another significant recent development motivating physicians to integrate their practices is the implementation of quality-based reimbursement mechanisms by health insurers, state and federal governments, and other payers. The following are a few examples of these types of quality-based reimbursement programs.

- A Physician Quality Reporting Initiative (PQRI) has been established within Medicare by the Tax Relief and Health Care Act of 2006. Congress has funded this program with $1.35 billion. The program increases by 1.5 percent payments to physicians and Medicare Part B practitioners who report information related to specific quality measures[4]. Similarly, the Medicare Payment Advisory Commission has continuously recommended to Congress the incorporation of quality incentives into Medicare's payment systems for physicians and health care providers.[5]

- Basing physician reimbursement on performance measures is gaining popularity among commercial health insurers. A recent publication issued by the Minnesota Medical Association in November 2007 entitled "A Review of Pay for Performance in Minnesota" (Minnesota P4P Review) illustrates this phenomenon. The Minnesota P4P Review shows how health insurers are utilizing specific practice measures to evaluate physician performance and structure reimbursement. The Minnesota P4P Review describes specific measures employed by each health insurer utilizing a pay-for-performance program.[6]

- The reimbursement transformation described in the Minnesota P4P Review is indicative of a national phenomenon. For example, on August 27, 2007, the Leapfrog Group and Med-Vantage published the results of a survey of 75 purchasers, government agencies, and health insurers. The results show that pay-for-performance programs had grown dramatically from 39 in 2003 to 148 in 2007.[7] According to the survey, since 2004 the top reason for implementing pay-for-performance programs remains improving clinical outcomes. The report also indicated that over 70 percent of all pay-for-performance programs are working to expand the scope or number of performance measures utilized and that "Advanced P4P programs are now developing tools to measure improvements in outcomes and eligibility for rewards directly from medical charts."

[2]R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R Taylor, Can Electronic Medical Records Systems Transform Health Care? Potential Health Benefits, Savings, and Costs, *Health Affairs* 24, No. 5 (2005): 1103-1117.

[3]Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending, The Commonwealth Commission on a High Performance Health System, December 2007, located at *http://www.commonwealthfund.org/usr_doc/Schoen_bendingthecurve_1080.pdf?section=4039*.

[4]A resource entitled "2008 Physician Quality Reporting Initiative Specifications Document" provides detailed descriptions of the 2008 quality measures and how to effect associated reporting. This resource is located at *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIMeasureSpecs.pdf*. Further information concerning the 2008 PQRI program is located at the following address on the CMS Web site: *http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp#TopOfPage*.

[5]See e.g., K. Milgate and S. Cheng, Pay-For-Performance: The MedPAC Perspective, *Health Affairs* 25, No. 2 (2006): 413-419.

[6]The Minnesota P4P Review is available at *http://www.mmaonline.net/Portals/mma/Publications/Reports/P4P%20Report.pdf*. The Minnesota P4P Review describes the Minnesota Medical Association's policies regarding pay-for-performance programs. The AMA also has adopted Principles and Guidelines for the formation and implementation of pay-for-performance programs, as well as an extensive white paper entitled "Physician Pay for Performance (PFP) Initiatives." Both AMA documents can be viewed at *http://www.ama-assn.org/ama/pub/category/18016.html*.

[7]See *http://www.leapfroggroup.org/media/file/MV-Leapfrog_P4P_Press_Release.pdf*.

Closer integration enables many physicians to finance, develop, implement, and maintain the infrastructure necessary to collect, track and report the types of quality information that these performance-based reimbursement programs presuppose. Closer integration may also be essential to create the collaborative environment needed to make real quality improvement. Without collaborative implementation of practice standards and the infrastructure needed to support and monitor the effect of that collaboration, physicians may be disadvantaged in demonstrating quality outcomes and may ultimately be unable to compete in the changing health care market.

Finally, health insurers, employers and consumers are demanding data on physician performance upon which to base informed health care purchases. This information can be based on a number of factors, including: adherence to quality outcome and process measures; patient satisfaction survey results; and, increasingly, assessments of the cost of care. Health insurers are now ranking physicians based on quality and cost-related metrics and disseminating that ranking information to the pubic as an aid to physician selection. Insurers are also using these ranking systems to score or "tier" physicians, with higher scoring physicians receiving superior reimbursement or patient "steerage."[8] Many physicians view integration as a means of developing the infrastructure that can capture their own performance data—data that is essential to correct any inaccuracies in designations imposed on them by third-parties.

Tools already exist that can greatly facilitate medical practice and the integration process

Many physicians are already achieving remarkable success with affordable HIT systems. Physicians are improving practice efficiency and productivity by utilizing relatively simple HIT tools in their offices. For example, patient registries[9] are enabling practices to evaluate and track the care of one patient, as well as populations of patients, by using nationally recognized evidenced-based clinical performance measures[10] aligned with benchmarks. In this way, registries can highlight actionable items—when a patient's care does not meet population-based goals, for example, or when an assessment is overdue. This type of comparative analysis can greatly facilitate a practice's ability to take advantage of pay-for-performance reimbursement mechanisms. HIT can also incorporate non-physician staff into a practice's clinical workflow. This incorporation has allowed one network to provide each physician an additional 3.5 hours of revenue per month.[11] HIT programs can also facilitate patient compliance by providing patients with post-visit print-outs that show the patient's trends over time and goals for the next visit. The Docsite Web site is one of a number of Web sites that describes some of the HIT practice tools that physicians are currently utilizing.[12]

Additional reasons to integrate

Aside from these recent policy and reimbursement integration drivers, among the more significant motivations that may help to explain the trend toward greater integration among physicians is the desire to aggregate capital for the significant information and technology investments that are involved in health care delivery. Individuals and entities seek to share the risks they must bear, especially when capitated payments are involved. For instance, creating a larger group practice may provide a way for physicians to pool the financial risks associated with treating unusually costly patients. Integration may also be driven by economies in monitoring and evaluation. Larger groups may be able to use costly management information systems to evaluate performance and promote themselves to third-party payers. Finally, integration may yield negotiating efficiencies vis-à-vis large third-party payers. For example, a solo physician is likely to have less skill than a professional manager retained by an integrated group in negotiating and analyzing managed care contracts. Moreover, larger integrated groups may be favored by

[8]The AMA's Private Sector Advocacy unit has developed a number of advocacy resources to help physicians understand and, if necessary, challenge health insurer quality rankings. See *http://www.ama-assn.org/ama/pub/category/18016.html*.

[9]A patient registry is an electronic or manual system that compiles and manages information on a practice's chronically ill population. By using a patient registry, the physician can monitor the incidence and course of chronic diseases and observe the condition of patients before and after medical interventions. While simple manual patient registries function primarily as storehouses for information, electronic patient registries use practice-management software to perform multiple tasks. For further information regarding patient registries, see the document entitled "Patient registries: Outcomes and pay-for-performance: Can patient registries help?" This document has been developed by the AMA's Private Sector Advocacy unit and is available to AMA members at *http://www.ama-assn.org/ama/pub/category/14416.html*.

[10]The National Quality Measures Clearinghouse defines "clinical performance measure" as "A subtype of quality measure that is a mechanism for assessing the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in the optimal time period." The National Quality Measures Clearinghouse is sponsored by the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, and provides a glossary of clarifying definitions and examples of terms used to describe common properties of health care quality measures. This glossary can be viewed at *http://www.qualitymeasures.ahrq.gov/resources/glossary.aspx*.

[11]See *http://www.docsite.com/solutions/population_management/*.

[12]See generally *www.docsite.com/*. The AMA does not endorse any HIT vendor.

managed care organizations because they offer payers the mix or geographic scope of services that patients want or the payers need to offer. (See Exhibit A for a more detailed description of reasons supporting integration).

The necessity of strategic and business planning

The decision as to whether and how to integrate should be based on an assessment of the relevant market, the capabilities and compatibility of the participants, and the business prospects of the combined entity.

An obvious integration goal is to enable the physician practice either to be the highest quality/best-value producer or to have a significant economic stake in an entity having those same attributes. Factors that will enhance a physician's ability to succeed are:

- collaboration with an integrated network of primary care physicians, specialists, and appropriate allied health personnel;
- ability to access, coordinate, or develop data that demonstrate competitive costs and outcomes;
- retention of organizational flexibility to modify incentives and to respond to regulatory, technical and practice pattern changes; and
- commitment to motivating and supporting the best clinical practices.

Physician groups will also need strong management that can negotiate and analyze managed care contracts. Physician group management should be able to access and develop the kinds of information systems that are required to assume capitated risk or to demonstrate the effectiveness in a fee-for-service system.

The complexity and interdependence of integrated arrangements are likely to result in governance changes. For example, some integrated entities may delegate decision-making responsibilities to professional management—a significant culture change from the typical shareholder governance of most physician groups. The effective allocation and coordination of administrative and clinical decision-making responsibilities will be a major challenge for any integrated organization.

Exhibit A describes some factors that may be considered as part of a strategic planning process. Exhibit B illustrates elements that may serve as part of a business planning process.

The structure of this Guidance

This Guidance is composed of three parts. Part I discusses physician practice mergers (Merger Model). Part II examines financial and clinical collaborative models (collaborative models) through which physicians may integrate their separate practices. Part III contains an analysis of the antitrust issues implicated when physicians utilize a joint venture or competitor collaboration to negotiate fee-related terms with health insurers and other purchasers of physician services.

Those interested in exploring antitrust issues prior to examining the specifics of the merger or collaborative models may wish to proceed immediately to Part III. Physicians should keep in mind, however, that their primary motivation for integrating should be to bring to market a valuable and competitive product that they could not otherwise produce acting independently. Physicians should develop their models and only then determine whether their proposal needs some tweaking or modifications because of the antitrust laws. Physicians should not view the antitrust laws as a bar that prohibits them from creating innovative health care products that enhance quality and lower cost.

Although in some cases this Guidance provides legal information, this Guidance does not provide legal advice. Physicians thinking about embarking on a practice merger or a financial or clinical integration project are strongly encouraged to obtain the advice of private legal counsel experienced in antitrust law and physician-specific legal and reimbursement issues before proceeding.

I. The Merger Model

A. Introduction

The Merger Model is not a new concept. By "merger" this Guidance means the consolidation of separate physician practices into one surviving medical group in which participating physicians have a complete unity of interest. The merged firm controls all of the resources of the combined practices such that none of the participating physicians compete with one another. Physicians have been merging into such firms for many years. For example, the Marshfield Clinic, the Mayo Clinic, the Cleveland Clinic and the Palo Alto Medical Foundation are all examples of