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
March 2008

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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."

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[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

long-standing, successful, fully-merged medical practices.[13] For many physicians, practicing in that environment is ideal, as the continuing growth of such practices through medical group practice hiring and merging attests.[14] Many physicians remain reluctant, however, to consider a practice merger for fear of having to forfeit all of their autonomy and reward for individual productivity.

At the same time, many physicians are realizing that the Merger Model may be a more flexible practice model than they had appreciated. The Merger Model in many cases allows participating physicians to: (1) remain in their local practice settings, (2) oversee many day-to-day practice operations, and (3) be rewarded based on individual productivity. Much of this flexibility is due to new technology that has permitted a level of integration that, in the past, could only be achieved by setting up shop in a single location. Developments in telecommunications, Internet access and functionality, and practice management software now permit firms to function in an integrated manner, even if their physical offices are located all around the country.

B. General requirements for fully-integrated physician practice mergers

1. Creating a single legal entity

Typically, under the Merger Model, the merged independent physician practices create a single legal entity. Any number of legal forms may be used, e.g., a professional corporation, professional association, limited liability corporation or a partnership, although individual state laws may circumscribe legal structure.

For the remainder of this Guidance, the single legal entity is designated the "merged medical practice" (MMP). The physician practices that are merged into the MMP are referred to as "practice divisions" (PDs) in the sense that although the merging physicians will no longer be practicing medicine through their separate pre-merger practices, one can for organizational or conceptual purposes consider them as divisions (or perhaps subsidiaries) of the MMP. It may be possible, for example, for the pre-merger practices to retain a sense of post-merger identity by functioning as PD/profit centers within the MMP. In some circumstances, PDs may also continue to function as holding companies which lease certain PD assets to the MMP. (See I.B.5 below).

2. Each physician practice will generally have to make a capital investment in the single legal entity.

Practices wanting to merge into the MMP must be prepared to make a capital investment in the MMP, e.g., by directly contributing funds or through the assistance of an authorized lender. While it is true that a larger medical group might have sufficient capital and be in the market to purchase assets of smaller practices and employ the formerly independent physicians, this is not the typical scenario. More commonly, small and solo practice physicians come together to create new, larger medical practices. The particular type of investment may again depend on state law. For example, if the MMP is a professional corporation, the PDs would have to purchase MMP shares. The capital investment here may be significant because it must fund all of the following: corporate restructuring; consolidation; the purchase of any necessary operational infrastructure, such as a practice management system; and, depending on projected market demand, the development of ancillary services.

While the capital investment may be substantial, technological advancements may make the integration of practice management systems less expensive than in the past. In many cases, merging practices may be able to integrate their business and information systems using existing hardware, e.g., workstations and servers. Additionally, there are a number of companies that can provide turnkey information services that can include virtually all business systems, e.g., scheduling and practice management software, as well as central business office functions.

3. All PDs must be integrated into, and be subject to, the MMP's governance.

The PDs will transfer all governing authority to the MMP. The MMP will have ultimate governing authority over all of the following: practice assets; liabilities; budgets; compensation; salaries; revenue and cost distribution; the operation of all PD business systems, e.g., billing, collection, accounting, and financial reporting systems; managed care contracting; and general administrative processes and information systems. The MMP will also have ultimate authority over the distribution of PD income and expenses, and

[13]See *www.marshfieldclinic.org/patients/default.aspx* (Marshfield Clinic Web site); *www.mayoclinic.com/* (Mayo Clinic Web site); *www.clevelandclinic.org/* (Cleveland Clinic Web site); and *http://www.pamf.org/* (Palo Alto Medical Foundation Web site).

[14]See e.g., L.P. Casalino, The Growth of Single-Specialty Medical Groups, *Health Affairs* 23, No. 2 (2004): 82-90.

the MMP's tax identification number and provider numbers must replace those of the PDs.

4. The MMP should hold itself out to the public as a single medical practice.

Once the MMP is formed and operational, all PDs will likely promote a new practice name but may link their prior practice affiliation with the group in order to transfer their goodwill to the combined entity and assure patients of equivalent or improved quality. Each individual PD site should be re-designated as an MMP site, under the MMP's new name subject to transitional use of any valuable prior trade name.

5. Leasing arrangements

Each PD may need to reassign any office space and other leases to the MMP. In cases in which a prior physician practice owns medical equipment, furniture or other similar assets, the PD may in some circumstances be able to choose between (1) transferring ownership of those assets to the MMP or (2) functioning as a holding company for those assets and leasing them to the MMP. In some cases, the MMP may want to consider establishing a separate legal entity that holds all practice equipment and other tangible assets that are then leased by the MMP.

6. Consolidation of PD employee benefit plans/ employee transfer

Subject to employee leasing arrangements for certain regions, it may make the most economic sense to consolidate PD employee benefit plans into a single MMP plan. The MMP should employ all PD physicians. Although the MMP can employ all non-medical personnel as well as PD physicians, in some cases the MMP may wish to establish a separate legal entity to employ all non-physicians. In states having strong corporate practice of medicine prohibitions, a separate entity may allow easier buy-in to and buy-out from the MMP for new physicians and may permit ownership by nonphysicians.

7. MMP-controlled billing and collections operations

Before the MMP commences operations, all merging practices must transfer the ultimate authority over their billing and collections operations to the MMP. All PD billings and collections must be performed under the MMP's federal income tax identification number and/or provider numbers. All professional and any ancillary revenue generated by PD physicians or clinical staff will be collected by agents of the MMP, deposited in MMP controlled accounts and owned by the MMP.

Transferring ultimate control and responsibility for PD billing and collections operations does not mean, however, that all billing staff need to be located in the central MMP office. In many cases, efficient and accurate billing and collection activities require a close cooperation and consultation between practicing physicians, health care professionals and billing staff that can only be achieved when those physicians, professionals and staff work side-by-side at the same location. PD practices should expect, however, that they will be required to provide regular billing and collection data to the MMP to ensure adherence to MMP-wide billing and collection policies and compliance with regulatory requirements.

8. Quality-of-care-related functions

Because the development of a cost control and quality improvement infrastructure are essential not only in creating and enhancing efficiencies but also to respond competitively to emerging market demands and public and private value-based reimbursement methodologies, the MMP may need to develop formal group-wide quality improvement programs that mandate PD physician participation. These programs could encompass peer review, utilization review, quality assurance, and the adoption of clinical performance measures and associated benchmarks. Because some MMPs may be comprised of specialty-specific PDs, the development of these quality-of-care-related protocols will probably require significant input and ongoing implementation by relevant PD physicians.

9. The MMP will perform all risk-based and fee-for-service contracting.

The PDs will transfer all authority to negotiate, execute, retain and manage all payer, e.g., health insurer, contracts to the MMP. Each PD should terminate its existing payer agreements, which the MMP will then renegotiate. For fee-for-service contracts, the MMP should develop a single fee schedule. The MMP will negotiate all payer contracts *exclusively*, which means that payers will only be able to contract with the PDs through the MMP.

10. Physicians may continue to practice in their offices.

Under the Merger Model, physicians are able to remain in, and practice at, their own offices. While merger requires the central governance of all practice business functions and operations, it does not require relocation of physician practices to centralized facilities. Although state licensure issues complicate the consolidation of practices located in different states, these practices too may consider using the Merger Model to create a fully-integrated practice.

11. Physicians may retain a significant degree of autonomy over local practice operations.

Although the MMP has overarching, group-wide governing authority, the MMP may delegate significant authority to a PD managing physician, physician group and/or office manager to enable them to oversee the day-to-day clinical and administrative operations of each satellite office. For example, each PD can have its own medical director and/or quality assurance committee to which the MMP may delegate responsibility for oversight of the PD's delivery of medical services. This delegation recognizes that local control of these operations may be preferable to management from a centralized source that may not be familiar with the particular PD's practice environment. It also recognizes that specialty and/or sub-specialty PDs may be in a much better position to monitor and control the quality of specialized medical services than a centralized body of physicians lacking the PD physicians' expertise. The MMP could also delegate day-to-day PD operations, such as patient scheduling, call scheduling and the ordering of practice supplies.

12. The Merger Model allows physicians to be rewarded for individual productivity.

Central to the success of any fully-integrated medical group is finding a compensation model that rewards individual productivity and at the same time promotes overall group performance. Unless the compensation model can achieve a balance between these two goals, it is unlikely that a fully-integrated practice organized under the Merger Model will enjoy the physician practice satisfaction enabling the longevity or stability necessary to deliver projected efficiencies and bring a beneficial consumer product to market. The following describes just a few ways in which compensation can be structured in the Merger Model.

(a) Allocating income and practice expenses

Some physicians may not be aware that there are numerous ways under the Merger Model that the MMP may reward physicians for their individual productivity and many different ways to allocate practice expenses. Although some medical groups may compensate their physicians based on a straight salary or on an equal share of the medical group's net income, these arrangements are not always necessary or appropriate. The following are just a few compensation models that can be used to reward productivity and allocate expenses under the Merger Model:

(i) Paying individual physicians a salary plus a performance bonus;[15]

(ii) Paying the individual physician his or her collections less a pro rata share of collection expenses as a percentage of his/her collections to the group's total collections,[16] less an equal share of fixed overhead costs;

(iii) Paying the individual physician his or her collections less an equal share of fixed overhead expenses less a pro rata share of collection expenses as allocated per (ii) above, less certain expenses that can be directly attributed to the physician.[17]

(iv) The Merger Model also allows the Board of the MMP to delegate control of PD physician revenue, expenses and compensation to the PD. PD physicians will still need to share responsibility for expenses incurred on the corporate level by the MMP.[18] After this

[15]There are many ways to structure this bonus. The bonus could, for example, be based on relative value units or patient encounters.

[16]For example, if, in a three-physician medical group, Physician A earned 50% of the entire practice collections and the other two physicians (Physicians B and C) accounted each for 25%, Physician A would also be allocated 50% of the group's collection expenses, with Physicians B and C each being allocated 25% of the group's collection expenses.

[17]For example, in footnote 19, the physicians would share equally all fixed overhead expenses, e.g., utility bills; Physician A would be allocated 50% of the group's collection expenses, and Physicians A, B, and C would be allocated expenses directly attributable to them, e.g., cell phone usage.

[18]These expenses will include the MMP's start-up costs and expenses incurred on a regular basis, e.g., central administrative costs, billing and collections operations, payment of medical liability insurance, accounting, legal, and other consulting and professional fees.

expense sharing, the MMP may be able allocate and distribute to each PD the remaining expenses and revenue that are directly attributable to the PD's operations.[19] Each PD may then allocate expenses and distribute income to its physicians according to a formula determined by the PD that reflects each individual PD's productivity and efficiency.

There are many other ways in which the Merger Model may structure physician compensation. The main point of highlighting the different compensation methodologies described in (i) through (iv) above is to remove any physician misperception that, by utilizing the Merger Model, physicians cannot be rewarded for their initiative or entrepreneurial spirit.

II. Collaborative integration models

A merger is not for everyone. Some physicians do not want to lose the degree of autonomy required by a merger. Other physicians do not want to contribute all of the financial and human capital needed to make a merger work. Still others may not want the level of risk created whenever a group of individual physicians combine to make a group practice. For these physicians, there is a wide range of collaborative arrangements available. Indeed, the type of collaborative arrangement a group of physicians can adopt is really a function of their creativity and understanding of what patients, employers, health insurers and other payers want.

Some physicians may develop a "joint venture" or a collaboration of actual or potential physician competitors (a "competitor collaboration") offering the advantages of substantial clinical integration and risk sharing to health insurers. Other physicians may simply want to sign a contract with a firm that acts as a messenger communicating offers to health insurers and providing some basic information services. Which of these arrangements makes sense for any individual physician depends on that physician's personal preferences and practice goals. The less integration between otherwise competing physicians, the less they can do collectively in the marketplace under the antitrust laws.

Physicians can choose from an almost infinite range of integration options. From a business perspective, the level of integration a group of physicians should adopt depends on their business goals and the types of services demanded by patients and payers. Whenever actual or potential physician competitors want to collectively negotiate fees with health insurers, they must integrate to a significant degree in order to avoid the prohibition against price-fixing contained in the antitrust laws. Put differently, if physicians do not consider it essential to collectively negotiate their fees, the level of integration they select is a business decision as to the most effective way of structuring their joint venture. However, if physicians want to collectively negotiate and set their fees, they must establish a level of integration that will take their collective action beyond the scope of the rule against price-fixing. The following section will generally describe the integration options that various physician groups have used in the past but without analyzing their antitrust ramifications. The antitrust limitations and concerns are discussed in Part III.

A. Financial integration

1. Introduction

"Financial integration" as used in this paper refers to the collective negotiation of risk-based contracts with health insurers. Typically under these arrangements, individual physicians will enter into a contract with a firm that will collectively negotiate risk-based contracts on behalf of its member physicians. Physicians may create and own the entity negotiating the risk-based contracts, join as members to a preexisting entity or simply sign participating agreements.

Under this type of arrangement, physicians are not integrating their practices as they would in a merger. Instead, physicians are authorizing a separate entity to negotiate risk-based contracts on their behalf. The risk sharing aspect of these agreements is invariably connected to a program of utilization review, practice protocols and quality benchmarks. These utilization review programs, protocols and benchmarks are created because they are essential for making risk-based contracting profitable for the entity negotiating the contracts and the participating physicians. Physicians, therefore, have a strong financial incentive to comply with the established cost and quality control measures. A well-known organizational structure through which physicians have successfully integrated financially is the independent practice association (IPA).

[19]Examples of directly attributable expenses include expenses associated with clinical and administrative support staff located at each PD practice site, the costs of the PD's supplies and PD overhead.

2. What sharing financial risk means

There is no single definition for financial risk sharing. Instead, a wide range of risk sharing methodologies is available to physicians:[20]

(a) Capitation arrangements;

(b) Percentage of premium or revenue compensation arrangements;

(c) The creation of significant financial incentives for participating physicians as a group to achieve specified cost containment goals, such as:

Withholding from all participating physicians a substantial amount of the compensation due them with distribution of that amount to the physician participants only if cost containment goals are met; or

Subjecting participating physicians to substantial financial rewards or penalties based on group performance in meeting overall cost or utilization targets for the network as a whole; and

(d) Global fee or all-inclusive case rate arrangements.

This is not an exhaustive list of risk-sharing arrangements. The Federal Trade Commission and the Department of Justice have recognized, for example, that "new types of risk-sharing arrangements may develop" and that the examples of substantial financial risk sharing previously provided do not "foreclose consideration of other arrangements through which the participants in a physician network joint venture may share substantial financial risk...."[21] Accordingly, physicians can explore new methods of sharing substantial financial risk in order to "ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."[22] There are virtually unlimited opportunities for structuring creative risk-sharing arrangements that capitalize on physician expertise and commitment, as evidenced by the wide variety of gain-sharing arrangements in which physician groups successfully reduce hospitalization, worker absenteeism or emergency department use.

3. Benefits and drawbacks of financial risk sharing

Financial risk sharing arrangements have various benefits. First, they are well-recognized and understood by employers and health insurers. Accordingly, they are potentially easier to market than more novel methods of integration. Second, physicians sometimes have considerable discretion concerning the extent to which they enter into risk contracts. For example, although a physician may be contracted with a health maintenance organization (HMO) to receive capitated payments, the HMO contract may represent only a small portion of the physician's payer mix, which otherwise could consist primarily of fee-for-service contracts that lack any risk-sharing elements. Physicians may, therefore, be able to control to some extent the level of risk they assume and the impact risk contracting will have on their practice. Third, risk-sharing physician contracts contain terminology that is by now familiar to many physicians.

Financial risk sharing, however, has some drawbacks. First, a physician will have to keep track of the patients that are covered by the risk-sharing arrangement and have the capability of applying the cost-saving measures and utilization controls to those patients. Second, if many of the physicians involved in the risk-sharing arrangement do not follow the cost-saving measures and utilization protocols, a real risk exists that the negotiating entity will fail, and the participating physicians will lose money on the arrangement. This is a risk that even the physicians that fully comply with the cost-saving measures and utilization protocols would face.

B. Clinical Integration

1. Introduction: overview of clinical integration

In a nutshell, clinical integration arises when a group of physicians puts in place a series of procedures that modify the manner in which they provide health care services to patients and communicate with one

[20]These examples are taken from Statements of Antitrust Enforcement Policy in Health Care ("Health Care Guidelines") that were jointly issued by the Department of Justice and the Federal Trade Commission in 1996. The Statements can be viewed at *www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf*.

[21]Id. at 86-87.

[22]Id. at 88.

another. Clinical integration arrangements may offer the most efficiency in multi-specialty settings in which primary care physicians coordinate patient care with specialists and the various specialists coordinate care among themselves, and in single specialty settings in which, through closer collaboration, the group is able to provide care more efficiently. As stated by the FTC, a clinically integrated physician network creates "a degree of interaction and interdependence among the physician participants in their provision of medical services, in order to achieve jointly cost efficiencies and quality improvements in providing those services, both individually and as a group."[23]

Physicians can combine clinical integration with financial risk sharing, but this is not always necessary or appropriate. As with financial risk sharing, physicians are free to choose any level of clinical integration if they do not collectively negotiate fee-for-service contracts. If physicians want to collectively negotiate fee-for-service contracts, they will have to create a network with a significant level of clinical integration. The antitrust analysis for clinical integration models is contained in Part III below.

2. Basic elements of a clinically integrated network

There is not much written concerning pure clinical integration models. This should not be a significant impediment to creating a clinical integration template because the basic elements of a clinical integration arrangement are commonly known in the market. Further, at least three FTC advisory letters have set forth the details of some clinically integrated networks. (This paper will subsequently refer to these opinions and correspondence as "Agency guidance").[24] In 2007 alone, the FTC issued a favorable advisory opinion to the Greater Rochester Independent Practice Association (GRIPA) concerning its proposed clinical integration program and favorable follow-up correspondence to MedSouth regarding its program.[25] The importance of this Agency guidance from an antitrust perspective is addressed in Part III below. The following description of the elements of a clinically integrated network is derived primarily from Agency guidance. This Agency guidance describes steps actually taken by some physicians to clinically integrate their practices.

Overall, clinical integration involves "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[26] Some of the basic elements include: (1) mechanisms that control utilization and establish quality benchmarks; (2) practice protocols that are designed to improve care; (3) information databases and sharing treatment information in order to streamline care and lower costs; (4) selectively choosing physicians that will actively participate in the operation of the clinically integrated network, follow the practice protocols and work towards achieving the quality benchmarks; and (5) investment of the financial capital needed to create necessary infrastructure.

(a) Electronic health records and HIT generally

An effective clinical integration program will almost certainly have an integrated HIT system, which may include, but is not limited to, e-prescribing and electronic health records. A robust HIT system allows physicians to share clinical information concerning their common patients and enables physicians to collaborate in and coordinate patient care by providing immediate access to clinical and outpatient data.[27] Consequently, an integrated HIT system

[23]Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition, Federal Trade Commission, to John J. Miles, (MedSouth, Inc.) (June 18, 2007) (MedSouth II) at 2, located at *www.ftc.gov/bc/adops/070618medsouth.pdf*.

[24]Letter from Jeffrey W. Brennan, Assistant Director, Health Care Services & Products Division, Bureau of Competition, Federal Trade Commission, to John J. Miles, (MedSouth, Inc.) (February 19, 2002) (MedSouth Advisory Opinion) at *www.ftc.gov/opa/2002/02/medsouth.shtm*; Letter from David R. Pender, Acting Assistant Director, Health Care Services & Products Division, Bureau of Competition, Federal Trade Commission, to Richard A. Feinstein, (California Pacific Medical Group, Inc.) (April 5, 2005) (Brown and Toland correspondence) at *http://www.brownandtoland.com/publish/en/about/news_room/-ftc_information.-Par-0005-DownloadFile.tmp/4.5.05FTCNotice.pdf*; Letter from David R. Pender, Acting Assistant Director, Health Care Services & Products Division, Bureau of Competition, Federal Trade Commission, to Clifton E. Johnson and William H. Thompson, (Suburban Health Organization) (March 28, 2006) (SHO Advisory Opinion) at *www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaff-AdvisoryOpinion03282006.pdf*; Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition, Federal Trade Commission, to John J. Miles, (MedSouth, Inc.) (June 18, 2007) (MedSouth II) at *www.ftc.gov/bc/adops/070618medsouth.pdf*; Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition, Federal Trade Commission, to Christi J. Braun and John J. Miles, (Greater Rochester Independent Practice Association Inc.) (September 17, 2007) page 5, note 14 (GRIPA Advisory Opinion) located at *www.ftc.gov/os/closings/staff/070921finalgripamcd.pdf*.

[25]GRIPA Advisory Opinion; MedSouth II.

[26]Health Care Guidelines at 91.

[27]See e.g., MedSouth Advisory Opinion at 4; GRIPA Advisory Opinion at 5; Brown & Toland Medical Group's Second Follow-Up PPO Submission at 1 located at *www.ftc.gov/os/adjpro/d9306/index.shtm*.

is typically essential for creating a high degree of interdependence and cooperation between physicians in the network. The network should endeavor to capture as much information as practicable concerning the care provided to network patients.

Physicians may also achieve remarkable results using patient registry systems. A patient registry can generate significant practice efficiencies and therefore lower costs and improve care. Accordingly, physicians may want to use a patient registry as an initial step toward a complete transition to an integrated HIT system. The initial use of a patient registry may be particularly attractive to physicians who have not obtained sufficient capital to fund HIT implementation or who want to adopt a wait-and-see attitude concerning the success of the network.

(i) Acquiring and implementing HIT systems: financial and human capital

Acquiring and implementing an HIT system can entail a significant financial investment. One study examining the electronic health record (EHR) acquisition costs of solo and small group practices concluded, "Initial EHR costs were approximately $44,000 per FTE provider per year, and ongoing costs were about $8,500 per FTE provider per year."[28] These costs may be prohibitive for many solo and small group practices acting individually. Nevertheless, solo and small group practices may, by combining to form a clinical integrated network, create economies of scale sufficient to purchase an effective HIT system. For example, GRIPA estimated its costs to implement a Web-based clinical information management system at $7,000 per physician and estimated hardware costs at $6,000-$7,000 per physician office.[29] Although another large IPA, Brown & Toland, estimated that implementing and managing an electronic Internet-based medical records system would cost $12 million over a ten-year period, this cost was presumably allocated over the 700 physicians that would be utilizing the system.[30] Additionally, recent regulatory guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services, the Center for Medicare and Medicaid Services, and the Internal Revenue Service now enables some third parties greater flexibility to subsidize physicians' purchase of HIT.[31]

Implementing an HIT system may also necessitate a significant contribution of human capital. Physicians and their office staff will be required to devote time to training on clinical integration program requirements and on the HIT system. GRIPA estimated that the dollar value of lost patient revenue due to time spent on such training was $3,200 per physician.[32]

(ii) Utilization of the HIT system

Based on Agency guidance, it may be useful for the network to require all participating physicians to utilize the HIT system. More specifically, the network could mandate, as a condition of initial and continuing participation, that all network physicians undergo training on HIT system use and appropriately utilize the system on an ongoing basis. To ensure required utilization, the network may want to have a mechanism in place to: (1) monitor individual physician HIT use; and (2) generate regular performance reports based in part on whether or not the physician appropriately utilized the HIT system as instructed.[33]

(b) Development of clinical performance measures and associated benchmarks

(i) The development of clinical quality and efficiency measures/reporting

[28]R.H. Miller et al., "The Value of Electronic Health Records in Solo or Small Group Practices," *Health Affairs* 24, No. 5 (2005): 1127-1137, at 1130.

[29]GRIPA Advisory Opinion at 14-15.

[30]Brown & Toland Medical Group's PPO Submission at 1, located at *www.ftc.gov/os/adjpro/d9306/-index.shtm*.

[31]See *http://oig.hhs.gov/authorities/docs/06/OIG%20E-Prescribing%20Final%20Rule%20080806.pdf* (describing new safe harbors to the federal antikickback statute for e-prescribing and electronic health records); *http://frwebgate3.access.gpo.gov/cgibin/waisgate.cgi?WAISdocID=64425227342+0+0+0&WAISaction=retrieve* (establishing new exceptions from the Stark statute for e-prescribing and electronic health records); *http://www.irs.gov/pub/irs-tege/ehrdirective.pdf*; *http://www.irs.gov/pub/irs-tege/ehr_qa_062007.pdf* (allowing nonprofit hospitals to donate electronic health records systems without violating otherwise applicable federal tax law requirements and IRS regulations).

[32]GRIPA Advisory Opinion at 15.

[33]GRIPA Advisory Opinion at 7.