



Strengthen your practice:

How to collaborate with peers and other practices

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Preface

Produced by the American Medical Association, **“Strengthen your practice: How to collaborate with peers and other practices”*** provides a practical and pragmatic overview of the integration options available to physicians—from initial steps that physicians can take to start collaborating with other physicians and health care providers, to practice mergers. While acknowledging that many of its members may want to continue practicing independently, the AMA also recognizes that some form of physician collaboration may be one of the best means through which physicians may take advantage of opportunities and proactively face challenges both resulting from, and independent of, the Affordable Care Act (ACA).

“Strengthen your practice” discusses a range of collaboration options that address the desire of many physicians to retain some level of autonomy while at the same time acknowledging the realities of today’s marketplace. To help physicians choose for themselves a level of collaboration that makes sense given their specific goals, the AMA identifies many of the benefits and limitations of several collaboration arrangements in this resource.

The AMA also recognizes that physician collaboration efforts sometimes raise antitrust issues. For example, antitrust issues arise when physicians seek to jointly negotiate fee arrangements with health insurers. This resource identifies the relevant antitrust concerns when physicians seek to jointly negotiate fees and describes the current state of the law on the subject. This resource is not, however, designed to provide an antitrust opinion on any specific physician network or specific physician joint venture. Instead it is intended to point out possible antitrust pitfalls and describe generally the types of arrangements that are acceptable under the antitrust laws, as those laws are currently interpreted.

*This resource was formerly titled, “Competing in the marketplace: How physicians may increase their value through medical practice integration,” third edition.

I. Introduction

A. Why collaborate?

The market and regulatory environment that physicians practice within is undergoing rapid and dramatic change. This change is motivating many physicians to explore the potential benefits of practice collaboration. There are a number of motivations driving physicians towards greater collaboration and mutual interdependence.

One motivation is the need to develop economies of scale and raise capital sufficient to acquire and implement health information technology (health IT), such as electronic health records (EHR), data collection and analytics software, etc., to maximize practice efficiency, or to fund permissible investments in ancillary service lines, or care coordination and disease management outreach services associated with collaborative efforts to improve quality or manage patient health such as accountable care organizations (ACOs) or patient centered medical homes.

A second motivation is the desire to improve quality and efficiency, as closer integration among physicians becomes more essential to creating the collaborative environment needed to make significant improvements in quality and cost-effectiveness. 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 and cost-effectiveness results and may ultimately be unable to compete in the changing health care market.

A third motivation arises from health insurers’, employers’ and consumers’ demands for data demonstrating physician performance upon which to base informed health care purchases. This information can be based on a number of factors, including adherence to quality measures, patient satisfaction survey results and, increasingly, assessments of the cost of care, e.g., efficiency and/or total-cost-of-care measures. Health insurers are now ranking physicians based on performance results and disseminating this information to the public as an aid to physician selection. Insurers are also using these ranking systems to tier physicians or determine participation in *narrow networks*. 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 ranking or other performance-related designations imposed on them by third-parties.

A fourth motivation is the need to adapt to, and take advantage of, opportunities to participate in performance-based reimbursement programs sponsored by health insurers, state and federal governments, and other payers. These programs include, but are not limited to, pay-for-performance, shared savings, capitated and bundled payment arrangements.

Finally, in some cases physicians who are sufficiently integrated may want to explore the possibility of jointly contracting with health insurers. Although physicians should not pursue collaboration as merely a means to joint contracting, the ability to jointly contract may be very desirable to physicians in highly concentrated health insurance markets.

The American Medical Association has developed this guidance (Guidance) to apprise its members of the lawful ways in which they may successfully integrate with other independent, and sometimes competing, physician practices in order to respond proactively to the changing practice environment and, in some cases, bargain collectively with health insurers and other third-party payers. This Guidance covers a number of collaborative options available to physicians, including 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.

Physicians should keep in mind, however, that their primary motivation for collaborating 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.

The AMA continues to advocate through all legally appropriate channels to maximize physicians' ability to integrate creatively in response to the needs of their

local markets without concerns about potential antitrust liability chilling those innovative efforts. For further information regarding this Guidance or other AMA antitrust activities, please contact Wes Cleveland at wes.cleveland@ama-assn.org, or Henry Allen at henry.allen@ama-assn.org, or call the American Medical Association at (312) 464-5000.

Physicians in solo or small group practice may think it is prohibitively expensive and time consuming to adapt to and/or take advantage of recent market and reimbursement changes. This is not necessarily true. Many physicians may simply be unaware of the flexibility permitted by the numerous lawful integrative 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 to amass the capital sufficient to acquire and implement health IT 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 increased collaboration among physicians that already have cooperative call, consultation and referral relationships.

B. 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

- 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 enter into other performance-based payment systems, or even to demonstrate 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.

[Appendix A](#) describes some factors that may be considered as part of a strategic planning process. [Appendix B](#) illustrates elements that may serve as part of a business planning process.

II. The merger model

A. Overview

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 such an environment is ideal. 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 also 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 staffing decisions, 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. While the merger model may be an attractive option for some physicians, the overriding strategic issues that will likely determine whether merger is the most desirable means of integration will depend on the local market conditions where the physicians practice. These conditions will of course include the presence of other health care providers or provider organizations in that market, including but not limited to: large integrated systems, hospital foundation groups, independent practice associations, and hospitals and hospital systems.

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, partnership of professional corporations, 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 that 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. The capital may be contributed in the form of cash, personal property (equipment), real property (leaseholds/leasehold improvements), and intangible property (accounts receivable). In addition, a portion of the investment can be funded through group borrowing depending on the practice's credit-worthiness and tolerance for leverage.

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 the MMP's tax identification number and provider numbers must replace those of the PDs. Typically the compensation plan fundamentals and any cost allocation formulas are approved as part of the merger transaction and can only be modified by a super majority vote.

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 and group provider number subject to transitional use of any valuable prior trade name.

5. Leasing arrangements

Each PD may need to assign or sublease 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.

There are a number of options along a continuum of medical group integration that may be available to physicians in their specific markets. These options may include, but not be limited to, the creation of a management services organization that is wholly owned by PD physicians that can manage PD operations, or creating a physician-owned accountable care organization that can contract with hospitals and other lay institutional providers. In many markets there may be myriad options, and discussions of all the possibilities are beyond the scope of this Guidance. Visit the AMA website (ama-assn.org/practice-management/understanding-accountable-care-organizations-aco) for more information. Physicians who are exploring the options available to them in their particular markets should consult local, experienced health care legal counsel.

6. Employee transfer and consolidation of employee benefit plans

The MMP should ultimately employ all former PD physician and non-physician personnel and all former PD employee benefit plans should be consolidated. However, during the first year after the merger, in some cases physicians may be able to remain employees of their pre-merger medical practices. During this one-year period a disengagement agreement (sometimes referred to as a "prenuptial agreement") could apply that would allow medical practices to withdrawal from the merged entity should relationships between one or more of the

practices and the merged entity become problematic. Disengagement agreements typically also address such key issues as the return of practice assets to the medical practice by the merged entity, and patient notification. After the one-year period has expired, however, such disengagement agreements would no longer be applicable and withdrawal or separation from the merged entity will likely be much more difficult.

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 needs 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. However, PD practices should expect 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 to creating and enhancing efficiencies but also to responding 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 performance measures and associated benchmarks. Because some MMPs may be composed 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 payers, 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 office hours, patient scheduling, call scheduling, local staffing and scheduling, the extent of PD's use of physician assistants and nurse extenders, 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.
- (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, 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.
- (iv) Physician bonus models as to certain ancillary service revenues must be structured to fall in within an appropriate Stark Act exception and generally are reviewed by the MMP's counsel.

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. After this 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. 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. Also, each direct expense attributable to the PD's individual physicians, e.g., continuing medical education, professional dues, etc. are subtracted from the physician's pool of dollars.

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 adopting the merger model, physicians cannot be rewarded for their initiative or entrepreneurial spirit. Further information concerning how physician compensation may be structured is discussed in the AMA's "Annotated Model Physician Employment Agreement," which can be accessed at ama-assn.org/life-career/understanding-employment-contracts.

III. 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 (i.e., a *competitor collaboration model*) 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. These integration options and their antitrust ramifications are discussed below in section IV.

IV. Antitrust issues

A. The Sherman Act and the Clayton Act: A general overview

The antitrust laws are built upon a number of federal laws that prohibit a wide range of anticompetitive conduct. While these laws are expressed in very general terms, they are supplemented by a significant body of case law and by actions taken by the federal agencies responsible for the public enforcement of the antitrust laws. In the case of physician mergers and integration efforts, the primary antitrust laws that physicians must consider are Section 1 of the Sherman Act and Section 7 of the Clayton Act.¹

1. Section 7 of the Clayton Act

Section 7 of the Clayton Act (Section 7) prohibits mergers that may substantially lessen competition. An analysis under Section 7 asks whether a merger will result in such a concentration of economic power in the hands of the merged entity that the new entity could exert *market power*. “Market power” is commonly understood to mean the ability by a firm to raise price above the competitive level or to reduce output below the competitive level.

Case law and the federal antitrust enforcement agencies recognize that it is difficult, if not impossible, in most situations to directly measure market power. Given this practical difficulty, market power is typically evaluated indirectly. This indirect evaluation requires identification of the markets in which the merged entity operates.

Then, the merged entity’s share of those markets is calculated. With respect to physician practices, market share is commonly calculated by comparing the number of physicians in any given specialty working for the merged entity with the total number of physicians in those specialties who are located in the relevant geographic market. The market share of the merged entity is used as a proxy for market power. How high a market share is needed to create a presumption of market power is a complex issue that depends on many different factors. (The issue of market power and its relation to market share is addressed below in section IV., D.)

2. Section 1 of the Sherman Act

Section 1 of the Sherman Act prohibits concerted conduct between individual competitors that unreasonably restrains trade. The first and most basic question in any Section 1 analysis is whether the conduct is concerted (i.e., contracts, combinations or conspiracies) or unilateral. Without this distinction, Section 1 would conceivably outlaw every corporation, partnership and independent firm that assembles employees that could have competed against one another. The antitrust laws recognize that the marshalling of economic resources and actors is oftentimes essential to the efficient provision of goods and services. For example, Boeing Corporation hires engineers who could theoretically compete against one another and against Boeing Corporation, and to that extent Boeing is a combination of numerous competitors. It is absurd to think, however, that Boeing Corporation violates Section 1 of the Sherman Act when it sets its own prices and decides how much to produce. Similarly, as a single entity, a joint venture (comprised of physician practices), like any other firm, must be free to determine the prices of the services it sells.²

The antitrust laws do not have special rules for physicians. Physicians can lawfully create firms by merging their practices. *If physicians properly merge their practices, they will not violate Section 1 when this new merged firm sets prices on behalf of the firm’s physicians.*

If otherwise competing physician practices engage in any collaborative activity short of a full merger to sell their services or to pursue other objectives such as forming and operating a physician network that contracts with health plans, then the antitrust inquiry becomes whether this concerted conduct unreasonably restrains trade. The word “unreasonable” is critical because the courts recognized shortly after the enactment of the

1. There are other antitrust laws that may have relevance to the creation and subsequent operation of a merged entity and integrated physician network. This Guidance is not intended to provide a comprehensive analysis of all of the antitrust laws or all of the antitrust ramifications that are raised by the creation and operation of a merged entity or integrated physician network.

2. *Texaco Inc. v. Dagher*, 547 U.S. 1, 8 (2006).

Sherman Act that some level of cooperation between competitors is oftentimes essential to consumer welfare. Generally speaking the antitrust laws only condemn those restraints that injure consumers.³ The U. S. Supreme Court has explained that the proper focus of antitrust inquiry is “whether the effect . . . of the practice is to threaten the proper operation of our predominantly free market economy—that is, whether the practice facially appears to be one that would . . . tend to restrict competition and decrease output, and in what portion of the market, or instead one designed to ‘increase economic efficiency and render markets more rather than less competitive.’”⁴

Arrangements between competitors can enhance efficiency and benefit consumers. The struggle with respect to the enforcement of the antitrust laws is distinguishing concerted conduct that benefits consumers by creating efficiencies and is procompetitive from concerted conduct that harms consumer welfare and is therefore anticompetitive.

a. *The per se test*

As the antitrust laws evolved, the courts created two basic tests for distinguishing procompetitive conducts from anticompetitive conducts. One test is the application of the so-called *per se* prohibitions. The *per se* prohibitions are based on the belief that certain types of behaviors are so blatantly anticompetitive that any consideration into their possible procompetitive effects is unnecessary. Accordingly, an arrangement falling under a *per se* prohibition is condemned as “unreasonable” without conducting any analysis into whether the concerted conduct actually has any effect (positive or negative) on competition or consumers. The traditional *per se* offences include price fixing, market allocation agreements, customer allocation agreements, certain group boycotts and some tying arrangements. With respect to *per se* unlawful price fixing, for example, the only issue is whether a price fixing agreement exists. Whether the price fixing arrangement can benefit consumers or creates efficiencies is *not* a question a court or an enforcement agency will consider. Relatedly, a court will *not* determine if the price fixing agreement actually harmed consumers.

A benefit provided by the use of *per se* prohibitions is that the *per se* prohibitions define with a high degree of clarity the types of concerted conduct in which competitors cannot engage. This clarity,

however, comes with some costs. For example, *per se* prohibitions may outlaw arrangements that are procompetitive and will benefit consumers.

b. *The rule of reason test*

The second test is the so-called rule of reason. Under the traditional rule of reason test, a court was required to determine whether the restraint was, on balance, anticompetitive. Thus, a court needed to determine whether the concerted conduct was anticompetitive and then determine whether procompetitive benefits also existed. Many types of concerted activity were lawful under the rule of reason because a threshold showing for any liability was the existence of market power. This reflects the recognition by the courts that firms or individuals engaged in concerted conduct could not harm competition if they lacked market power. Put differently, without market power the concerted conduct could not harm consumers by harming competition.

This traditional dichotomy between the *per se* rule and rule of reason underwent considerable modification over the last 20 years. Driving this change was the recognition that a broad interpretation of the *per se* prohibitions would prevent the development of many collaborative undertakings that could create significant benefits for consumers and actually make markets more competitive. This did not mean, for example, that blatant or *naked* price fixing arrangements were thought to have procompetitive possibilities. What was recognized is that an otherwise lawful joint venture or collaborative undertaking may need a price fixing component in order to operate efficiently. Condemning the price fixing component without giving any thought to the efficiencies the venture or collaboration could create would prevent the realization of those efficiencies and stands the antitrust laws on their head. This concern has resulted in the steady erosion of the *per se* prohibitions and their limitation to the most blatant types of anticompetitive conduct. The result is that concerted conduct that was once considered *per se* unlawful is now analyzed under the rule of reason.

These changes, however, have also changed the rule of reason. Today, the first question under the rule of reason is whether the arrangement raises obvious antitrust concerns or has a component that raises an obvious antitrust concern. A good rule of thumb is that a form of concerted conduct similar to an

3. See *e.g.*, *Reiter v. Sonotone Corp.*, 442 U.S. 330 (1979).

4. *Broadcast Music Inc. v. Columbia Broadcasting Systems, Inc. (ASCAP)*, 441 U.S. 1, 19-20 (1979).

arrangement that traditionally fell under a *per se* prohibition will raise antitrust concerns. For example, a joint venture between a group of physicians that, among many other things, negotiates prices with payers for its members will raise an antitrust issue. The joint negotiation of fees embedded in the arrangement is a form of price fixing. If the arrangement does raise a price fixing concern, the issue becomes whether the participants can show that the venture has real and substantial procompetitive benefits. They must also show that the price fixing component is *reasonably related* to the procompetitive benefits and *reasonably necessary* to the realization of these procompetitive benefits. Suspect arrangements that are not tied in this manner to a procompetitive efficiency are considered unlawful. When this connection does exist, the analysis will look to whether the arrangement gives market power to the participants in the collaborative activity. A collaborative endeavor that gives its participants the ability to exert market power will raise serious antitrust risks. Without market power, however, it is unlikely that the arrangement could harm competition or consumers, and is therefore unlikely to raise antitrust problems.

3. The enforcement of the antitrust laws

The single largest source of antitrust enforcement comes from the private sector. The antitrust laws authorize the commencement of private lawsuits for antitrust violations by those persons or entities injured by the unlawful conduct. To give added incentives for private antitrust lawsuits, a successful antitrust plaintiff is entitled to treble damages and the payment of its attorneys' fees by the defendant(s). Private parties also are oftentimes responsible for reporting possible antitrust violations to the federal enforcement agencies.

The Federal Trade Commission (FTC) and the Antitrust Division of the United States Department of Justice (DOJ) (collectively referred to as the "Agencies"), also play a significant role in the enforcement of the antitrust laws. The Agencies have the ability to investigate possible antitrust violations and commence enforcement proceedings. The DOJ can also criminally prosecute blatant *per se* violations of Section 1 of the Sherman Act. The FTC and DOJ, however, do much more than investigate antitrust violations and commence lawsuits. These Agencies provide advisory letters to firms concerned about the

possible antitrust ramifications of a proposed collaborative arrangement. These advisory letters are published and provide insight into how the Agencies will evaluate various arrangements. These advisory letters, however, are not binding on a court and therefore have limited value when defending a civil lawsuit. The FTC and DOJ Antitrust Division have also issued various guidelines explaining how they will apply the antitrust laws in various settings. The most important guidelines for physicians are the Statements of Antitrust Enforcement Policy in Health Care (the "Statements"),⁵ the FTC/DOJ Statement of Antitrust Policy Enforcement regarding Accountable Care Organizations ("Statement on ACOs")⁶ and the Antitrust Guidelines for Collaborations Among Competitors (1999) ("Collaboration Guidelines"). Finally, the FTC and DOJ Antitrust Division publish speeches given by their top personnel that provide some additional guidance as to how certain arrangements are viewed.

B. Physician collaborative arrangements

When independent physicians pool resources in order to engage in a common endeavor and the physicians are actual or potential competitors, they are engaged in what may be characterized as a *competitor collaboration* or *joint venture*. Such joint ventures may involve the formation of a new legal entity or simply be a contractual arrangement for pooling resources, sharing risks and/or clinically integrating their professional activities. Such collaborative arrangements are subject to review under Section 1 of the Sherman Act, as well as Section 7 of the Clayton Act (under certain circumstances). If these collaborating physicians want to collectively negotiate fees with health plans through the venture, a significant price fixing issue is raised.

In order to avoid liability under Section 1 of the Sherman Act for price fixing, the threshold issue is whether the physician competitors have sufficiently integrated their economic resources and whether the price fixing component to their venture is reasonably related and reasonably necessary to the creation of the efficiencies promised by the venture.

Simply characterizing a new legal entity composed of potential or actual physician competitors as a joint venture will not save it from condemnation, if it does not provide the appropriate efficiencies. A good example can be found in the FTC enforcement action of *In the Matter*

5. See Dep't of Justice & Fed. Trade Comm'n., Statements of Antitrust Enforcement Policy in Health Care, Statement 8 (Aug. 1996), available at <http://www.justice.gov/atr/public/guidelines/0000.htm> [hereinafter, "Statements"].

6. Federal Trade Commission, Department of Justice Issue Final Statement of Antitrust Policy Enforcement Regarding Accountable Care Organizations, Fed. Trade Comm'n. (Oct. 20, 2011), available at <http://www.ftc.gov/news-events/press-releases/2011/10/federal-trade-commission-department-justice-issue-final-statement>.

of *Surgical Specialists of Yakima, P.L.L.C. (SSY)*.⁷ In this action competing physician practices created a legally separate and distinct limited liability corporation. The FTC alleged that while SSY was characterized as an *integrated* single entity, the physician practices members of SSY: (1) were separate and independent from SSY in all material respects, (2) were not subject to the control of SSY, (3) did not unify their economic interests and incentives through SSY, and (4) were not significantly integrated (either clinically or financially). The FTC accused SSY of fixing prices for its members by jointly negotiating non-risk contracts, because SSY's negotiating fees on behalf of its members constituted the combined action of those members and not unilateral action by SSY.

Many independent practice associations (IPAs) composed of a network of otherwise competing physicians become joint ventures (physician network joint ventures) by doing much more than simply negotiate contracts for their physicians. They may engage in significant risk sharing or create clinical programs designed to improve the level of care they provide. Such efforts vary considerably, and the relevant antitrust question is whether these integration efforts make the joint negotiation of fees reasonable under Section 1 of the Sherman Act. As discussed below and consistent with the antitrust laws being a "consumer welfare prescription," the antitrust inquiry must determine whether these efforts are likely to achieve significant efficiencies.

1. The messenger model

Physicians are interested in negotiating favorable pricing terms with health insurers or other payers. However, when competing physicians try to collectively negotiate price, they confront the rule against price fixing. Two traditional ways for physician groups to overcome the rule against price fixing have been to employ a pure *messenger model* or to financially integrate.

The messenger model is described in the Statements.⁸ The messenger model allows independent physicians to jointly market themselves as a network. In contrast to a joint negotiation, the messenger model is a process whereby physicians use a common messenger to convey information on fees and fee-related terms that an individual physician is willing to accept. This is done by having a messenger manage a process whereby each of the physicians in the network arrives at individual agreements with the payer. It is not a process for joint negotiations of fees.

In the messenger model process, each physician (or physician group) independently communicates to the messenger the fee range the physician is willing to accept. The messenger then aggregates the information obtained from each physician. The messenger generally develops a schedule that shows the percentage of physicians would accept offers at various fee levels. However, the messenger may not share this information with any of the physicians.

After aggregating the data the messenger presents the schedule to payers. Any payer may then make an offer to the physicians in the network. The messenger may accept the offer on behalf of any physician who has given the messenger authority to accept offers within the fee range specified by the physician. The messenger must forward any offer that is not within the fee range authorized by a physician to that physician for acceptance or rejection. After establishing whether a physician will accept the offer, the messenger then communicates the physician's decision to the payer.

The messenger may not engage in any negotiations with the payer on behalf of physicians involved in the messenger model process. The messenger may not advise physicians concerning whether to accept the offer or not. Independent physicians utilizing the messenger model process may not communicate with each other about whether to accept a given offer or not. The messenger may also not, directly or indirectly, lead or facilitate a boycott of a payer that is designed to influence the terms of the payer's offer. In short, the messenger model process does not allow self-employed physicians the ability to collectively negotiate fees with health plans or otherwise agree on what fee schedule they collectively will accept. (The messenger may, however, provide objective information to physicians in the network about a contract offer made by a payer, such as the meaning of terms and how the offer compares to offers made by other payers.)

Physicians using the messenger model process should ensure that the process comports with the requirements specified in the Statements and other sources of Agency guidance concerning the messenger model process. The Agencies consistently assert allegations of price fixing and other antitrust violations against alleged misuse of the messenger model process.⁹

7. See In the Matter of Surgical Specialists of Yakima, P.L.L.C.; Cascade Surgical Partners, Inc., P.S.; and Yakima Surgical Associates, Inc., P.S., Docket No. C-4101, Fed. Trade Comm'n., <http://www.ftc.gov/os/caselist/0210242.shtm> (last updated Nov. 18, 2003).

8. See Statements, *supra* note 11, at 125-7.

9. See *e.g.*, In the Matter of Health Care Alliance of Laredo, L.C., Docket No. C-4158, Fed. Trade Comm'n., available at <http://www.ftc.gov/enforcement/cases-proceedings/0410097/health-care-alliance-laredo-lc-matter> (last updated Mar. 28, 2006) (where a Texas IPA entered into a consent agreement with the FTC pursuant to FTC allegations that the IPA improperly used a messenger model to negotiate physician contracts).

2. Financial integration

When otherwise competing physicians financially integrate, there are associated efficiencies that can benefit consumers. Recognizing this consumer benefit, the anti-trust laws allow physicians engaging in a proper level of financial integration to jointly negotiate fees without violating the rule against price fixing. The Statements emphasize that the common feature underlying financial integration is the sharing of substantial financial risk. It is believed that this risk sharing provides strong incentives for physicians to practice efficiently by cooperating in the controlling of costs and in improving quality.¹⁰ The sharing of financial risk also makes it necessary for the physicians sharing the risks to jointly negotiate the fees they received under the risk-based contracts.

It is critical that IPAs recognize that their sharing risk with respect to risk-based contracts may not justify the joint negotiation of any non-risk contracts that the IPA may also wish to enter. On the other hand, the Statements contain an example of an IPA network whose capitated arrangements produced significant efficiencies that carried over to the fee-for-service business and that justified rule of reason treatment to the IPA's non-risk contracting. That carryover exists, reasons the Agencies in their example, where (i) the IPAs procedures for managing the provision of care under the capitation contracts and its related fee schedules produced significant efficiencies, and (ii) the same procedures and fees are used for the fee-for-service contracts and result in similar utilization patterns.¹¹

There are many ways in which physician practices can financially integrate that will place the joint negotiation of fees into the rule of reason and then allow them to demonstrate that the joint negotiation of fees is reasonable. The Statements provide a nonexclusive list of the assorted arrangements that constitute *risk sharing*. These arrangements include: (1) capitated rate arrangements in the health insurer or other payer pays the network a fixed “predetermined payment per covered life . . . in exchange for the joint venture’s (not merely an individual physician’s) providing and guaranteeing provision of a defined set of covered services . . .,” and (2) risk pools, which are described as the “withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of the amount to the physician participants based on group

performance in meeting the cost-containment goals of the network as a whole . . .”¹²

A capitated payment arrangement creates risk for the network and its physicians because the network must provide the covered services for a fixed rate. If the network does not institute utilization controls and treatment protocols designed to keep costs down, the network and the participating physicians will lose money. This provides strong incentives for the network to institute and for the physicians to follow such controls and protocols. This will have the potential of lowering prices and make the network more competitive.

Risk pools are another common method used by physician networks to create financial risks and rewards that have the benefit of increasing efficiency. If the physician network withholds a significant portion of the funds received under fee-for-service arrangements and pays its participating physicians a discounted fee, the potential distribution of withheld funds creates an incentive to follow efficiency protocols created by the network. No magic number exists for the size of the risk pool. FTC advisory letters suggest that a 15 percent withhold may not be sufficient¹³ to justify the joint negotiation of contracts, while a pool within a 15–20 percent range might be sufficient.¹⁴ The size of the necessary withhold depends on the nature of the venture and its importance to the participating physicians. For example, the size of the necessary withhold can depend on the number of patients the participating physicians expect to receive under the contract subject to the risk pool.

Other potential sources of substantial risk sharing recognized in the Statements may include a global fee or all-inclusive case rate arrangements.¹⁵ Under these arrangements, the joint venture has to put in place mechanisms that ensure its costs per patient do not exceed the global fee. The joint venture assumes the risk with respect to those costs exceeding the revenues generated by the global fee arrangement. The joint venture, therefore, has a strong incentive to operate efficiently and control costs.

This is not an exhaustive list of risk sharing arrangements. The Agencies have recognized that “new types of risk-sharing arrangements may develop” and that

10. Letter from Jeffrey W. Brennan to Martin J. Thompson (Sept. 23, 2003), available at <http://www.ftc.gov/bc/adops/bapp030923.shtm>.

11. See Statements, *supra* note 11, at 88-89.

12. *Id.*, at 68-69.

13. Advisory Opinion from Fed. Trade Comm’n. to Paul W. McVay, President, ACMG, Inc. (Jul. 5, 1994), available at www.ftc.gov/bc/adops/007.shtm.

14. Advisory Opinion from Fed. Trade Comm’n. to David v. Meany, Esq., on behalf of Yellowstone Physicians, L.L.C. (May 14, 1997), available at www.ftc.gov/bc/adops/yelltone.shtm.

15. Statements, *supra* note 11, at 69-70; For further information, see the resources provided on the AMA’s website, entitled “Pathways for Physician Success Under Healthcare Payment and Delivery Reforms,” which can be accessed at <http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/shaping-delivery-and-payment-models/payment-model-resources.page>.

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 . . .”¹⁶ For example, there are now a wide variety of gain-sharing arrangements in which physician groups successfully reduce hospitalization, worker absenteeism or emergency department use. Whether in the view of the Agencies, participation in a commercial health insurer’s shared savings program (perhaps similar to the Medicare Shared Savings Program) with or without downside risk constitutes “substantial financial risk” is yet to be determined, perhaps within some future FTC advisory opinion.

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, sharing “the risks of loss as well as the opportunities for profit” was discussed approvingly by the United States Supreme Court in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), as a litmus test for a legitimate joint venture. In contrast, clinical integration (discussed below) is merely a creature of federal antitrust enforcement policy that has never been recognized in a judicial opinion.

Financial risk sharing, however, has some drawbacks. First, a physician will probably have to apply many of the cost saving methods to all of his or her patients as a practical matter. Segmenting the level of care physicians provide to different sets of patients will create administrative problems and could become a negative factor in possible malpractice claims. 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.

3. Clinical integration

Overview

In 1996 capitation arrangements were on decline, creating the need for an alternative to financial integration as a pathway for the joint contracting of health care collaborations. In response the Agencies decided that *clinical integration* would suffice. This type of integration essentially obtains the benefits associated with the internal arrangements of any firm—the improved organization and coordination of work and division of labor. As described by the Agencies, 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.”¹⁷

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.

There is no modern case law that addresses the analysis of clinical integration under the antitrust laws. At the moment, the primary source of guidance comes from the Statements, the Statement on ACOs, and from FTC advisory opinions that have discussed proposed clinically integrated networks and the possibility of participants’ joint contracting in extensive detail.¹⁸

A. Basic elements of a clinically integrated network regardless of MSSP participation

In the Statement on ACOs, the Agencies have stated that they will “afford rule of reason treatment to an ACO that meets the CMS’s eligibility requirement for, and participates in, the Shared Savings Program and uses the same governance and leadership structures and clinical and administrative processes it uses in the Medicare Shared Savings Program (MSSP) to serve patients in commercial markets.”¹⁹ The Statement on ACOs provides that the CMS may approve ACOs that meet certain eligibility

16. Statements, *supra* note 11, at 86-87.

17. Statements, *supra* note 11, at Statement 8 § B. 1.

18. Letter from FTC to John J. Miles, (MedSouth, Inc.) (Feb. 19, 2002) available at www.ftc.gov/opa/2002/02/medsouth.shtm [hereinafter “MedSouth I Advisory Opinion”]; Letter from FTC to John J. Miles (MedSouth, Inc.) (Jun. 18, 2007) available at <http://www.ftc.gov/sites/default/files/documents/advisory-opinions/medsouth-inc./070618medsouth.pdf> [hereinafter “MedSouth II Advisory Opinion”]; Letter from FTC to Richard A. Feinstein, (California Pacific Medical Group, Inc.) (April 5, 2005) available at <http://www.ftc.gov/enforcement/cases-proceedings/0210143/california-pacific-medical-group-inc-matter> [hereinafter “Brown and Toland Correspondence”]; Letter from FTC to Clifton E. Johnson and William H. Thompson, (Suburban Health Organization) (March 28, 2006) available at www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaff-AdvisoryOpinion03282006.pdf; Letter from FTC to Christi J. Braun and John J. Miles, (Greater Rochester Independent Practice Association Inc.) (September 17, 2007) available at www.ftc.gov/os/closings/staff/070921finalgripamcd.pdf. [hereinafter “GRIPA Advisory Opinion”]; Letter from FTC to Christi J. Braun (TriState Health Partners) (April 13, 2009) available at <http://www.ftc.gov/policy/advisory-opinions/tristate-health-partners-inc> [hereinafter “TriState Advisory Opinion”]; Letter from FTC to Michael E. Joseph, (Norman PHO) (Feb. 13, 2013) available at <http://www.ftc.gov/policy/advisory-opinions/norman-physician-hospital-organization> [hereinafter “Norman PHO Advisory Opinion”].

19. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67028 (Oct. 28, 2011) [hereinafter “Statement on ACOs”].

criteria and that the “CMS has further defined these eligibility criteria through regulations.”²⁰ When the CMS adopted these eligibility criteria through its regulations, it by and large employed similar language used in a dozen previously published FTC’s advisory opinions which the AMA has at various times characterized as overly prescriptive. Thus, the Statement on ACOs provides insufficient guidance to physicians dealing with the issue of clinical integration—both for those who seek MSSP participation and those who do not.

Not all physician network joint ventures will want to participate in the MSSP as ACOs. Even those that do may not use their MSSP/ACO governance, leadership and administrative structures and processes in the commercial health insurance markets. Accordingly, the sufficiency of their clinical integration remains a concern.

For physician networks that do not seek to participate in the MSSP as an ACO, the Statement on ACOs is not applicable. However, a physician network that does not seek MSSP participation can still avoid *per se* condemnation if it can show a proper level of clinical integration. The discussion below addresses what clinical integration entails and methods and procedures that physician networks will need to consider.

Some of the basic elements of clinical integration include: (1) implementation of an integrated health IT system; (2) mechanisms that control utilization and establish quality benchmarks; (3) practice protocols that are designed to improve care; (4) information databases and sharing treatment information in order to streamline care and lower costs; (5) 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 (6) investment of the financial capital needed to create necessary infrastructure.

(i) Integrated health IT system

An effective clinical integration program will almost certainly have an integrated health IT system or electronic platform, which may include, but is not limited to, e-prescribing, clinical decision support and electronic health records. A robust health IT 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.²¹ Health IT may also help physicians evaluate patients for purposes of improving care; meeting quality measures; reducing errors; measuring and evaluating participating physician performance, including the extent to which those physicians are adhering to clinical practice and resource-utilization guidelines; and to fulfilling Medicare’s and other payers’ data reporting requirements.²² Consequently, an integrated health IT system 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 into an integrated health IT system. The initial use of a patient registry may be particularly attractive to physicians who have not obtained sufficient capital to fund health IT implementation or who want to adopt a wait-and-see attitude concerning the success of the network.

Acquiring and implementing a health IT system can entail a significant financial investment. 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 health IT system. For example, Greater Rochester Independent Practice Association 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.²³ Although another large independent practice association, Brown & Toland, estimated that implementing and managing an electronic Internet-based medical records system would cost \$12 million over a 10-year period, this cost was presumably allocated over the 700 physicians who would be using the system.²⁴

Additionally, regulatory guidance issued by the Office of the Inspector General of the U.S. Department of Health and Human Services, the Center for Medicare & Medicaid

20. *Id.*

21. See e.g., MedSouth II Advisory Opinion at 4; GRIPA Advisory Opinion at 5; Brown and Toland Correspondence.

22. See e.g., Norman PHO Advisory Opinion at 8.

23. GRIPA Advisory Opinion at 14-15

24. Brown and Toland Correspondence.

Services, and the Internal Revenue Service now enable some third parties greater flexibility to subsidize physicians' purchase of health IT.²⁵

Implementing a health IT 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 health IT system. GRIPA estimated that the dollar value of lost patient revenue due to time spent on such training was \$3,200 per physician.²⁶

Based on Agency guidance, it may be useful for the network to require all participating physicians to use the health IT system. More specifically, the network could mandate, as a condition of initial and continuing participation, that all network physicians undergo training on the use of the health IT system 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 health IT use, and (2) generate regular performance reports based in part on whether or not the physician appropriately utilized the health IT system as instructed.²⁷

- (ii) Development of performance measures and associated benchmarks

The collaborative development and implementation of evidence-based performance measures and associated benchmarks is a standard element in a clinically integrated network.²⁸ The FTC, for example, has acknowledged that “[w]ide-spread attention has been given to the prospect that greater adherence to practice guidelines based on solid evidence can improve the quality, and in many cases, reduce the cost of medical care.”²⁹ Perfor-

mance measures and benchmarks are essential because the network will need to use them to evaluate whether physicians, both individually and in the aggregate, are achieving the network's quality and utilization goals. These measures can focus on clinical processes and outcomes as well as utilization and physician productivity.³⁰

Based on Agency guidance, a network may want its performance measures to cover the majority of the participating physicians' patients and most of the diagnoses and conditions that are prevalent in the participating physicians' practices. For example, MedSouth estimated that its measures would cover 80 percent to 90 percent of the diagnoses that were prevalent in its physicians' practices.³¹ TriState indicated that it wanted to have “at least 80 percent of the medical conditions comprising at least 80 percent of the cost of care in the community, covered by at least one clinical guideline.”³² In many cases, a small percentage of the network's patients may be responsible for most of the total health care costs incurred by the patient population for which the network is responsible. Focusing measure development applicable to the highest cost portion of the patient population may initially be the most efficient way for the network to achieve cost savings.³³ Participating physicians could be required to report data to the network concerning measure compliance (e.g., why in specific cases a physician determined that it was not medically appropriate to follow a performance measure).³⁴

Finally, when developing its performance measures, the network should be fully cognizant of other, external measures that may be used to evaluate its physicians. Governmental programs may apply, or be in the process of applying, performance measures to network physicians. One example here is the Centers for Medicare & Medicaid

25. See Dep't of Health and Human Serv., *Medicare and State Health Care Programs: Fraud and Abuse; Safe Harbor for Certain Electronic Prescribing and Electronic Health Records Arrangements Under the Anti-Kickback Statute; Final Rule*, 71 Fed. Reg. 45110 (Aug. 8, 2006), available at <http://oig.hhs.gov/authorities/docs/06/OIG%20E-Prescribing%20Final%20Rule%20080806.pdf> (describing safe harbors to the federal anti-kickback statute for e-prescribing and electronic health records); <http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30923.pdf> (establishing exceptions from the Stark statute for e-prescribing and electronic health records); Lois G. Lerner, *Internal Revenue Serv. Memorandum: Hospitals Providing Financial Assistance to Staff Physicians Involving Electronic Health Records* (May 11, 2007), available at <http://www.irs.gov/pub/irs-tege/ehrdirective.pdf>; Q&A on Hospitals' Health IT Subsidy Arrangements with Medical Staff Physicians, available at 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).

26. GRIPA Advisory Opinion at 15; see also TriState Advisory Opinion at 19 (discussing opportunity costs associated with HIT training).

27. GRIPA Advisory Opinion at 7; see also TriState Advisory Opinion at 11 (indicating that TriState required all participating physicians to be trained in, and use, the network's HIT system); Norman PHO Advisory Opinion at 9, (The Norman PHO required a similar obligation on all participating physicians).

28. See e.g., MedSouth I Advisory Opinion at 3; MedSouth II Advisory Opinion at 3-4; Brown and Toland Correspondence (Specifically, see Brown & Toland Medical Group's PPO Submission at 5-7); GRIPA Advisory Opinion at 6-8; Tri-State Advisory Opinion at 8; Norman PHO Advisory Opinion at 7; See also Statement on ACOs, *supra* note 26, at Statement 8 § B (for example of a clinically integrated network).

29. MedSouth I Advisory Opinion at 4.

30. See e.g., GRIPA Advisory Opinion at 8 (providing an example of a process measure (“percentage of diabetic patients receiving an eye exam”) and an outcome measure (“measuring percentage of diabetic patients achieving hemoglobin A1c measures of less than seven percent”)); Norman PHO Advisory Opinion at 8.

31. MedSouth I Advisory Opinion at 3.

32. Tri-State Advisory Opinion at 8, note 22. (The Tri-State Advisory Opinion stated that, as of mid-July 2008, Tri-State had “reported that 18 clinical practice guidelines had been approved by Tri-State's Board of Directors, and that 30 others were in various stages of development and review.” *Id.*).

33. Tri-State Advisory Opinion at 8, note 23; see also Norman PHO Advisory Opinion at 7 (Norman PHO was expecting “to develop its own evidence-based clinical practice guidelines for as many as 50 disease-specific conditions” . . . and had collected physician data to assess “high prevalence, high-cost, and high risk chronic conditions that most affects its current patient population.” As of the date of the advisory opinion, Norman PHO had developed clinical practice guidelines for nine diseases, including diabetes, anemia, and hypo- and hyperthyroid disease).

34. See generally GRIPA Advisory Opinion at 7; MedSouth I Advisory Opinion at 3. The Norman PHO required participating physicians to provide practice data and medical records to the network. Norman PHO Advisory Opinion at 8.

Services' Physician Quality Reporting System. Third-party payers may also have adopted their own measures.

(iii) Upfront commitment to measure compliance and implementation

Agency guidance indicates that a network may want to require, as a condition of network participation, that each physician agree to be subject to performance evaluations based on compliance with applicable performance measures.³⁵ For example, the Norman PHO required physicians to sign its Participating Provider Agreement that obligated physicians to participate in the development of clinical practice guidelines and to adopt, implement, adhere to, and participate in the enforcement of those guidelines.³⁶ Likewise, TriState required its physicians to sign its TriState Member Participating Provider Contract-Clinical Integration Agreement. This contract obligated physician compliance with TriState's clinical practice guidelines.³⁷ Upfront agreement may be crucial because measure compliance may constrain some physicians' practice patterns and ultimately lead to disciplinary action or even network expulsion for chronic noncompliance. In addition to performance measures, some clinically integrated programs use case and disease management programs to improve the care of, and reduce expense concerning, the treatment of chronic diseases.³⁸

To maximize collaboration as well as compliance, it is generally prudent for a network to involve as many network physicians as practicable in the process of implementing performance measures and establishing appropriate benchmarks. Measure/benchmark collaboration can be an excellent means of fostering the interdependence and coordinated care between network physicians that is imperative for substantive, effective clinical integration and can help encourage physician confidence in, and compliance with, clinical practice guidelines.³⁹ One way that the network can maximize collaboration is to establish a committee (or committees) that fairly represents network physicians to oversee all aspects of the measure implementation and benchmark development process. The network may also

want to ensure that specialists or subspecialists who will be affected by a measure participate in the measure's implementation and in the development of the measure's associated benchmarks.⁴⁰ The creation of specialty advisory committees may help ensure this specialty input.⁴¹ For example, the Norman PHO reorganized itself in part to ensure that physicians worked together to establish the network's guidelines. This reorganization included the formation of specialty advisory groups, which were charged with developing and updating clinical practice guidelines. A specialty advisory group was created for each of the specialties practicing in the network, and all physicians were required to participate in a specialty advisory group.⁴²

(iv) Significant investment of human and financial capital

One of the criteria that the Agencies often use to evaluate whether a network is sufficiently clinically integrated to engage in joint contracting is the extent to which physicians have made significant investment of financial and human capital in the program's infrastructure.⁴³ In the Agencies' view:

Such 'investment' by participants can evidence their stake in, and degree of commitment to, the successful operation of the venture, and therefore support the likelihood of the program achieving efficiencies as a result of the participants' joint activity through the enterprise. While not necessarily sufficient in itself, substantial financial or other investment by participants in a joint venture supports the view that the participants are likely to be motivated to work toward the venture's success in the market—which, in this case, requires it to succeed in improving the quality, and controlling the costs, of the health care services provided pursuant to the proposed program to their patients who are enrolled in the program.⁴⁴

In the Tri-State Advisory Opinion, the FTC discussed in detail the issue of financial and human capital investment. TriState physicians made several financial commit-

35. See e.g., MedSouth Advisory Opinion at 3; Brown and Toland Correspondence (Specifically, see Brown & Toland Medical Group's Follow-Up PPO Submission at 8), GRIPA Advisory Opinion at 7.

36. Norman PHO Advisory Opinion at 9 and 15.

37. Tri-State Advisory Opinion at 12.

38. See e.g., GRIPA Advisory Opinion at 6.

39. GRIPA Advisory Opinion at 6-7; Norman PHO Advisory Opinion at 7.

40. See e.g., MedSouth Advisory Opinion at 3; Brown and Toland Correspondence (Specifically, see Brown & Toland Medical Group's Follow-Up PPO Submission at 5); MedSouth II Advisory Opinion at 6; GRIPA Advisory Opinion at 6-9.

41. See e.g., GRIPA Advisory Opinion at 6; Norman PHO Advisory Opinion at 5.

42. Norman PHO Advisory Opinion at 5-6.

43. Statement 8 at § B.1; Tri-State Advisory Opinion at 15.

44. Tri-State Advisory Opinion at 17.

ments. First, they were required to pay a \$2,500 membership fee, although the majority of physicians had paid this fee *prior* to the creation of the clinical integration program. (Some newer members did, however, pay this fee to specifically participate in the clinical integration program). Second, physicians had to invest \$2,600 in computer equipment. Finally, physicians incurred \$2,500 in lost time in order to be trained to use the program's health IT system. The FTC questioned whether, for those physicians who had paid the \$2,500 membership fee prior to the creation of the clinical integration program, these financial commitments were, by themselves, enough to sufficiently commit those physicians to the success of the program.⁴⁵ However, for those physicians who paid the \$2,500 specifically to join TriState's clinical integration program, the FTC noted that that the fee for joining might provide "some sense of financial investment in the program and a consequent degree of 'buy in' by them to the program's success."⁴⁶

The FTC recognized, however, that financial commitments were not the only investments TriState physicians made. The FTC stated that TriState physicians had made, or would make, "nontrivial investments of time and effort in the development and ongoing operation of TriState's proposed program."⁴⁷ These investments included serving on TriState's committees, incorporating TriState's clinical practice guidelines and medical management into their practices, coordinating patient care, and collaborating to achieve network quality and cost benchmarks.⁴⁸ The FTC also noted that required training in TriState's health IT systems would also impose significant opportunity costs on participating physicians.⁴⁹ According to the FTC, these financial and human capital investments evidenced "a substantial degree of commitment to the program's success."⁵⁰

Similarly, in the Norman PHO Advisory Opinion, the FTC found that the expected investments of financial and human capital were sufficient to give physicians a "stake in the success of Norman PHO such that the potential loss or recoupment of their investment is likely to motivate them to work to make the program succeed."⁵¹ These investments included participation in the PHO's clinical operations and infrastructure, purchasing com-

puter equipment, undergoing computer training, paying membership fees and dues, and continued support of the program through withholds from payers.⁵²

- (v) Upfront commitment to participation in monitoring and enforcement processes

As a condition of inclusion in the network, the network will need to require its physicians to agree to contribute to oversight and operations functions on an ongoing basis. These ongoing contributions will likely include some, or all, of the following: reporting data to the network, collaborating with other participating physicians in providing patient care, and serving on the network's committees, including peer review, quality assurance or other committees charged with monitoring and, if necessary, enforcing compliance with performance measures and other network requirements.

- (vi) Tying quality and utilization benchmarks to performance measures

Based on Agency guidance, a network may wish to tie its evidence-based performance measures to pre-established quality and, where appropriate, utilization benchmarks applicable to both individual physicians and to the network as a whole. For example, for each measure, the network may wish to establish a target percentage of compliance for all physicians (individually and then in the aggregate) who have patients to whom the measure applies. For example, in MedSouth, the network set an aggregate compliance rate goal of 79 percent with respect to a colon cancer screening measure (and actually achieved an 88 percent compliance rate).⁵³ Once the network obtains reliable information concerning the achievement of its goals, the network could make that information available to consumers and other health care service purchasers. Release of information regarding positive achievements may increase the network's stature and reputation in the market and could help make physicians individually and collectively accountable for their performance.⁵⁴

There are a number of organizations that may provide useful benchmarks.⁵⁵ For example, MedSouth was using the Healthcare Effectiveness Data and Information Set

45. *Id.* at 18.

46. *Id.*

47. *Id.* at 19.

48. *Id.* at 18.

49. *Id.* at 19.

50. *Id.*

51. Norman PHO Advisory Opinion at 15-16.

52. *Id.* at 16.

53. MedSouth II Advisory Opinion at 5.

54. MedSouth Advisory Opinion at 4; Norman PHO Advisory Opinion at 6.

55. The GRIPA Advisory Opinion at 15-16 lists a number of governmental and private nonprofit organizations which have developed benchmarks.

goals for its benchmarks, when applicable. In cases in which no national benchmark is available, it may also be appropriate for the network to set benchmarks based on the experience of network physicians⁵⁶ or on the community performance goal set by a payer.⁵⁷ The Integrated Health Association is an excellent source for benchmark information.⁵⁸ The FTC's follow-up correspondence to MedSouth concerning MedSouth's clinical integration program contains an informative description of how a clinically integrated network can establish and then achieve performance measure benchmarks.⁵⁹

- (vii) Publication, education, review, and modification of performance measures and ongoing commitments

Once network physicians have collaboratively implemented performance measures and their associated benchmarks, the network could publish the measures to the entire network and educate physicians whose practices will be affected by each measure. Publication could be coupled with providing medical education to further compliance with the network's measures.⁶⁰ It may be prudent for a network committee to review the measures periodically to ensure that measures incorporate recent research and technological advancements. Measure review might take into account other relevant factors, e.g., whether the measure effectively modified physician behavior, whether it helped the network reach its performance goals and whether the network should modify the measure.⁶¹ A formal process could also regularly solicit feedback from physicians to determine whether the network should revise specific measures. To solidify physician commitment to measure compliance, the network may require each physician to review and sign off on any applicable measure at its introduction and whenever the measure is subsequently modified.⁶²

- (viii) Monitoring individual physician and aggregate network performance

Agency guidance indicates that a network seeking to clinically integrate may want to develop a formal process

or establish a committee that: (1) monitors and evaluates individual and aggregate physician compliance with the network's measures and benchmarks, (2) works with individual physicians to improve their performance, and (3) compares its physicians' aggregate performance with the measures and benchmarks to determine whether or not aggregate utilization and quality benchmarks are being achieved as expected.⁶³ To achieve (1) through (3), network systems may ultimately need to be able to collect accurate information concerning network physicians' practice and referral patterns. This information collection may be achieved through mechanisms such as using the network's electronic health IT systems to perform medical record audits and obligating physicians to provide practice data and medical records to the network.⁶⁴ It may also be desirable for network systems to capture reasons why a physician or patient may not be following a particular measure (e.g., when not following the measure might be appropriate given unique patient characteristics, such as the possibility of an allergic reaction, lack of insurance coverage or religious considerations).

To support the ongoing monitoring process, it may be useful for the network's information systems to be able to generate regular reports concerning individual and aggregate physician measure compliance rates. These reports could be made available to the clinical integration committee or other committee that is performing the network's monitoring function, as well as to individual physicians.⁶⁵ These reports may enable physicians to monitor their own compliance as well as their peers' compliance via the monitoring committee. These reports can include the following types of information: (1) the physician's compliance rate under each applicable measure, (2) a comparison of the physician compliance rate with the rate of the prior evaluation period, (3) a cumulative compliance rate for each measure that is applicable to the individual physician, (4) the average compliance rate for all physicians to whom each measure applies, and (5) a network-wide performance report.⁶⁶ The Norman PHO expected to provide such reports to individual physicians, to physicians as a group, and to payors, as

56. In the GRIPA Advisory Opinion, if no national, regional, or local benchmarks were available, then GRIPA would set its initial benchmark at the 80th percentile of current network performance. GRIPA Advisory Opinion at 8.

57. MedSouth II Advisory Opinion at 4.

58. See Integrated Healthcare Organization, www.ih.org.

59. MedSouth II Advisory Opinion at 5.

60. Norman PHO Advisory Opinion at 6.

61. See MedSouth Advisory Opinion at 3.

62. See e.g., MedSouth II Advisory Opinion at 4.

63. See e.g., Statements, *supra* note 11, at 107. (The Agencies' example of a successful clinically integrated network).

64. Norman PHO Advisory Opinion at 8 and 15.

65. In GRIPA the reports were provided on a quarterly basis. GRIPA Advisory Opinion at 9; See also Tri-State Advisory Opinion at 9.

66. See GRIPA Advisory Opinion at 9; See also Tri-State Advisory Opinion at 13.

a means to “promote transparency, compliance, and accountability.”⁶⁷

Obviously, the monitoring and evaluation process must be fair. Ensuring the accuracy of practice information that the monitoring and evaluation processes receive is essential because the network will use that information to determine measure effectiveness and whether modification is appropriate.⁶⁸ Accuracy is also essential because the information will be used to evaluate all physicians’ performance, and the receipt of financial rewards or network discipline may hinge on the results of that evaluation. The monitoring and evaluation process should also include a mechanism through which affected physicians may provide feedback concerning evaluative reports and enable reports to be corrected, if necessary, based on that feedback.

If in the course of the monitoring/evaluation process, the network is not achieving some of its benchmarks, then the network may want to investigate the root cause of the deficiency and develop a documented rectification strategy, which may include: (1) general network education, (2) convening with affected specialties to determine whether physician practice patterns need to be changed or whether patient education or intervention is necessary, (3) revising the measures, (4) reevaluating benchmarks, (5) creating medical-management programs to work with physicians and their patients, or (6) working with payers to identify other ways to improve network performance.⁶⁹

- (ix) Monitoring patient compliance with physician recommendations and care plans

Patients who do not follow physicians’ recommendations can significantly hinder the network’s ability to achieve its benchmarks and negatively reflect on physician measure compliance. A network may want to monitor reports in order to be able to differentiate between appropriate and inappropriate reasons that physicians or patients may not have followed applicable measures so that physicians are not penalized unnecessarily. If inappropriate patient deviation from measures is an issue, patient education may be desirable.⁷⁰

- (x) Compliance enforcement and rewards

Agency guidance indicates that the network may want to have a standing committee and formal process in place that will educate, counsel, more closely monitor, or impose corrective action or behavior modification on noncompliant physicians. If necessary, the network must be prepared to expel chronically noncompliant physicians. For example, in the Norman PHO Advisory Opinion, a quality assurance committee was charged with correcting cases of noncompliance with the network’s requirements (in this instance via physician-to-physician mentoring). The committee also had the authority to impose financial penalties on noncompliant physicians and could also expel physicians from the network “in extreme cases.”⁷¹ Similarly, TriState’s program would include mechanisms addressing instances of noncompliance and “if necessary, impose sanctions for physicians whose performance is chronically deficient regarding program requirements and standards.”⁷²

An inability to consistently enforce the clinical integration program’s requirements will ultimately compromise the network’s ability to generate expected quality improvements and efficiencies, resulting in the program’s failure. Yet some network physicians may find the prospect of imposing discipline unpleasant. Imposing discipline for noncompliance may be the most significant obstacle to creating and maintaining a clinically integrated network. Participating physicians must, therefore, be prepared to play an active role in enforcing network requirements. Accordingly, the network may wish to require each physician to agree, as a condition of participation, to be subject to the network’s educational and disciplinary processes and to participate in the peer review and enforcement processes at the network’s request.⁷³

For example, in GRIPA all participating physicians were required, if selected by lot, to participate on the network’s Quality Assurance Council, which was responsible for reviewing measure compliance and for implementing decisions regarding physician discipline and sanctions.⁷⁴ Norman PHO required its physicians to participate in the enforcement of its clinical practice guidelines.⁷⁵ Depending on the circumstances, networks may also consider the use of external decision makers for significant disciplinary matters to eliminate claims of improper bias. A network’s ability to financially reward

67. Norman PHO Advisory Opinion at 6.

68. MedSouth II Advisory Opinion at 3.

69. See GRIPA Advisory Opinion at 9.

70. *Id.*

71. Norman PHO Advisory Opinion at 6, 10, and 15.

72. Tri-State Advisory Opinion at 20; see also TriState Advisory Opinion at 9.

73. GRIPA Advisory Opinion at 7; see also MedSouth Advisory Opinion at 3.

74. GRIPA Advisory Opinion at 15.

75. Norman PHO Advisory Opinion at 9 and 15.

participating physicians may be essential for the network's long-term success. Networks can reward physicians individually and/or in the aggregate through a wide array of options, e.g., based on individual or aggregate physician compliance with performance measures or on the aggregate achievement of particular quality or utilization benchmarks. Reward mechanisms may also be used within the context of payer quality-incentive reimbursement programs, e.g., pay-for-performance mechanisms. For example, in MedSouth, performing physicians were able to realize fee increases over several years in conjunction with pay-for-performance programs.⁷⁶ GRIPA also planned to pursue pay-for-performance and gain-sharing arrangements with payers that could result in further financial rewards.⁷⁷ GRIPA also represented to the FTC that, through its clinical integration program, it would be seeking and expecting to receive higher physician reimbursement rates from payers.⁷⁸

- (xi) Selectively choosing network physicians who are likely to further the network's efficiency objectives

One indication of an effective clinical integration program is the network's selectively choosing, both initially and on an ongoing basis, network physicians who are likely to further the network's efficiency objectives.⁷⁹ Selectivity evidences the commitment to the network's quality and utilization goals that is essential if the clinically integrated program is to achieve significant efficiencies.⁸⁰

Selectivity means that the network ultimately only includes those physicians who are committed to the clinical integration program's goals and who agree to be subject to the network's requirements. One suggested way of implementing and documenting selectivity is to require as a condition of network membership that a participating physician sign a written agreement wherein the physician acknowledges that the physician: (1) has received information concerning the network's requirements; (2) will be subject to the network's data collection, monitoring, referral, practice modification and disciplinary requirements; and (3) will participate in the network's peer review and enforcement committees and processes when asked.⁸¹

Selectivity may also be an ongoing, not just an initial, aspect of an effective clinically integrated network. As the network implements its requirements, physicians who initially sought network membership may decide that they do not want to be subject to the network's participation obligations. MedSouth appears to have experienced this ongoing selectivity. After noting that since 2002 MedSouth's clinical integration program had witnessed a reduction of primary care physician and specialist participation, the FTC stated "The reduced number of physicians participating in the program since MedSouth's inception may well be indicative that a program of clinical integration requires a very serious commitment and effort by physicians . . . as well as the physicians' weighing of the economic costs and benefits of participating in such a program."⁸²

The Norman PHO similarly anticipated "some natural attrition" among initial physician participants because some physicians might not want to continue making the commitments required for continued participation in the program.⁸³ To ensure the ongoing selectivity of physicians, Norman PHO expects to implement a comprehensive review process to evaluate physician performance, which could ultimately lead to the exclusion of physicians who did not comply with the program's requirements.⁸⁴ Also, the requirements of TriState's program were expected to "discourage providers not fully committed to the program from seeking to join it and thus assure that those who do choose to participate will be fully committed to its goals and requirements."⁸⁵

- (xii) Network size and scope

Physicians interested in forming a clinically integrated network may want to consider structuring the network around primary care physicians and the medical specialists with whom they have established professional relationships. For example, MedSouth's clinical integration program included specialists to whom MedSouth's primary care physicians (PCPs) most frequently referred. MedSouth estimated that its member specialists accounted for 90 percent to 95 percent of the PCPs' specialty referrals, although the specialists also received large numbers of referrals from sources outside of

76. MedSouth II Advisory Opinion at 4.

77. GRIPA Advisory Opinion at 9.

78. *Id.* at 26.

79. Statements, *supra* note 11, at 91; MedSouth II Advisory Opinion at 3.

80. GRIPA Advisory Opinion at 13-14; Norman PHO Advisory Opinion at 9.

81. *See e.g.*, MedSouth Advisory Opinion at 3. *See also* Tri-State Advisory Opinion at 10-11; Norman PHO Advisory Opinion at 5.

82. MedSouth II Advisory Opinion at 8.

83. Norman PHO Advisory Opinion at 9-10.

84. Norman PHO Advisory Opinion at 9. *See also* Norman PHO Advisory Opinion at 16.

85. Tri-State Advisory Opinion at 16.

MedSouth's clinical integration program. GRIPA appears to have followed a similar approach; it estimated that 93 percent of referrals occurred within the clinically integrated network.⁸⁶ In GRIPA the network physicians also agreed to refer patients to other GRIPA network physicians, "except in unusual circumstances."⁸⁷ The FTC has indicated that an in-network referral requirement is likely to foster efficiencies because it: (1) helps assure that the network's patients will receive care under the oversight of the network's performance measures and other quality improvement mechanisms, and (2) facilitates the network's ability to capture more information regarding patient care and network physician performance.⁸⁸

(xiii) A market must exist for the clinically integrated network's services

Physicians should engage in careful business planning when thinking about whether or not to create or participate in a clinically integrated physician network. One key component of the planning process is determining whether a market for the potential network's services exists. Otherwise, physicians may spend significant human and financial capital on a product in a market lacking the level of demand necessary for long term success. As the FTC noted in its Norman PHO Advisory Opinion, the Norman PHO clinical integration program "will be financially viable only to the extent that customers recognize its value and wish to do business with the network."⁸⁹

Consequently, physicians thinking about developing a clinically integrated network must do so within the context of ongoing and transparent discussions with employers and other purchasers of health care services, including health insurers and other payers. These discussions will be crucial for success—not only will they help determine whether a market for a clinically integrated product exists, the discussions will also ensure that any clinically integrated product can be structured to match the unique needs of the local health care market. These unique needs may include quality and physician performance initiatives of interest to employers and health insurers, e.g., pay-for-performance programs.

Because a clinically integrated network must be developed within the context of discussions with health care purchasers, clinical integration should not be conceived

as a means primarily of collectively negotiating price-related terms with health insurers. Rather, physicians should regard clinical integration as a means by which they may proactively position themselves to improve patient care and anticipate changes in public and commercial reimbursement mechanisms, as well as strengthening their economic position, reputation and value in the market.

C. Is joint contracting reasonably necessary to attain efficiencies?

For a physician network joint venture to qualify for rule of reason treatment under the antitrust laws, it is not enough that the venture generate efficiencies by being financially or clinically integrated. In addition, to the extent that the venture involves agreements on price, such agreements must be reasonably related to the physician's integration through the group and reasonably necessary to achieve its procompetitive benefits. This requirement that price restraints be *ancillary* to the procompetitive features of a joint venture is well established in the Statements and FTC advisory opinions, including the most recent Norman PHO advisory opinion.

In the case of financial integration, the joint setting of price is clearly integral to the ventures use of such an arrangement and therefore warrants evaluation under the rule of reason.

Running through the FTC's approving opinions on clinical integration is the FTC's conclusion that the doctors need to be able to rely on the participation of other members of the group in the network. Joint contracting assures this. Absent joint contracting, each physician would be required to independently evaluate contracting opportunities and decide whether or not to participate in them. Thus the absence of joint contracting could result in physician panels that vary significantly from contract to contract. The FTC has employed a similar line of reasoning in a 2009 advisory opinion giving conditional approval to a PHO structure that had prohibited physician members from opting out of a joint contracting arrangement to participating in individual contracts. In that opinion, the FTC notes that "while it might be theoretically possible to have a program without joint contracting on behalf of all physicians in the program, such an approach appears likely to be far

86. MedSouth Advisory Opinion at 2; GRIPA Advisory Opinion at 5, note 13.

87. GRIPA Advisory Opinion at 5, 13. The AMA has policy concerning out-of-network referrals. For example, H-285.914 Patient Access to Specialty Care in Managed Care Systems states in part "Our AMA: (1) will take all appropriate action to require all health plans or sponsors of such plans that restrict a patient's choice of physicians, hospitals, or surgical pathology and cytopathology services, to offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, an optional and affordable 'point-of-service-type' feature so that patients who choose such plans may elect to self-refer to physicians, hospitals, or surgical pathology and cytopathology services outside of the plan at additional cost to themselves."

88. GRIPA Advisory Opinion at 5, 13; See also TriState Advisory Opinion at 11.

89. Norman PHO Advisory Opinion at 10.

more difficult, and potentially could compromise [the PHO's] ability to effectively integrate its physician members."⁹⁰ Thus, the FTC has expressed its reservation about whether clinical integration can realistically even be achieved without contracting practices that result in the inclusion of all network physicians in network contracts. Moreover, the FTC has opined on other procompetitive benefits of joint contracting. In the Norman PHO Advisory Opinion, the FTC said that contracting practices that tend to bind physicians to a single contract would give them a greater incentive "to contribute their time and effort to the networks clinically integrated efforts, to collaboratively develop and pursue network goals, and otherwise to promote the program's success. Additionally, the use of a single panel of readily identifiable physicians will facilitate marketing to patients, payers, and physicians."⁹¹ The FTC's past opinions thus suggest that the FTC acknowledges that joint contracting is reasonably necessary to attain the efficiencies generated by clinical integration.

D. The role of market power in the rule of reason analysis applied to physician network joint ventures

As explained above, the prohibition against price-fixing raises a structural issue for physicians that they can overcome with proper financial risk sharing or clinical integration. The primary focus of the rule of reason analysis is whether the physician network joint venture will have anticompetitive effects. The first and oftentimes dispositive issue is whether the entity has *market power*.

The market power inquiry directly addresses the question of whether the physician venture actually has the ability to injure competition and consumers by, for example, forcing fee increases upon payers or preventing the formation of rival physician networks or ACOs. A joint venture's ability to increase the fees received by its participants should be based on its providing an overall better product that consumers want and are willing to purchase at a higher price.

A critical step in any market power analysis is calculating the venture's market shares in the relevant markets for antitrust purposes. The first step in calculating a venture's market share(s) involves identifying the markets in which that venture operates. These markets, however, may not be the same types of markets that are commonly referred to in business planning. A relevant market for antitrust purposes is based on a specialized analysis developed to meet the purposes and goals

established by the antitrust laws. Accordingly, it is important that physicians contact antitrust counsel concerning this issue and not rely exclusively on the markets identified in their business plans.

Under the antitrust laws, a "market" consists of what are called the relevant product market and the relevant geographic market. A relevant product market is defined by identifying the products or services provided by the venture and then identifying the reasonable substitutes for those products and services. With respect to physicians, relevant product markets are typically based on specialty or type of practice. For example, patients cannot substitute cardiac services if they have a problem with their eyes. Accordingly, ophthalmic services and cardiac services will typically represent separate product markets. The relevant product market(s) in any given situation will depend on the unique facts and structure of the physician network. Most physician ventures will involve many different relevant product markets.

After the relevant product markets are identified, the next step is identifying the relevant geographic market for those products or services. A relevant geographic market is the area in which consumers can reasonably obtain the relevant products or services. For example, if a physician venture operates in county A, the relevant geographic market will include county A. The issue then becomes whether consumers in county A can reasonably obtain competing services outside county A. Defining a relevant geographic market is a fact intensive process that will turn on many different factors. For example, geographic markets can vary in size based on the product or service at issue. The size and shape of a geographic market is also influenced by geography.

Once the product and geographic markets are established, market shares are calculated. With respect to physician ventures, market shares are typically based on the number of physicians that provide the relevant services in the geographic market. For example, if a venture has 10 urologists, and there are 50 urologists practicing in the geographic market, the venture will have a 20 percent market share in urology services. Other market share measures are also used, such as patient counts and total levels of reimbursement. A low market share (in ranges not exceeding 30 to 40 percent) will prevent a finding of market power. However, a high market share does not necessarily mean that a physician venture has market power if, for example, competitors can easily enter the market. Market share measures are merely a tool designed to evaluate

90. See Letter from Marcus H. Meier, Assistant Director, Health Care Services and Products, Bureau of Competition, Federal Trade Commission, to Christi J. Braun, April 13, 2009, available at <http://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413tristateaoletter.pdf>.

91. Norman PHO advisory opinion at 17.

the physician network joint venture's ability to have an actual impact on market conditions by profitably triggering a non-insubstantial increase in price or by forcing terms on health plans that damage competition.

E. Exclusive dealing

Related to the issue of market power is the nature of the relationship between the venture and the participating physicians. Some ventures are non-exclusive, meaning the physicians are free to enter into contracts with payers through other ventures or individually. In this scenario a high market share would provide a poor estimation of market power—any payer that did not wish to support the physicians' experiment in clinical integration could simply walk away, without losing access to any desirable physicians who belonged to the network.

Some physicians may determine that the economic structure of their venture requires *exclusivity*, generally meaning that the network's physicians are restricted in their ability to individually contract with health plans or affiliate with other network joint ventures. Exclusive arrangements are common throughout the economy and typically create efficiencies. One such efficiency—the avoidance of *free riding*—may be necessary to the success of physician collaborations. Free-riding occurs when a buyer (a health plan) can get the improved quality and outcomes generated by the clinical integration program even though it does not have a contract with the clinical integration program. This free ride is made possible by a health insurer contracting directly with the clinical integration program's physicians. If enough insurers take a free ride, the clinical integration program will fail, and all or most of the efficiencies created by the program will be lost at some point. It is worth noting that the more likely this outcome, the less likely it becomes that physicians will set up such arrangements in the first place. Physicians, especially those in small practices, understand the overwhelming bargaining power of the major health insurer's vis-à-vis small physician practices. They know that if the health insurers are free to cut deals around the physician network joint venture they will be successful because no small practice will be willing to decline the health insurers' offer and run the risk of being left out in the cold. Therefore, physicians will be unlikely to make the initial investment in a clinical integration program in the absence of ACO exclusive dealing.

The avoidance of free riding is the sort of efficiency that generally redeems exclusive dealing arrangements from

condemnation as an unreasonable restraint of trade, except in the rare cases where the efficiency gains are outweighed by market power concerns. Even if the exclusive network were found to possess some degree of market power, an antitrust tribunal may nevertheless conclude that, on balance, the exclusive arrangement did not unreasonably restrain trade. For example, without exclusivity, physicians might not invest in a joint venture by coordinating their work, purchase expensive technologies, pool knowledge by educating each other on best practices, or engage in forms of practice supervision to advance patient care.

The DOJ and FTC Statement on physician network joint ventures establishes a low market share—20 percent—as the upper limit for exclusive networks desiring to fall within the Agencies' *safety zone*. Court decisions suggest that low market shares (in ranges not exceeding 30 or 40 percent) make dismissing claims easy. Accordingly, the Statement on ACOs adopts a 30 percent market share as the upper limit for ACOs falling within the agencies' safety zone for ACOs. Also, the Agencies' Statements recognize that physician networks with greater shares may have the potential to create significant efficiencies and therefore do not necessarily raise substantial antitrust concerns. This is consistent with antitrust case law that generally concludes that even significant market power associated with a high market share (perhaps in the 50 percent range) does not necessarily render an exclusive arrangement illegal.

Currently, there are no FTC opinions discussing the lawfulness of physician joint ventures engaged in exclusive dealing, only letters to provider networks stating that their clinical integration programs were lawful because they were non-exclusive. Also discouraging exclusive dealing is the Statement on ACOs. It identifies "exclusive dealing" as among certain types of conduct ACO "may wish to avoid, if [the ACO does not] fall within the safety zone."⁹²

F. Physician collaborations participating as ACOs in the Medicare Shared Savings Program

As discussed earlier, the Agencies have stated in the Statement on ACOs that they will "afford rule of reason treatment to an ACO that meets the CMS's eligibility requirement for, and participates in, the Shared Savings Program and uses the same governance and leadership structures and clinical and administrative processes it uses in the Shared Savings Program to serve patients in commercial markets."⁹³

92. *Id.* at 67030.

93. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67028 (Oct. 28, 2011) [hereinafter "Statement on ACOs"].

One criticism leveled against the Agencies' Statement on ACOs is that it appears to prescribe a CMS clinical integration platform. The Agencies themselves note that in the past they had not listed specific criteria required to establish clinical integration but instead had responded with advisory letters to detailed proposals from health care providers. However, the Statement on ACOs takes the new "listed criteria" approach because the Agencies had worked with CMS to insure that its requirements for ACO participation in the Medicare Shared Savings Program (MSSP) incorporated the clinical integration requirements found in the Agencies' letters. Therefore, the Agencies were comfortable declaring that a collaboration satisfying CMS' Medicare Savings eligibility requirements would satisfy the Agencies' integration requirements as well. And in any event, the agencies reasoned, CMS would be monitoring results in the marketplace.

Importantly, there appears within the Statement on ACOs an agency expression of some flexibility in meeting the Agencies clinical integration requirements: "The Agencies further note that CMS's regulations allow an ACO to propose alternative ways to establish clinical management and oversight of the ACO, and the Agencies are willing to consider other proposals for clinical integration as well."⁹⁴

G. Impact of Medicare Shared Savings Program participation on antitrust analysis

A physician network joint venture's MSSP participation has a significant impact on antitrust analysis. First, the Agencies have concluded that participation in the MSSP insulates the ACO from *per se* condemnation. MSSP participation ensures rule of reason treatment for the ACO that shifts the focus to market share and market power issues.

Second, safe harbor standard is simplified and applied to the market share mechanism set forth in the Statement on ACOs. The prior Statements established a two-tier safe harbor structure. A non-exclusive physician network joint venture faced a safe-harbor market share cap of 30 percent while an exclusive physician network joint venture faced a safe-harbor market share cap of 20 percent. Under the Statement on ACOs, all qualified ACOs face a 30 percent market share cap. The Statement on ACOs states "[f]or an ACO to fall within the safety zone, independent ACO participants that provide the same service

(a "common service") must have a combined share of 30 percent or less of each common service in each participant's primary service area (PSA), wherever two or more ACO participants provide that same service to patients from that PSA."⁹⁵ A PSA is a primary service area that ACO's must identify for each ACO participant.

The Agencies are looking for competitive overlaps between independent physicians or groups that are being brought together in the ACO. An overlap is not created by an ACO having a multi-physician practice with a number of physicians that practice in the same area. When no overlap exists, the "ACO would fall within the safety zone regardless of its share, subject to the dominant participant limitation described below."⁹⁶ The dominant participant limitation provides that an ACO cannot have an exclusive arrangement with any participant that has more than a 50 percent "share in its PSA of any service that no other ACO participant provides to patients in that PSA."⁹⁷

The Statement on ACOs identifies a specific method for determining the relevant PSAs and the ACO's market in each PSA. The PSA is not necessarily a relevant geographic market, and the Statement on ACOs expressly states that while "a PSA does not necessarily constitute a relevant antitrust geographic market, it nonetheless serves as a useful screen for evaluating potential competitive effects."⁹⁸

An important caveat exists for hospitals and ambulatory surgery centers. Under the Statement on ACOs, these entities' cannot receive safe-harbor treatment regardless of their PSA share, if they contract exclusively with the ACO.

Second, the Statement on ACOs identifies certain types of conduct that the ACO "may wish to avoid, if [the ACO does not] fall within the safe-harbor."⁹⁹ The conduct expressly identified by the Agencies includes (a) exclusive dealing; (b) certain tying arrangements; (c) anti-steering and most favored nation clauses in contracts with payors; and (d) restrictions on the ability of payors to share "cost, quality, efficiency and performance" information with their enrollees.¹⁰⁰

Third, an expedited review process is provided to ACO's that want further guidance from the Agencies. The Agencies have offered to provide this guidance within

94. *Id.*

95. *Id.*

96. Statements on ACOs, *supra* note 26, 76 Fed. Reg. at 67028, n.27.

97. Statements on ACOs, *supra* note 26, 76 Fed. Reg. at 67029.

98. *Id.* at 67028.

99. *Id.* at 67030.

100. *Id.*

90 days of their receipt of the information identified in the Statement on ACOs. In this review the Agencies will “consider the factors in the rule of reason analysis as explained in the *Antitrust Guidelines for Collaborations Among Competitors* and the Health Care Statements.”¹⁰¹

The above shows that the Statement on ACOs is centered around the issue of *per se* treatment and the safe-harbor. An MSSP ACO that falls outside the safe-harbor will face the same rule of reason analysis that health care collaborations faced before the Affordable Care Act and the recognition of ACOs. Unfortunately, the Statement on ACOs does not help clarify the rule of reasons analysis the Agencies will apply to ACOs. The structure of the Statement on ACOs incentivizes the creation of ACO’s falling within the safe-harbor. This is so despite the fact that the Agencies have expressly stated that falling outside the safe-harbor does not necessarily indicate an antitrust problem.

V. Conclusion

This Guidance describes some integration methodologies that physician practices may consider if they are seeking new ways of creating a more efficient and value-added means of delivering health care. Depending on local circumstances, these models may be available to solo and small group practices. These models may be of interest to independent practice associations that are considering ways to increase their efficiencies by further integration. These models may also be open to larger group practices. Although particular antitrust analyses will vary depending on the facts and circumstances of particular practice environments, the experience of existing physician practices, guidance from the Agencies and legal authority indicate that the integrative models described in this Guidance may in some circumstances enable physicians to: (1) jointly negotiate lawfully fee-for-service contracts with third-party payers, and (2) foster the development of efficiencies that will be highly valued in the rapidly evolving health care delivery market.

Appendix A: Evaluating affiliation options

Assessing your market

The presence of:

- Large integrated systems
- Hospital foundation groups
- Independent practice associations
- Hospitals and hospital systems

Assessing the other entity

Compatibility

1. Shared interests and goals
2. Compatible culture, management philosophy, mission and ethical directives or standards
3. Ability to manage change
4. Articulation of a coordinated strategic plan providing mutual advantage
5. Degree of current interdependence
6. Shared clinical expertise and priorities
7. Compatibility of compliance commitment
8. Compatibility of market reputation as to quality
9. Other affiliations which might benefit or burden existing or contemplated operations

Financial strength

1. Capital to fund growth, facility expansion, care coordination and information systems
2. Financial stability (debt/equity ratio) and total capital
3. Access to capital
4. Market share/service and geographic coverage/potential for growth
5. Profit margins/fixed expense levels/efficiency of service
6. Capacity to assume risk and historic success in obtaining and managing at risk contracts
7. Other affiliations which might benefit or burden existing or contemplated operations

Management strength

1. Expertise in marketing, office operations, billing and collections
2. Procurement advantage
3. Expertise on information systems and care coordination
4. Managed care contracting/capitation contracting

¹⁰¹ *Id.*

- and pay for performance or at risk contracting experience, expertise and historic success
- 5. Demonstrated expertise in site selection and outpatient service development
- 6. Number of current primary care physicians in organization and demonstrated ability to recruit and retain primary care physicians and need specialists
- 7. Clinical reputation and expertise
- 8. Ability to satisfy regulatory, licensing and reimbursement requirements with excellent compliance record
- 9. Expertise in other ancillary services (e.g., behavioral health, outpatient services, home health, PT)
- 10. Demonstrated ability to package and price comprehensive benefit package, including outpatient services
- 11. Stability of management and physician
- 12. Physician involvement in management/quality of physician leadership
- 13. Appropriate staffing and occupancy levels with efficient physical plants and appropriate equipment and service capabilities

Assessing the combined entity

Perceived synergies

- 1. Potential expense savings for lower unit costs, more efficient utilization and economies of scale
- 2. Revenue enhancement
- 3. Market share expansion and market reach
- 4. New products/services or pay for performance or shared savings contracting opportunities
- 5. Greater utilization of existing facility
- 6. Avoidance of learning curve expense
- 7. Greater ability to assume risk and provide a broad array of service
- 8. Improved care co-ordination

Other considerations

- 1. Other up-front benefits (e.g., access to new software, purchasing efficiencies and reimbursement expertise)
- 2. Access to better liability insurance coverage and reinsurance (e.g., less expensive through the use of group discounts and deductibles)
- 3. Effect on current referral sources/access to practice sites
- 4. Licensing, certificate of need and other regulatory issues
- 5. Antitrust, Medicare, fraud and abuse, private inurement and corporate practice of medicine restrictions
- 6. Ability to retain/necessity to fire key employees
- 7. Effect on existing contracts

- 8. Costs of integration (consultant fees, lease buy-out, severance, etc.)
- 9. Required investment to support post-merger business plan
- 10. Impact upon physician autonomy, compensation, staffing and overhead
- 11. Legacy issues surrounding current buy-sell agreements, governance, physician owned real estate

Assessing the deal terms

Financial and other business issues

- 1. Valuation of practice assets and intangibles, including effect of not-for-profit as opposed to for-profit status of other entity
- 2. Percentage participation in profits from professional fees
- 3. Participation in total enterprise profits and/or cost savings
- 4. Allocation of managed care contract revenues and impact on managed care analyses and negotiations
- 5. Upside and downside risk allocation (e.g., salary guarantees, bonus formulas, etc.)
- 6. Effect of legal restrictions on physician ownership and referral and assessing potential revenues from ancillary services
- 7. Terms of physician compensation plan (term, calculation and structure)
- 8. Overhead and revenue allocations/quality metrics

Governance issues

- 1. Allocation of clinical/administrative decisions (e.g., selection of hospital, admission and length-of-stay decisions; participation in central appointment scheduling; etc.)
- 2. Management strength
- 3. Degree of physician input/control over profitability and compensation (e.g., setting office visit fees, etc.)
- 4. Retained autonomy by physicians and/or other institutions relative to other business decisions
- 5. Control over contracting, purchasing, technical personnel, scope of service and other affiliations
- 6. Control over managed care contracting, selection, pricing and other terms (including provider eligibility, selection and utilization criteria)
- 7. Limits on and rights to participate in other affiliations

Other terms

- 1. Physician control over practice efficiencies
- 2. Historic relationship
- 3. Willingness to assume risk
- 4. Noncompete covenants and dissolution terms
- 5. Tax and retirement plan considerations

Appendix B: Community physician organization: Business plan outline

I. Executive summary

- a. Brief description of objectives and business opportunity
- b. Company capability/services description
- c. Quantification of financial requirements, sources and uses of proceeds
- d. Description of organizational and management structure
- e. Summary of market competition
- f. Identification of earnings, projections and potential return

II. Business objectives and opportunity

- a. To develop a physician-controlled organization capable of assuming capitated or pay for performance risk, or to demonstrate shared savings and demonstrating quality outcomes to employers, insurers and other payers
- b. To create efficiencies in health care delivery through limiting participation to quality providers whose participation would be attractive to plan beneficiaries
- c. To assure a continuum of quality care over hospital, outpatient, physician office and home health and skilled nursing and rehab settings
- d. To identify appropriate interventions for high-risk patients at early stages through improved preventive, diagnostic, treatment and rehabilitation services
- e. To rely upon and utilize the professional judgment of physicians to serve the health needs of the individual patient and through education, peer review and other techniques to assure quality and cost-effective care
- f. To fund additional care coordination human and IT resources to more proactively obtain patient compliance and engagement, facilitate communication among all clinicians with responsibility for the patient, and monitor patients between visits or procedures

III. Description/capabilities/services

- a. Network description
 - Listing of physician providers via selection criteria, geographic coverage, specialties and hospital affiliations
 - Identification of hospital and other facilities contracting with the physician organization
 - Identification of management information systems and other methods of addressing effectiveness, patient access and claims management
 - Description of unique attributes to success
 - Listing of care coordination and clinical integration resources
- b. Service description
 - Managed care products
 - Claims administration
 - Utilization and peer review
 - Identification of services provided through subcontracts and affiliations with other health providers
 - Availability of reinsurance
- c. Operations description
 - Explanation of physician organization's mechanism for administering managed care contracts
 - Procedures by which physician organization educates, motivates and manages the physicians, including the establishment of protocols
 - Management incentives for use of treatment protocols and for cost effective and quality of care
 - Use of gatekeepers, inpatient specialists and other treatment protocols for the management of patient care
 - Identification of areas in which physician autonomy produces savings and clinically appropriate care
 - Identification of use of physician assistants and extenders and other patient and care coordination support resources and personnel
- d. Revenue sources
 - Practice revenues
 - Key managed care contracts/key employer contracts
 - Facility revenues
 - Employer programs
 - Management service organization and other service income

IV. Quantification of financial needs

- a. The organization requires capital to integrate information systems and to build and create a provider network capable of meeting the above objectives
- b. As set forth in the projections, the organization needs to develop an administrative infra-structure capable of implementing quality assurance and peer review functions
- c. The organization needs capital to purchase an existing managed care entity with whom a substantial number of its physicians are within the provider network
- d. The sources and uses of funds

V. Management and organizational structure

- a. Form of entity
- b. Equity ownership and governance structure
- c. Identification of board members and qualifications
- d. Resumes and backgrounds of administrators
- e. Governance structure

VI. Market analysis

- a. Identification of existing HMO, PPO and other health networks in the market place and a summary of their products
- b. Description of the trends relative to managed care products
- c. Identification of Medicare/Medicaid managed care initiatives
- d. Identification of target market
- e. Listing of competing providers
- f. Assessment of physician organization's position in the market of terms of market share, quality, geographic coverage, and other indicators of sustainability and long-term viability

VII. Marketing strategy

- a. Strategy which permits physician organization to be price competitive, to differentiate itself and otherwise have a sustainable market share
- b. Identification of provider relations and methods for preserving same
- c. Listing of specific pricing policies of practice (i.e., discount or premium pricing based upon market strategy)
- d. Covered lives
- e. Marketing method (preexisting contracts, prospective contracts, other programs)

- f. Shared savings and pay for performance or global pricing strategies
- g. Strategies to expand ancillary services and to migrate care to less acute settings
- h. Wellness and large employer occupational health services and resources to lower cost, improve access, and engagement
- i. Possible expansion of intermediate and urgent care services and expansion of clinic hours
- j. Use of open scheduling to improve access and patient satisfaction for quicker access to specialists for more rapid diagnosis

VIII. Financial

- a. History of the entity or predecessor entity
- b. Financial projection for three to five years (first year by month and second year by quarters and later years annually)
- c. Identification of key assumptions and explanations of projections
- d. Listing of key business ratios (debt to equity, cash flow and income to senior debt interest and to senior debt service, net worth, current assets to current liabilities ratio, return on invested asset, return on equity, etc.)
- e. Description of sources and uses of funds
- f. Illustrative example of return to investors, including description of exit strategies (such as recapitalization, sale of enterprise, eliminated pay down of debt from cash flow or other)