Practice Opportunities: Practice Integration, Management Contracts, Hospital Integration

REPORT OF THE AD HOC TASK FORCE ON PRACTICE MANAGEMENT STRATEGIES

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Background:

For the past decade, physician practices have experienced progressive difficulty in managing the accelerating administrative complexity, increasing overhead, and decreasing reimbursement.

In the past, physician practices were faulted for not utilizing business efficiency principles. There is a general lack of understanding by the business community and bureaucrats with differences in delivering medical care compared with producing the same product time after time. Medical services are a handmade product that is delivered specifically for the patient being evaluated and treated. There are an infinite number of ways the patient can present with the same underlying illness. When practices tried to adopt business principles, they were faulted for being insensitive to patient needs, self-serving, and greedy.

CMS and commercial payers have steadily eroded the value of the RVU payments to the point where those payments now have 50% of the buying power that they had in 1995. That means the physician has to see twice as many patients or perform twice as many procedures to just break even. Since that is physically impossible, physicians explored and invested in ancillary services. It is not surprising that practices would look to developing ancillary services to remain solvent. It is exactly what any small business would do. While much has been made about the increased volume of procedures and ancillaries, little has been stated about patient benefits. Cardiovascular morbidity and mortality have continued to drop with decreases on the order of 25–30% in death from coronary artery disease and stroke in the last 6 years. While it is difficult to measure, one can assume that improved diagnosis and management of patients through access to ancillary services and procedures have contributed to some of this decline. On the other hand, there has been little guidance provided to physicians on the appropriateness and frequency of ancillary services. Recently, ACC has published Appropriate Use Criteria (AUC) to provide that guidance. This should help to ensure that studies and procedures are necessary. No one condones the performance of unnecessary or inappropriate procedures.

Parallel with these changes has been the increasing cost of health care despite the continued decrease in physician reimbursement. The number of uninsured and underinsured patients has continued to increase even more so as the economy has weakened. Health care delivery, which has been focused on the individual patient, lacks coordination of care and efficiency. Interconnected health information technology is an important part of the foundation on which to build a new delivery system. Currently, health information technology still fails to provide acceptable interconnectivity, affordability, and implementation strategies that fit into the practice workflow.

The legal climate in many states continues to contribute to defensive medical practices. Defensive medical practices may add as much as 9% to the overall health care budget ($210 billion dollars). This will continue to add cost to our health care cost until a reasonable solution is implemented.

Over the past two decades, cardiovascular practices have increased in size because of the evolving complexity of management and the subspecialization of cardiovascular medicine.

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Apprehension among practicing physicians has continued to intensify because of the misgiving in how to evaluate and address the changes that are taking place or are proposed. Most physicians would rather practice cardiovascular medicine and not worry about the administrative or structural aspects of their practice. They realize, however, that physician leadership is necessary to make certain that patient care is at the center of the decision-making. Discussed later in the review will be the financial pressures, regulatory changes, practice cultural changes, and hospital concerns that are driving practice interdependence and integration strategies.

Practice integration, hospital management contracts, and hospital integration are some of the concepts that will be discussed in this paper. This is not meant to be an exhaustive treatment of these choices but is meant to put forward strategies for consideration.

Practice Integration Strategies:

The AMA has recently published a monograph on competing in the marketplace by Henry Allen and George M. Sanders. With permission of the authors, this section will summarize many of the points made in that document. In the past, practice integration has referred mostly to merging of single-specialty practices or larger multi-specialty entities. Merging of subspecialty practices with primary care practices 10 or 15 years ago met with the same fate the hospitals experienced when they purchased primary care practices. Now cross-specialty integration warrants consideration because of increasing need to coordinate care, and the location and delivery of quality of care. There is also a need for added capital to support a more sophisticated administrative structure and the purchase of electronic health records. In smaller communities, practice mergers have been restrained by the fear of antitrust violations. Below is a discussion of the various practice merger concepts; the reader is referred to the AMA document on *Competing in the Marketplace* for a more detailed description.

The Merger Model

This model is not a new concept. It would allow the physicians to preserve most of the control of their individual daily practice. The combined talents of the physicians can increase access to better administrative support, coordination of care, and the needed capital for technology purchases. The structure is to create a single entity while preserving practice divisions. Overall capital investment and governance are delegated to a single entity, as are the leasing arrangements, employees, billing, and insurance contracting. These are roles that physicians don't normally like to do, so the delegation of these services is welcomed. Physicians continue to practice in their own individual modules of care with fairly preserved autonomy, income related to production, and individual quality metrics. They will, however, need to abide by the quality standards set for the entire group.

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Collaborative Integration Model

For physicians who are uncomfortable in ceding the authority or control required in the Merger Model, they may prefer the Collaborative Integration Model. This model can take various forms, depending on the degree to which the individual physicians or practices choose to integrate. Some may develop joint ventures; others messenger model contracting, and varying degrees of financial and clinical integration. The degree to which they integrate and the desire to collectively negotiate their fees will determine the exposure to antitrust laws.

Financial Integration

Physicians may create an entity to negotiate risk-based contracting. These physicians are not integrating their practices. They may negotiate capitation, global fees, premium withholds, or other strategies to control cost and improve quality. An Independent Practice Association (IPA) is an example of this approach. There are many different financial risk-sharing measures, but all of them to be successful will require utilization review, practice protocols, and quality benchmarks. Without these being in place, the entity is likely to fail.

Clinical Integration

In this model, there is collaboration among physicians to provide health care services to patients that are efficient and result in quality improvements in providing those services as individuals and as a group. This interdependence is designed to decrease cost, and improve quality and efficiency. Physicians are not limited in this collaborative model unless they choose collectively to negotiate fees for service contracts. Sharing informational databases, implementing practice protocols, control of utilization, and investment of financial capital to build the necessary infrastructure are just some of the strategies employed. In order to be included in the network, physicians must agree to peer review and disciplinary action when indicated. Enforcement of these quality measures is an essential component of continued participation in the clinical collaborative network. The FTC requires this rigorous oversight. The Greater Rochester IPA (GRIPA) is an example of clinical collaboration. There is a much more detailed discussion of these models in the AMA document *Competing in the Marketplace*.

Hospital Cardiology Management Service Contracts

Background

The single most important issue is “the relationship” in developing a successful contract with hospital administrators. Successful management contracts are forged between hospital administrators and cardiovascular groups that are prominent in their service area. Those practices that have a history of integrity and a reputation for high-quality care are preferred. Based on experience, it is strongly suggested that one forge a relationship with the CEO of the hospital and not middle management.

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The essence of management relationships is that it is necessary for the hospital to gain the experience and expertise of the cardiovascular group in the delivery of cardiovascular services. The hospital is looking to create alignment with physicians to grow cardiovascular services, avoid waste, increase efficiency, and improve quality and outcomes. The quality and outcome measures need to be developed correctly and a process of measurement and reporting needs to be put in place. It is important for the cardiovascular group to have a thorough understanding of capital expenses, patient satisfaction, quality measures, issues related to length of stay, and patient satisfaction. In addition, a major responsibility of the CV partner will be to bring other cardiovascular specialists and physician competitors working at that institution together to "play ball." All cardiologists must be brought to the table to engage in quality and efficiency measures, which the hospital and its cardiologist manager intend to develop and manage. It is helpful, therefore, if the cardiovascular partner has a history of being respected by their competitors and a history of building consensus.

Prerequisites

General prerequisites for the cardiovascular practice, which would like to enter a management agreement, would be as follows:

1. Experience in building, maintaining, and directing a cardiovascular program as well as providing leadership among peers and competitors.
2. Be successful as a consensus builder, even among competitors.
3. Ideally, the hospital administrator and the cardiologist partner will need a legacy of trust or at least the ability to build a trusting relationship about mutual integrity and common goals of improving patient care.
4. In general, the cardiology partner will need to be willing to provide education for all the cardiovascular staff that will participate in the cardiology service line. This would include educating emergency room staff and physicians, cardiovascular technical staff, echo lab staff, cardiac cath lab staff, nursing, etc. in a continuing attempt to improve quality and to meet appropriate quality benchmarks as well as to have a more uniform approach to services.
5. It is important for the cardiology partner to be malleable and open to change. The management team will often be able to provide both administrative and physician-based information to one another, which may force a "new look" at different ways to deliver ideal care. All the cardiologists in the practice need to learn and engage as effective partners.
6. Though it is not a requirement, it is helpful that the cardiovascular specialist or some member of their team have a business background. This is not a requirement, but it makes it easier to understand contractual issues as well as capital budgets, etc.

Contractual Requirements

There are several potential contractual agreements related to management contracts. The first would be simple documentation of services where the CV partner is required to document hours of management services for reimbursement based on an hourly rate or fair market value. The second component of a contract may include benchmarks. The benchmarks could provide

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incentive compensation beyond a predetermined hourly rate or base fee as a bonus for achieving certain quality benchmarks. The third contractual possibility could include gain sharing. In this situation, an agreement could be forged including shared cost savings based on improved efficiency worked out by the management team. An example may be that if cath lab expenses were reduced by 50%, some of that gain would be shared with the management contractor. These options could become parts of the final contract. A contract may include a combination of documented services, benchmarking, and gain sharing. Gain sharing must be carefully structured to protect against incentives to under treat and typically require third party confirmation and oversight.

Red Flags

The most important red flag to be aware of is any tie between reimbursement and volumes. The implication of "payment for referrals" or similar system being in place is of great concern. Reimbursement for the physician management partners should be based on services delivered, achieving quality, and patient satisfaction benchmarks.

Selling or Leasing Cardiology Practices to Hospitals and Health Systems: The Rationale and Issues to Consider

As recently as two years ago, most cardiologists would never have considered selling or leasing their practices to a hospital or health system. Cardiologists are passionately independent – they know what is best for their patients and they know how to organize their practices in a way that best fits their practice and life styles. In addition, cardiologists are entrepreneurial and personally witness the bureaucracy and inefficiencies of hospital operations. These cardiologists shudder at the thought of having to get some administrator's approval for every personnel move or equipment order. The concept of physician-hospital integration is well accepted by physicians at The Cleveland Clinic, The Mayo Clinic, and university faculty practice plans. The private practice cardiovascular specialists who practice in the more traditional practice settings across the United States cherish their independence.

However, the physician-hospital relationship continues to evolve. Historically, the hospital provided inpatient facilities and staff, while physicians focused on the clinical side of the patient care equation. Hospitals and cardiologists have spent the last decade developing closer working relationships. These relationships have ranged from medical directorships and call coverage arrangements to more corporate-like cath lab and diagnostic joint ventures and cardiovascular service line management by group members. However, successes in these relationships have varied widely based on the ability of hospital administration to embrace physicians as business partners. Collectively, the political sensitivities to the remaining medical staff, that did not have the opportunity to participate in such relationships, require careful attention.

Many cardiology groups have successfully partnered with one or more local hospitals. This business relationship has had an added complexity: competition. As technical and

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technological advances allowed diagnostic and therapeutic modalities to move from inpatient to outpatient and in-hospital to physicians' offices, cardiologists have seen substantial financial improvements through adding ancillary services. Cardiology practices have had the implicit cooperation of third-party payers who were willing to pay for these services often without regard for site-of-service. Hospitals have tried to slow this escape of ancillary revenue through everything from broad-based regulatory barriers (for example, certificate-of-need laws and lobbying for state and federal physician referral restrictions) to location-specific lease restrictions in hospital-owned medical office buildings. These attempts to have both cooperative and competitive business arrangements have led to an obvious tension where new business opportunities for one party could result in business loss for the other.

Now, however, both cardiologists and hospitals have shown a keen interest in creating a new working relationship. Those relationships range from Professional Services Agreements (as described in the previous section) through hospital purchases of designated physician services to outright Employment Agreements. The first question is: what has led both sides to decide that this may be the right time for an integration relationship? There are at least four reasons:

1. Financial Pressures
2. Regulatory Constraints
3. Practice Culture Changes
4. Hospital Fears and Strategies

Financial Pressures

This is the near universal force behind the decision to integrate. Physician reimbursement from Medicare and commercial payers has declined and that trend will not reverse. At the same time, overhead escalates with increasing costs for personnel and professional liability coverage. There is the need for new or replacement technology and integrating Electronic Health Record. These divergences in revenue and costs are made even more difficult by increasingly scarce capital because of economic and business concerns. Banks are demanding personal guarantees and the resulting risks are not attractive to some physicians, especially because of an uncertain future.

Some groups have felt conflicted about exploring integration strategies after a recent improvement in the financial performance of their groups. These groups recognized the looming reimbursement challenge and that recognition resulted in a renewed attention to expense control and productivity improvement. However, as one leader of a large Midwest practice (50+ cardiologists) which sold in late 2008 said, "We decided that this was the perfect time to sell since we believed that our practice would never be worth more than it is today."

These financial pressures also exist on the hospital side. Stock portfolios have been reduced by 30% or more, hospitals have been frozen out of the credit markets, capital projects have been deferred, and employee layoffs have begun. One response has been the continued growth in hospitalists, a program chiefly for the hospital's benefit rather than in support of existing private practices. These hospitalists have changed the nature of many cardiologists' hospital practice. Physicians are adapting a consulting practice with a resulting loss of

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relationships with the physicians who used to send those referrals – both in and out of the hospital setting.

Hospitals also have learned that active physician participation is key in adapting to both revenue improvement and expense control measures. Revenue enhancement is legally permissible through such efforts as attention to physician coding and its impact on the hospital's case mix index. Reaching objective quality goals might slow or stop the referral of patients to other tertiary-level facilities. Expense control opportunities vary from process improvement measures that reduce length-of-stay to narrowing the pharmacological and medical devices used. Fewer vendors can result in volume/price discounts. Physician participation is essential on both sides of the financial equation.

Regulatory Constraints

Those responsible for the Medicare program have set up laws and regulations that have made the business of cardiology more challenging. Regulatory changes from the Centers for Medicare and Medicaid Services contained in the last two Medicare Physician Fee Schedules have set the end of cardiologists' "under arrangement" contracts with hospitals, prescribed when physicians could "mark-up" their diagnostic tests, and almost eliminated "per-click" arrangements between physicians and the hospitals to which they refer. In addition, the coming of the Recovery Audit Contractor (RAC) highlights the regulatory environment that will continue to mandate a significantly higher cooperation among cardiology providers and their hospitals.

Over the past decade, cardiologists have increasingly sought to assure clinical efficacy and exercise control over the delivery of outpatient and minimally invasive cardiac services under various approaches. The approaches have ranged from ownership of specialty hospitals, provider based joint ventures under arrangements, and gain sharing affiliations with health systems, and ownership of cardiac cath labs and other cardiac related ancillary services as part of their group practice. Effective October 1, 2009, without legislative, regulatory, or judicial intervention under the recent Stark amendments, fair market value "per click" equipment leases and certain management arrangements, in which clinical personnel were employed physicians, would be banned based on ownership of the leasing or management company by referring physician. While "gain sharing arrangements" have been approved to allow payments to cardiologists by the hospitals to whom they refer, those arrangements have been substantially restricted in duration and require substantial independent review and safe guards, and are subject to further regulatory modifications.

In the past two years, Congress has considered legislation that would remove or severely restrict the applicability of the "whole hospital exception" to the self-referral prohibitions under Stark. Multi-specialty group practices have been under increasing cost pressures. The trend in health policy reform is to incentivize demonstrable quality and medical information integration. Investment in information technology and the cost of compliance have added to the cost pressures on physicians who face reduced or insufficiently increased reimbursement from all payer categories. This has created renewed interest by hospitals and health systems to buy the practices of their cardiologists and to employ them.

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The Federal government has been active in other areas as well. Senator Charles Grassley (R.-IA) has been at the forefront in proposing laws to restrict physician ownership of specialty hospitals. Congress successfully passed the Medicare Improvements for Patients and Providers Act (MIPPA), which calls for a pay-for-performance approach to reimbursement by 2010 and certifying all diagnostic equipment by 2012. Referring to the importance of ancillary revenues to cardiology practices, one industry leader said, "Cardiologists are one regulation away from being internists."

While Medicare is widely recognized as a standard-setter for reimbursement policy, commercial payers have not been idle. Based on research begun by two health economists working at Florida State University 20 years ago and since updated by Med PAC and others, it is widely accepted that physician ownership of diagnostic imaging equipment results in higher utilization rates and increased costs to Medicare. The benefits of these imaging studies in reducing morbidity and mortality have been ignored. The result has been that commercial payers have contracted with aggressive Radiology Benefit Managers (RBMs) that are compensated based on reducing imaging claims. RBMs have impacted patient access to necessary tests, added administrative burden, and had a negative impact on volumes – not necessarily quality nor eliminating "unnecessary" testing.

Finally, reimbursement schemes are changing. It is widely accepted that the viability of fee-for-service reimbursement is waning. Medicare, commercial payers and even large employers are exploring some form of bundled payments, episodes of care, capitation, or single point contracting. Cardiology practices acting alone often lack the size and resources needed to negotiate and operationalize these contracts.

Practice Culture Changes

Cardiologists who finished their fellowship training in the last decade are more mobile than their predecessors. These physicians, often referred to as "Gen X'ers," are as interested in their family life as their professional life. While they enjoy the respect granted to them as cardiologists, they think of cardiology as "what they do" rather than "who they are." As a result, many younger cardiologists are more interested in the clinical practice of cardiology and less about the business of cardiology.

An integrated physician-hospital practice is appealing to these cardiologists. An integration model provides both practice stability and income security. For those cardiologists who are uninterested in the business side of the practice, hospitals are willing to provide a management that allows cardiologists to focus on clinical care and leave the administrative load to others.

Hospital Fears and Strategies

Many hospitals are less than sanguine about physician integration. The debacle of employing primary care physicians without the proper productivity protections is an experience

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that hospitals have no interest in repeating. In addition, an integration model is contrary to the traditional arms' length working relationship of hospitals and their medical staffs.

However, when cardiologists want to open the dialogue about possible integration strategies, hospitals cannot ignore that entreaty. Cardiovascular services are an important contributor to almost every hospital's bottom line. These hospitals cannot risk the potential loss of these services to a competitor. Also, hospitals can see the same reimbursement horizon as cardiologists and recognize the importance of physician-hospital partnerships in reaching and preserving expense control goals.

Because of these four factors, more cardiologists and hospitals are at the negotiating table to discuss whether there is an integration model that meets the goals of the respective parties without breaching the culture of either. That is not to say the integration models discussed below will not require some stretching for both sides. The most integrated models include physician participation and leadership in the hospital's cardiovascular product line. Similarly, cardiologists have to allow hospital participation in the strategic planning and budgeting for the "physician practice" piece of the integrated model. Creating an integrated model is hard work, but the potential rewards are alluring.

Hospital Integration Models

An Introduction

Each of the models discussed below has three groupings or "silos" of issues: valuation, compensation, and governance. Within these three silos, there are a myriad of topics. The following is merely an introduction and is meant to provide some ideas that will be important to discuss in much greater detail than provided here with potential hospital partners.

Valuation

Valuation is important whether the practice decides to pursue the sale of a practice or another integration model. In the sale of a practice, there are two aspects to valuation: tangible and intangible assets. Rarely is there much disagreement about valuation of hard assets. Typically a hospital will hire an outside valuation firm. This firm will request the practice's most recent depreciation schedule and use that as a basis to conduct an on-site inspection of the hard assets. In its final valuation, the firm will consider the asset's depreciated value as well as their value if the assets were sold on the open market.

A practice's intangible value is often a topic of considerable discussion and disagreement. Most cardiology practices, and especially the senior members, are rightfully proud of the reputation and practices of skilled clinicians they have built in the community. They are often recognized by their peers as providing high quality care for their patients and for being thought leaders among the medical staff. These cardiologists understandably believe and expect the value of their practice to include more than its hard assets.

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The discussion about intangible value or "goodwill" is one that hospitals hate. Measuring goodwill is more art than science, and hospital administrators are afraid this will turn into a mechanism through which they will end up overpaying for a cardiology practice. Early in the integration discussions, most hospital executives will quickly tell cardiologists that, "We don't pay for goodwill." The problem for these executives is that, absent explicit instructions from the hospital, it is unheard of for a nationally recognized valuation firm to think that a cardiology practice has no intangible value.

If the practice leases its assets to a hospital, the valuation takes on a more narrow focus. In essence, the purpose of the valuation is to set a Fair Market Value (FMV) lease rate for the hard assets and the clinical staff. There is often some profit potential in this calculation of the FMV rate that usually exceeds the costs of the assets and staff. There also is an opportunity for a management and a billing-and-collection component to this lease or separate contracts to cover these areas. However, while there is a theoretical basis for paying goodwill even in a lease arrangement, it is almost never a part of this type transaction.

Compensation

This is the silo that often gets the most attention. It is the easiest aspect of a potential transaction for a cardiologist. He or she has no problem remembering what number appeared on last year's W-2. As a result, cardiologists often decide whether the negotiations show they are "valued" or not, based on the compensation number.

However, the compensation number is often the least important part of the negotiations, because most hospitals have no trouble paying cardiologists more than they are currently making. Hospitals often have commercial payer contracts and Medicare provider-based reimbursement that pay higher reimbursement for the same services than physicians receive under their existing fee schedules. In addition, hospitals usually can provide savings through health insurance contracts and professional liability coverage, as well as medical and office supply buying programs. Hospitals also are willing to assume the costs of such areas as human resources, information technology, and purchasing. Even without expense reductions or financial subsidies, hospitals are able to improve compensation for cardiologists from 10-40% or more. Not-for-profit hospitals must be able to show that the compensation being paid does not exceed fair market value as they are prohibited from providing excess private benefit.

Governance

This is the most important aspect of a potential integration negotiation. Frankly, if a transaction is consummated, cardiologists will remember how much money they make once every two weeks, but how the practice runs will affect them every day.

There are three general governance models. The first is largely a continuation of the status quo. In this model, the physicians will largely continue to manage their practice within

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budget parameters negotiated with the hospital. Otherwise, there will be little change in the practice's operations the day before and the day after the transaction.

A more "advanced" model includes a co-management component in the physician-hospital relationship. This component provides hourly payments and financial incentives to physicians to help the hospital in managing the hospital's cardiovascular product line. Physicians provide clinical leadership through medical directorships, but also help hospital administration in operational matters. Examples include vendor negotiations, strategic planning for physician recruitment, growth of outreach markets, and process improvements aimed at everything from reducing length-of-stay to improving door-to-balloon times in STEMI care. In this model, hospital administration keeps the primary decision-making responsibility and the cardiologists play more of a stakeholder-consulting role.

The most integrated model is physician management of the product line. The physicians are not consultants; they are the decision-makers. The product line's employees report to an administrator who reports to a physician-CEO who, in turn, reports to a Board of Directors made up mostly of physicians. The cardiologists have profit-and-loss responsibility and are expected to manage both the inpatient and outpatient sides of the business. The purpose of this model is to create a decision-making model that considers what is best for the whole product line (and therefore, all of its stakeholders) and not the "squeaky wheel."

The Models

An Introduction

There are three primary models: the Professional Services Model, the Business Enterprise Model, and the Employment Model. There are several variations of each model, but the primary distinctions revolve around (i) whether the physicians are employed or their services are leased and (ii) whether a practice's assets are sold or leased.

The Professional Services Model

The Professional Services Model is essentially a lease arrangement and should be considered the least integrative. Under this model, a practice and hospital will negotiate for the services of a specified number of full-time equivalent (FTE) cardiologists. This model allows an entire group of cardiologists to provide the services of a lesser number of FTE cardiologists. For example, a cardiology group with 20 physicians practices mainly at two hospitals. If one of those hospitals wanted to contract for 12 FTE cardiologists, the entire group could provide those services, such as call coverage.

This model typically provides the ability to not only lease cardiology services, but also to lease assets and staff. Most hospitals will engage an independent firm to fix a lease rate for the non-diagnostic assets. The staff is often paid for as a pass-through cost with an added margin (for example, 10%) for supervision and management. Governance is rarely an issue since the cardiology practice stays intact and the physicians remain responsible for their own operational and financial decision-making. There may be a committee made up of hospital and physician

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representatives to discuss common interests and other potential avenues of cooperation. However, the cardiologists' primary duty under this model is to meet the contractual obligations that serve as the basis for the lease payments received.

This model is best suited for those hospitals and cardiologists who want to "dip their toe" in the integration pool, but are not ready to dive in. This is a model that is financially attractive to hospitals because there is no large up-front payment to the cardiologists for their assets. In addition, hospitals often lease only a portion of the group's services, thereby reducing the overall costs of this model. However, this model does not create a real sense of partnership with the cardiologists and rarely serves to address hospital expense reductions, process improvement, and market growth.

This model is attractive to some cardiology groups because it provides a "bump" in their compensation. It also lets the cardiologists preserve their autonomy and their ancillary diagnostic revenues. The other side of this coin is, if you believe that revenue and expenses will continue to diverge, you have only delayed the inevitability of full integration. The practice may receive a lower valuation and compensation package because of the delay. For those groups where incremental change is the better path, however, the Professional Services Model may be the better model.

The Business Enterprise Model

The Business Enterprise Model shares elements of both the Professional Services Model and the Employment Model. The essence of the Business Enterprise Model is the cardiologists are employed, but the assets and staff are leased. The reason for this model's existence is a difference in physician compensation. Some valuation firms have found it easier to justify higher compensation levels when physicians were employed by a non-profit entity rather than when there is a financial transfer between the non-profit hospital and the for-profit cardiology practice.

There is another powerful psychological factor that arises from this model: employing the cardiologists creates a greater sense of interdependence between the hospital and the physicians. This is important because that sense of interdependence can lead to a greater cooperation toward mutually worthwhile goals.

One of the largest areas of misgiving about physician-hospital integration is its long-term sustainability. First, hospitals start with greater financial resources than most cardiology practices. Second, hospitals currently receive better reimbursement for physician-provided services and the diagnostic tests they order. As a result, hospitals are able to provide physician compensation that serves to keep its existing cardiologists and recruit additional cardiologists where needed, even if the physician compensation requires a hospital subsidy. The question is: as hospitals experience an expected decline in reimbursement, are those subsidies sustainable?

Some hospitals have answered that question by insisting that improvements in physician compensation not exceed the combined effect of improved hospital reimbursement for the physicians' clinical services and the diagnostic tests for which they are responsible, as well as the

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cost reductions resulting from greater buying power. However, other hospitals have assumed that subsidies for 3-5 years would be necessary at the outset of the physician-hospital integration programs. For these hospitals, the sustainability of physician-hospital integration rests on the promise of cooperation with its physicians to identify and implement revenue improvement and cost savings opportunities that would help pay the costs of increased compensation.

Cardiologists are used to reviewing their own practice's financial statements and, where top line revenue or expenses diverge, considering methods to improve one or reduce the other to sustain their compensation. Employing cardiologists can result in the same behavior because, while the employer differs, the goal is the same.

An added upside to this Model as well as the Professional Services Model is that, because the assets and employees remain within the practice (though leased to the hospital), it is easier to unwind these transactions. However, the possibility the transaction might be unwound serves as a reminder that cardiologists adapting to one of these models should continue to work under the practice's name to avoid any marketplace confusion in case the parties unwind.

The Employment Model

The Employment Model is clearly the most popular of the three models and the most integrative. This Model assumes the practice's assets are sold, the practice's staff becomes part of the hospital's staff, and the cardiologists are employed by the hospital (or an affiliate). There are several key issues related to the silos discussed above.

For practice valuation, besides paying intangible assets, cardiologists should aim for a stock transaction with the hospital rather than an asset sale. The reason: the funds are treated as capital gains income in a stock sale. The proceeds in an asset sale are treated as ordinary income. Since the tax rate on ordinary income is more than double the capital gains tax rate, the difference for many cardiology groups would be in the hundreds of thousands dollars.

With compensation, there are two components: how compensation funds are earned and how compensation is divided. The hospital will be mostly concerned about how compensation funds are earned (which is more fully discussed in the next paragraph) and are unconcerned about the distribution methodology (other than to assure itself the distribution methodology is non-discriminatory since the hospital would be responsible for any liability as the ultimate employer). Therefore, cardiologists should negotiate for a compensation methodology that will be consistently applied for at least the first five years of the agreement. Cardiologists also should decide throughout the agreement the distribution methodology as well as keep the authority to alter the distribution as the cardiologists find necessary.

Compensation methodologies often are based on work units or time units. The most popular methodologies use the Medicare Work Relative Value Units (wRVUs). While some cardiologists object to this measure as containing inherent biases, they are objective, easily measured, and widely accepted for purposes of compliance with the Internal Revenue Code and Medicare laws and regulations. The most popular compensation methodologies either pay the cardiologists a fixed dollar value (also known as the "conversion factor") for each wRVU or pay

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a fixed dollar amount for a fixed number of wRVUs. In either case, the physicians should be rewarded if their productivity exceeds historical levels.

There are other compensation issues to be negotiated. For example, how are the non-clinical professional activities (for example, teaching, research, medical directorships, traveling to outreach clinics) compensated? What happens if a competing health system shuts out the acquired cardiology group from referrals from the Emergency Department or from opportunities to read unassigned diagnostic tests? What is the term of the employment agreement (five years is the norm) and do the parties start from scratch in negotiating renewals? Is there a non-competition agreement that would prevent the cardiologists from re-entering private practice in the same community? Experienced counsel can advise about each of these matters based on their experiences in similar deals.

In terms of governance, the goal is simple: cardiologists should seek to preserve primary responsibility for their practice's operations. If there are skilled leaders in the practice, the practice should seek to lead the overall cardiovascular product line. The rationale for this goal is twofold. First, most cardiologists have successfully managed their practices for decades where most hospital administrators have little to no experience in managing physician practices. Rarely do cardiologists view hospital operations as the gold standard. Second, the advantages that are available from an integrated model are best achieved if the cardiovascular product line is managed as an integrated whole rather than separate management of the physician practice and the hospital operations.

However, there is wisdom in the adage that begins, "Be careful what you ask for…." There are visionary hospital executives who recognize that, if they could successfully trust the combined business and clinical operations of the hospital's product lines to one or more physician leaders, the likely outcome would be higher quality patient care and improved financial performance. The problem is, if you ask for that responsibility, the rest of the adage suggests, "…you might get it."

For cardiology groups who already play an active role in the hospital's operations of the cardiovascular product line, taking on broader responsibilities is a logical next step. For those groups whose primary involvement has been to serve as a medical director or on the hospital's Board of Trustees, a "walk before you run" approach may make more sense. In either case, there will be some form of Joint Operating Committee that will have primary responsibility for the product line.

The primary difference in the broader versus more limited physician responsibility will be whether the ultimate administrator will be a physician or a hospital administrator. However, even where a physician is the ultimate administrator, there is an "operations" person who is a critical part of the team. It also is important to remember that in every state, the law prescribes that the Board of Trustees has the ultimate legal authority concerning a nonprofit hospital and its operations. As a result, the ultimate administrator can expect to report either to the hospital CEO or to the Board.

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Foundation Model

The employment models have generally been direct employment or employment by a wholly owned subsidiary of the health system. Unlike the transactions in the '90s, current valuation firms offer little if any payment for the "goodwill" of the practice. Notwithstanding, the positive benefits that full employment provides from an alignment and integration perspective, this approach has the risk associated with any non-physician control delivery system - that the clinical decision-making and initiatives will be delayed based on institutional priorities. Therefore, alternative models including physician ownership, physician management, service line management, or the foundation model should be considered as part of any restructuring.

The foundation model represents an alternative to hospital or health system purchase of physician practices followed by direct employment by the hospital or a wholly owned or controlled affiliate or subsidiary. Originally the foundation model was developed to address prohibitions against the "corporate practice of medicine." In the current regulatory and managed care environment, the foundation model may also provide the opportunity for both greater physician governance and over clinical practices (as well as internal compensation methodologies to the extent the contracting physicians can qualify for the group practice exception with respect to referrals to designated health service providers). In addition, this model can address the situation where cardiologists are affiliated with multiple hospitals.

Brief Description

Under the foundation model, the practice assets of the selling physicians, including any owned outpatient facilities or ancillary service lines would be transferred to a not-for-profit foundation whose member(s) would generally be affiliated hospital system(s) but whose managing boards and operating committees would contain significant but minority physician representation. To qualify for tax-exempt status, the foundation would need to prove that foundation and its affiliated hospital jointly provide a system of care.

The selling physicians (or their group practice) would enter into independent contracts to provide services at foundation practice locations. In those circumstances where each physician has his or her own service agreement, the compensation methodology is similar to the direct employment model in that physician compensation will be primarily determined based on reasonable and fair market value per unit of personal service by the physician. Bonus pools may consider other quality, patient satisfaction, gain sharing, education or other service, or outcome components. This methodology assures appropriate productivity while creating incentives to reward physician behavior that promotes system or community mission objectives.

Alternatively, independent selling physicians could form the group practice, which contracts with the system. Either approach can provide the capacity for flexible benefits subject to meeting ERISA requirements. The group practice contracting approach can also be structured to enable the group practice to decide the compensation share so long as the total compensation does not exceed fair market value. Any internal allocations must comply with Stark requirements for treating group practice ancillary revenue. As with medical faculty practice plans, governance

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under certain circumstances can be coordinated with the clinical inpatient department structures to promote clinical integration between the outpatient and inpatient settings, both on campus and other physician practice sites.

The foundation model is flexible and could support an aggregation of physician services and tie several group practices into a more integrated regional entity (this has significant governance issues and would require strong financial and operational management resources to implement). In rural settings, the Foundation model may enable physicians to affiliate constructively with several different hospitals to create a more rationale sharing of cardiac services based on community need and efficiency.

Attributes

The success of this model depends heavily on the physicians and their administrative team's demonstrated capacity to exercise their more independent clinical autonomy to the mission of the sponsoring member and the willingness and ability of the hospital system to align its internal service lines to achieve the goals of efficiency, effectiveness, and coordination between the inpatient and outpatient treatment settings. This model should allow continued clinical autonomy over outpatient treatment centers and the opportunity to collaborate in the inpatient setting. The foundation might be able to replace some of its ancillary income loss with system or hospital payments associated with mission outreach, community education, or wellness activities. The foundation model might also allow lower cost tax exempt financing for certain capital needs.

To the extent the cardiology group seeks tax exemption, the process will take substantial time to complete. The foundation, as part of that process and after that, will need to show compliance with its not-for-profit tax-exempt mission. To do this, the foundation will be accountable for diligently administering its charity care and strong conflict of interest policies and will need to demonstrate proper use of revenues to support education, wellness, access, quality, research, and charity care. The foundation model is a true partnership, not only with the hospital but also with the community at large, and cardiologists must understand that their income will be subject to independent review.

Many of the most recent collaborations between hospitals and cardiologist or group practices with cardiologist members have been driven by reimbursement or alignment objectives. The most recent changes to the Stark regulations will require restructuring of those arrangements. Under the right circumstances, the foundation model could be employed to preserve clinical autonomy over cardiac services and alignment with the health system.

Antitrust Issues

The federal antitrust laws are designed to both encourage and protect competition. The antitrust laws accomplish this goal by discouraging business arrangements that reduce or limit rivalry between competitors. Oftentimes, however, collaborative arrangements that limit rivalry between competitors actually enhance consumer welfare. The antitrust laws refer to these types of arrangements as being procompetitive. As a general rule of thumb, business arrangements do

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not run afoul of the antitrust laws when the consumer benefits created by the collaboration outweigh the reduction in rivalry caused by the collaborative effort.

A business collaboration by competitors is procompetitive, within the meaning of the antitrust laws, when it creates efficiencies. A business arrangement is efficient when it provides higher quality services at a constant or lower cost. Under basic economic theory, such efficiencies increase competitive pressures in the market, because the other firms in the market must improve their services, if they want to maintain their market share.

The phrase "business collaboration" spans everything from mergers to joint ventures, to IPAs to exclusive service contracts. This paper does not specifically address the antitrust issues raised by physician IPAs. The authors of this antitrust discussion have comprehensively addressed IPA issues in the AMA publication "*Competing in the Marketplace: How physicians can improve quality and increase their value in health care market through medical practice integration*." That AMA paper is being supplied at this ACC conference. Instead, this antitrust discussion will address the antitrust issues raised by mergers and joint ventures generally.

Section 7 of the Clayton Act

Mergers have and will continue to play a critical role in the improvement and modernization of markets. It is well recognized today that mergers can create substantial efficiencies leading to improved competition and enhanced consumer welfare. Consistent with this understanding, the courts and federal enforcement agencies do not look upon mergers as simply a device to consolidate markets in order to generate monopoly profits. However, the courts and the federal enforcement agencies will not rubber stamp mergers. Instead, they apply realistic analytical tools that are designed to separate mergers that create efficiencies from mergers that will improperly consolidate economic power.

1. Section 7 of the Clayton Act

Section 7 of the Clayton Act ("Section 7") prohibits mergers that may substantially lessen competition in any line of commerce. Combined in this sentence are a number of discrete issues. The first, and most important, is whether the merger will give the merging parties market power. Market power is commonly understood to mean the ability to raise prices above competitive levels or to reduce output below competitive levels. It is the creation of market power that can harm competition and reduce consumer welfare. Mergers that do not create any market power will not violate Section 7 of the Clayton Act.

Once the market power issue is addressed, a merger analysis will turn to the efficiencies the merger will create. If it is likely that the merger will create some market power, identifying significant efficiencies created by the merger becomes critical. If a merger creates substantial efficiencies, it could actually increase competition in the market even though the merger mildly increases the merged entity's market power.

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a. Market Power

Case law and the federal antitrust enforcement agencies recognize that it is difficult, if not impossible, to directly measure a firm's "market power," meaning the ability of the merged firm to raise prices or reduce output. In an analysis of a prospective merger, this difficulty is compounded because the merged firm does not yet exist. Merger analysis typically tries to make a prediction as to the market power the merged firm will possess after the merger is consummated.

Given these practical difficulties, market power is usually evaluated indirectly by calculating the relevant market shares of the merging parties, and then trying to determine if the market shares, when combined, could create market power given the specific characteristics of the affected markets. With respect to physician practices, market share is commonly calculated by comparing the number of physicians in any given specialty with the total number of physicians who compete against the merging physicians in the relevant geographic market. For example, assume that a merger of two cardiology practices will create a firm with 30 cardiologists. If there are 300 cardiologists in that market, the new firm will have a market share of only 10%. Such a low market share cannot realistically support market power. Given that 90% of the market is unaffected by the merger, consumers have many other cardiologists they can turn to if they do not like the prices or services offered by the merged entity. As a rule of thumb, a 30% market share is commonly recognized as below the level needed to show market power.

The existence of subspecialties and ancillary services, however, can complicate this analysis. For example, if the two cardiology practices each has a cath lab, the merger analysis will then have to look at the number of cath labs in the market. Merger analysis, therefore, requires a careful analysis of the many services that are provided by the firms creating the merged entity. The absence of market power with respect to one service does not preclude the existence of market power with respect to other services.

An equally important question is what constitutes the relevant geographic area. It is impossible to calculate a market share without knowing the geographic area affected by the merger. For example, assume a merger of two cardiology firms in county A that creates a new firm with 10 cardiologists. If county A has only 20 cardiologists, just looking at county A would support a claim that the merger has significantly concentrated the market. A market share of 50% for the merged entity could support a claim that the merger will confer market power on the merged firm. That limited analysis, however, could significantly overstate the economic power of the merged firm if the relevant geographic market was larger than just county A.

The analysis used to define a relevant geographic market looks at where consumers can practically turn for the services affected by the merger. Using the above example, the critical question is whether patients in county A can practically use cardiologists in different counties. If patients can and do use cardiologists located in other counties, those other counties, along with county A could constitute a relevant geographic market for antitrust purposes. Going back to the above example, assume that neighboring county B is part of the relevant geographic market and has 200 cardiologists. While county A has only 20 cardiologists, the relevant geographic market

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would have at least 220 cardiologists. In this market, the merged entity's 20 cardiologists would have a market share of less then 10%. Such a small market share could not realistically give the merged entity market power.

A proper economic analysis has to define the area in which effective competition takes place. While the economics of such an analysis are complex, most competitors in a market have a good general sense as to the size of the market in which they operate. This "general sense" is not a substitute for careful economic analysis, but it will oftentimes point out possible antitrust issues that need a more thorough evaluation.

The market share of the merged entity is only a proxy for market power. While a very low market share will almost conclusively disprove the existence of market power, a moderately high market share does not conclusively prove the existence of market power. Market power exists when a high market share is protected by entry barriers. An entry barrier is anything that prevents or hinders the ability of new competitors to enter a market or for existing competitors to expand. Entry barriers can come in many different shapes and sizes. For example, state certificate of need laws are entry barriers because they limit the ability of firms to build or expand competing medical facilities. A market's geographic isolation can also constitute an entry barrier. This type of barrier, however, can range from mildly significant to highly significant. The cost of entering a market can also constitute an entry barrier.

Further, the entry barrier has to prevent entry for a meaningful period of time. Two years is a commonly accepted time frame for evaluating entry conditions. Barriers that will limit entry for less than two years are not the types of entry barrier that typically support market power.

Given the critical role played by market power in merger analysis, the possibility that a merger will raise antitrust issues will depend on whether the parties to the merger actually compete with one another (a horizontal merger) or if the parties operate at different levels in the market (a vertical merger). The merger of two cardiology groups that operate in the same geographic area would constitute a horizontal merger. Such a merger eliminates the competition that previously existed between the practice groups and has to some extent increased their share of the relevant market. If these cardiologists have only a small share of the relevant market, it is unlikely that the elimination of competition between these firms will have any effect on the level of competition in the market.

It is important to keep in mind, however, that the antitrust laws look at the economic reality of a merger and not its specific structure. If three cardiology practices form a new company and then sell their practices to that company, the overall transaction is analyzed as a horizontal merger. As with a standard merger of two groups, the issue is whether the new company will have market power as a result of the transactions.

A cardiology group's merging with a hospital is theoretically treated as a vertical merger. The distinction between horizontal mergers and vertical mergers is important. Horizontal mergers typically receive more antitrust scrutiny than vertical mergers. Vertical mergers, by their very nature, do not have the ability to directly reduce competition, and are generally recognized as having the potential to create significant efficiencies. For example, vertically

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related firms typically provide complementary services to the ultimate consumer. A merger between firms that provides complementary services can create significant efficiencies by allowing the merged firm to adopt comprehensive strategies with respect to the creation and marketing of a single comprehensive service. Vertical integration can also lower the cost of providing both services. Precisely for this reason, many firms will vertically integrate their supply and distribution chains.

For example, surgeons and hospitals provide complementary services that, when combined, create a comprehensive surgical service. Both the hospital and the surgeon play vital roles in the provision of surgical services, and they both play a role with respect to improving those services. The hospital's providing excellent equipment and highly trained support staff gives the surgeon the ability to improve the overall quality of the surgical service. A surgical group's offering a hospital a comprehensive coverage arrangement can increase the hospital's efficiency. Business arrangements that improve the coordination between hospitals and surgeons can, therefore, create significant efficiencies. Further, if a hospital and surgical group do not compete, the possibility that the collaboration will injure competition is reduced. It is the plausibility of efficiencies and procompetitive effects, and the lack of any direct threat to competition, that results in vertical mergers having less antitrust exposure.

It is sometimes a challenge to determine whether the merger is vertical or horizontal. If a hospital employs cardiologists prior to its acquiring a cardiology group, the merger has both horizontal and vertical aspects. Even if the hospital did not previously employ cardiologists, a competitive overlap can arise from ancillary services. For example, if a hospital and a cardiology group each operate a cath lab, they are horizontal competitors with respect to that service. In any merger, it is essential that the parties identify all of the services that they offer and determine if any competitive overlap exists.

After looking at market shares and entry barriers, it is important to look at the level of concentration in the market. This step looks at the number of competitors in the market and their respective market shares. A market with 100 competitors, each of which has only a 1% market share, is an unconcentrated market. A market that has only five competitors, each of which has a 20% market share, is considered highly concentrated. A merger of two firms in a highly concentrated market has a greater potential to have anticompetitive effects than a merger between competitors who operate in an unconcentrated market.

a. Efficiencies

A proper merger analysis will also evaluate the efficiencies that the merger could create. Efficiencies are created when the merger allows the merged firm to offer consumers higher quality services at (a) the same price, or (b) the same level of services at a lower cost. For example, two independent cardiology groups may not have the resources or critical mass to make the purchase of an electronic medical records system practicable. If the combined firm has the ability to purchase an electronic medical records system, the new firm will be able to improve the care it offers its patients.

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If a merger creates significant market power, it is unlikely that created efficiencies will provide an adequate defense to an antitrust challenge. Efficiencies will play a significant role in cases where it is unclear whether the merger will create market power or if the increase in market power is relatively small. If a merger creates significant efficiencies, it will give the merged firm an incentive to act in a competitive manner. The efficiencies allow the merged firm to increase market share by lowering prices or demonstrating to consumers that its services are superior to those offered by its competitors. At some point, however, market power will give the merged firm the ability to act in a manner that eliminates any of the benefits consumers would realize from the efficiencies created by the merger. Efficiencies are not, therefore, a tonic that will save every proposed merger.

To mitigate the market power concern, the efficiencies created by a merger must be "merger specific." This means that the efficiencies are created by the merger and were made possible because of the merger. The ability of a merger to reduce administrative costs, for example, is a common type of merger specific efficiency. A merger can also give the combined firm access to levels of capital that were unavailable to the individual firms. For example, the merged firm may be able to acquire and implement an EHR system. This would constitute a merger specific efficiency. If, on the other hand, each cardiology group were able to purchase an electronic medical records system independently, the merged firm's plan to purchase such a system would not constitute a merger specific efficiency.

When considering a merger that could raise antitrust issues, it is important to identify and quantify, if possible, the efficiencies the merger is likely to create. This process has two benefits. First, it creates the data necessary to address a possible antitrust challenge to the merger. Second, this process can help the parties identify changes to the merger that will increase the necessary efficiencies or even create new efficiencies.

Merger law is flexible, and leaves firms considerable room in which they can operate. It is important to conduct the antitrust planning before the merger is close to consummation so any risks are identified and addressed.

Section 1 of the Sherman Act

Section 1 prohibits concerted conduct that unreasonably restrains trade. The first and most basic question, therefore, in any Section 1 analysis is whether some type of agreement exists (i.e., contracts, combinations or conspiracies) between two or more firms. Without this distinction, Section 1 would conceivably outlaw every corporation, partnership, and practice group that assembles employees.

Theoretically, every employee at a firm could have competed against the other employees or the firm in general. The antitrust laws recognize, however, that the marshalling of economic resources and actors is oftentimes essential to the efficient provision of goods and services. For this reason, the United States Supreme Court has long held that employees of a firm cannot conspire with their co-workers or with their firm. A firm is therefore free to set its own prices and to limit the types of work performed by its employees. Accordingly, physicians can lawfully create firms in which they merge their practices. If physicians properly merge their practices,

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they will not violate Section 1 when this new firm sets prices on behalf of the firm's physicians. The antitrust question is whether the merger violates Section 7 of the Clayton Act, which is discussed above.

The second basic question asked by Section 1 of the Sherman Act, is whether any agreement between two or more firms in the market unreasonably restrains trade. Section 1 of the Sherman Act applies to any agreement that has even a slight effect on commerce. Therefore, Section 1 covers more than just agreements between direct competitors. Section 1 applies, for example, to agreements between purchasers and suppliers, and agreements between providers and consumers. Agreements or concerted conduct between direct competitors typically raise the most serious antitrust concerns. Agreements between firms at different levels in the market (i.e., vertically related firms), however, can under certain conditions also raise antirust concerns.

For example, an agreement between a cardiology practice and a hospital making the cardiology practice the sole provider of cardiology services at the hospital is a vertical arrangement that could raise antitrust issues. In this situation, the agreement has not eliminated competition between the hospital and the cardiology group, but it could, under certain conditions, injure competition between hospitals in the market or between cardiology groups in the market. In this example, if the hospital was a monopolist, the exclusive contract might prevent other cardiology groups from practicing in the relevant geographic market. This could injure competition in the market for cardiology services. The exclusive contracts can also make it more difficult for other hospitals to enter the market if the exclusive contracts make it hard for a new hospital to offer a full range of services.

Vertical agreements, however, can create substantial efficiencies and most are not looked upon with suspicion by courts and antitrust enforcement agencies. More importantly, vertical arrangements do not directly reduce competition between competitors. For these reasons, a vertical arrangement will typically raise antitrust concerns only when one or more of the parties to the arrangement have market power.

Agreements between direct competitors receive greater scrutiny under the Section 1 of the Sherman Act than vertical arrangements. Certain agreements between competitors can directly reduce competition between the firms and thereby create a risk that the agreement will injure competition in the relevant market. For example, two hospitals agreeing that they will no longer advertise against one another would raise serious antitrust concerns. But not every agreement between two competitors raises the same level of antitrust concern.

Two hospitals agreeing to use a joint agent to purchase basic office equipment would not seriously threaten the competitive process. Indeed, if the joint purchasing arrangement allowed the hospitals to lower their costs, the arrangement could lead to more competition in the market for hospital services. The advertising restraint, on the other hand, directly reduces competition between the hospitals with respect to the sale of their services to patients. This restraint can make the market for hospital services function less efficiently, and thereby injure consumers. The purchasing agreement between two hospitals, however, will not directly affect competition for hospital services, because hospitals are not (presumably) in business of reselling office equipment. While the arrangement could hurt some suppliers of office services, the agreement

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cannot realistically injure competition in the equipment market, if the hospitals lack market power with respect to the purchase of office equipment. A joint purchasing agreement, however, can create real efficiencies that benefit the patients who use the hospitals' services. Identifying the markets affected by an agreement is a critical step when analyzing an agreement under Section 1.

Agreements between competitors that limit or regulate competition are not necessarily unreasonable. Such concerted conduct is oftentimes highly efficient and can lead to greater competition precisely because it reduces or regulates some aspects of competition. For example, most sports leagues could not function properly if the participating teams did not limit some types of competition between the teams. For example, the NFL needs rules concerning the recruitment of players that technically limit competition between the teams. These rules, however, create benefits to the NFL as a whole and make watching NFL games more entertaining to fans. The antitrust analysis required by Section 1 is designed to balance the need to sometimes restrain rivalry with the more general belief that strong rivalry is good for consumers.

As the antitrust laws evolved, the courts created two basic methods for distinguishing reasonable from unreasonable concerted conduct. One method is the application of the so called *per se* prohibitions. The *per se* prohibitions are based on the belief that certain types of behavior are so blatantly anticompetitive, any consideration into their possible procompetitive effects is unnecessary. Accordingly, an arrangement falling under a *per se* prohibition is condemned without conducting any analysis into whether the concerted conduct would have a positive effect 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 create efficiencies is not a question a court or an enforcement agency will consider. Further, whether the two competitors actually have the ability to injure competition is also ignored. For example, a price fixing agreement between two hospitals is unlawful, even if these hospitals had a collective market share of less than 1%.

A benefit provided by the use of *per se* prohibitions is that they provide a high degree of clarity. This clarity, however, comes with a cost. The cost is that the *per se* prohibitions may outlaw arrangements that are procompetitive and will benefit consumers. As a result, the types of agreements that fall within a *per se* prohibition are strictly limited.

As the antitrust laws have evolved, the courts and the antitrust enforcement agencies have recognized many exceptions to the rigid application of the *per se* prohibitions. The most commonly recognized exception exists when competitors form a joint venture (short of a merger) through which they undertake some type of common business venture. In order to make the joint venture viable, the participating competitors may, for example, have to agree on the prices charged by the joint venture. If the joint venture is otherwise lawful, the pricing agreement will

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not receive *per se* treatment if the pricing agreement is reasonably connected to the operation of the joint venture and is reasonably necessary to its operation.

Joint ventures come in an almost infinite variety. The role of antitrust analysis, when evaluating the application of a *per se* prohibition, is to determine the connection between the restraint and the operation of the joint venture. The positive side of this analysis is that competitors have flexibility when creating joint ventures. The negative side is that it is not always possible to eliminate the possibility that a joint venture will find itself subject to an antitrust challenge. Here, the question becomes the level of risk that the participants to the joint venture are willing to undertake.

With respect to the current paper, it is important to recognize that cardiologists and hospitals are not generally direct competitors. As health care markets have evolved, cardiologists and hospitals have found themselves sometimes offering the same types of ancillary services. Further, when a hospital employs cardiologists, it has made itself a competitor in the market for cardiology services. It is therefore important for cardiologists to determine whether a competitive overlap exists with a hospital before entering into a joint venture with the hospital. A hospital's competing against a cardiology practice does not prevent the two entities from creating a joint venture. The competitive overlap, however, does make it necessary to conduct a more complete analysis into whether the joint venture creates a horizontal agreement that could fall within a *per se* prohibition.

If a *per se* prohibition is not triggered, an agreement subject to Section 1 of the Sherman Act is evaluated under the so-called rule of reason. Under the traditional rule of reason, a court determines whether the restraint, on balance, is anticompetitive. To make such a determination, a court will determine whether the parties to the agreement have the ability to exercise market power. This step raises the fundamental question whether the parties could adversely affect competition by their conduct as a practical matter. If the answer to this question is negative, the parties should have the ability to experiment with business arrangements that could benefit consumers.

A court will also determine, under the rule of reason, whether the agreement is the type of agreement that commonly would raise antitrust concerns. For example, parties sometimes enter into agreements that could have some effect on price, but the arrangement does technically constitute price-fixing. While a court can deem such an agreement anticompetitive on its face, the parties to that agreement will have the opportunity to prove the existence of offsetting efficiencies that in substance can override the antitrust concerns.

Overall, the antitrust laws leave the door open to many types of business arrangements. The key is identifying the potential risks. Sometimes, the parties can achieve their goals by making changes that eliminate the antitrust issue. When the risks persist, the parties can develop their efficiency story in advance so they can proactively address the concerns of an antitrust enforcement agency, should it choose to evaluate the transaction.

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Case Studies

Case Study #1

Practice: Single group, 15 partners

Location: Stanford, Connecticut

Population: 90,000

Hospital system: Single, non-profit

The only group in this city, Cardiology Consultants of Stanford, has been growing steadily for the last 10 years, now reaching 15 partners. Because of the increase in practice expenses, and declining reimbursement, they have considered many options for business growth including construction of an outpatient cath lab. Hearing this, the hospital CEO approached the leaders of the group with a proposal for integration. The proposal involves complete integration of the group and employment by the non-profit hospital with purchase of the capital equipment and building. As the executive committee of the practice ponders the offer, several questions arise:

1. Who has the business expertise to help us consider this acquisition? What consultants should we consider?
2. How will compensation be determined? Value of our assets? Will incomes be published in non-profit news?
3. Who will govern this new entity? What model of shared governance exists and has been tested?
4. What will happen to our management team? Employees?
5. Does the ACC have resources to help us begin the process?

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Case Study #2

Practice: Single group, 10 partners, 2 MLP

Location; Fairfax, VA

Population: 600,000

Hospital systems: Three separate: One Catholic, one for profit, one non-profit

The smallest of the four major groups in Fairfax is Cardiology of Fairfax. Unlike the three larger groups, they have maintained control of their group size and management. However, political clout and recruiting have been an issue for them, often losing to the larger groups. The single EP physician left the group to join a competitor and the fear of losing more partners is a concern.

The local for profit hospital has had major issues with the dominant group (45 partners) and has approached Cardiology of Fairfax and another practice to consider merger and integration into their system. This new 24-physician group would provide exclusive coverage for all cardiac services and move into their offices on campus. With all the patients in this system, they could eliminate their service to the other two hospitals. Now they must consider:

1. What consultants can advise us on future profitability versus single hospital service?
2. What will happen with our imaging center that provides 35% of current income in our office?
3. Will changing focus to a single hospital trap us and eliminate options of working in the larger hospitals in the future?
4. How can we evaluate the fiscal stability and referral system of the for profit hospital?
5. Who is in control of our destiny if we choose this option?
6. Will the cultures of the two groups match well? Can administration changes affect our contract?
7. What will happen to the oldest partners in the group nearing retirement?

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Case Study #3: After the Ceremony, How Does the Marriage Work?

A 50-year old cardiology practice had reasons to consider full integration with the largest hospital system in the region. Initially, the two entities were aligned through medical directorships, service contracts, and other contractual arrangements. However, changes in regulations and legal restrictions created the need to develop another form of alignment. In addition, members of the group were themselves realigning with a new heart hospital that was developing. The economic pressures on the remaining members of the group made it important for both the hospital and the group to restructure.

The hospital had a large medical group that would support the patient volume needed. They had a regional aero medical transport system to feed cardiac acute care. Capital was available for needed investment in EMR, computers, HR, and other large infrastructure costs. With many cardiologists moving to the heart hospital, the group would provide continuing cardiac care as well as keep a large patient volume. It would be a strong start to bring together two willing and suitably oriented partners.

To accomplish this result the cardiology group, led by the group's CEO, and the hospital, led by the VP over practice management, went through the extended period of legal work, economic negotiation, and discussions of administrative integration to structure an effective working relationship. The merger of the cardiology group into the medical group involved acquiring the groups while retaining the name of the practice. The CEO of the cardiology group had experience, training, and education in administration and became a VP in the hospital eventually directing the cardiovascular service line. In addition, he became a member of the executive management team of the hospital.

The initial integration of the group into the hospital was successful in many ways. This included the economic agreements, the offloading of administrative responsibilities, which the cardiologists found burdensome, and the availability of added resources. Decision making within the larger medical group was acceptable and a member of the group sat on the medical group's board.

However, over time, the issues regarding integration with the hospital have had unforeseen consequences. It is instructive to discuss these issues to help others who are considering this path of alignment.

Traditionally, administrators and physicians have been trained in different ways. Although both supposedly work to take the best care of patients, administrators and doctors vary in their decision-making (individual patients vs. large groups), time frames (quick vs. prolonged), structure of responsibility (patients vs. boards), etc. Even with the best of intent, there is the tension of distrust.

Therefore, it is important to set up the correct structure at the time of the marriage. From an administrator's viewpoint, if it is not on the organizational chart, it does not count. If you do not have anyone reporting to you and the support staff to make you efficient, you can be undermined and marginalized. Once you have a representative within administration, he faces

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long odds from both sides of the aisle. Remember the organizational chart can be changed and the initial reserved powers can be removed arbitrarily unless protected.

So, when creating the alignment, remember to address the following areas:

- Common strategic goals: Rely on metrics that are reviewed regularly to assure joint efforts and not being discredited. This can be done with consultants but physicians must have input into the strategy and the tactics.
- Financial agreement and transparency: Hospitals are notorious for having data that are not particularly accurate. You must have input and you must own access to the financial data as appropriate to the alignment.
- Governance: You must have a seat at the table at the most senior levels to include the hospital board and senior administration. No voice = No vote.
- Capital needs: Once you are inside the larger entity, the competition for capital is intense. You must have a voice or the technology needed to support high quality practices will be limited.
- A physician champion must be identified so the group is not split into small voices. This person must be rewarded for time and expertise. He needs to be part of the organizational chart.

The group must be guaranteed a seat at the table as defined above. If there is a change in the administration, the group must protect itself through agreements that supersede the whims of the next hospital CEO.

Summary

Merger/acquisition is the start of the process. You must live with the agreements long-term. It is natural to focus on the early agreements (salary, staff, support, etc.). Do not forget to be well represented in the future. Beware of the difference in the mind-set of administrators and physicians. Protect yourself in the future in as many areas as possible expecting the worst and anticipating, “If it is not documented, it does not exist.” Lastly, try to get advice from those who have done it.

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