

Pay For Performance: The Case For Quality As An Integrating And Incentivizing Factor

By Robert H. Ryan, MD, Tobin N. Watt, Esq., Barry S. Herrin, Esq.,
Jennifer Pritzker Sender, MPH, Esq., Laura J. Cook, MHSA*

INTRODUCTION

American healthcare is at a crossroads. Our healthcare spending approximates about twice that, on a per capita basis, of other industrialized nations,¹ but we are encountering severe challenges. Our spending is not being reflected in comparable high quality. Patients complain of lack of attention by physicians, the high cost of pharmaceuticals, and excessive bureaucracy and complexity with regard to insurers and governmental programs, among other things. Most significantly, physicians complain of disinterest by payors in the quality of care, chafe under payor pressure to reduce utilization, and are aggrieved by payment processes that seem random.

It was assumed until only a few years ago that “quality” was a concept that, like good art, cannot be measured but “one knows it when one sees it.” However, significant effort on the quality front has created major advances in quality measurement.² Quality measurement now has a reasonable capacity to describe in factual terms standards for healthcare events in the clinical setting.³ We believe that the healthcare system is on the threshold of being able to use a quality measurement as a vehicle for advancing the integration and coordination of medical services, improving compensation patterns for providers, and improving the overall quality of care received by the public.

The topics addressed in this paper involve quality issues, reimbursement issues, and legal issues relating to physician collaboration. It will be helpful to set the stage, therefore, with a brief description of how the American healthcare system has developed.

BACKGROUND

At the end of World War II, the American medical delivery system almost certainly was the most advanced in the world.⁴ At that point, it was still relatively commonplace for Americans to have no health insurance, and their contact with the healthcare system was based on a personal relationship with a general practitioner physician. The 1950s saw significant advances in medical technology, processes, and pharmaceuticals, simultaneously with a major expansion of third-party payment programs.⁵ The expansion of third-party payment was based almost entirely on indemnity plans based on community ratings, minimal co-payments and deductibles, and open access.⁶ The third-party payor system thus had minimal impact on the manner in which healthcare was delivered. Most patients still maintained a direct, personal relationship with a physician, many of whom were general practitioners. During the 1960s, the situation began to change as healthcare spending rose significantly, culminating in 1965 with the introduction of Medicare and Medicaid.⁷ Medicare created a payment program for practically all Americans over age sixty-five, while Medicaid created a joint federal-state payment program for many indigent and low-income persons. At this stage, even with the Medicare and Medicaid programs, payment programs did not materially impact the delivery of care, and hospitals and physicians probably regarded them as being relatively benign. Again, Americans perceived that they had a high-quality system and maintained personal relationships with physicians. During the 1970s and 1980s, most Americans enjoyed some form of coverage from a third-party payment system, but the cost of healthcare was rising significantly. Indeed,

during this period, alternative forms of payment to physicians began to arise. While most physicians and hospitals continued to be paid under a fee-for-service⁸ system, other forms of payment, such as capitation,⁹ were advancing rapidly. As we moved into the 1990s, all of these payment models demonstrated inadequacies. Traditional fee for service (FFS) has enabled widespread variation in processes and outcomes and is seen to reward providers for a greater quantity of medical services regardless of effectiveness. Capitation and other models based on pre-set, fixed budgets (i.e., percent-of-premium arrangements) proved exceptionally difficult to implement and burdened the healthcare system with layers of administration. In addition, these programs seemed to operate in ways that are contrary to the interests and natural inclinations of both patients and physicians, in that they depend upon curtailing care for their profitability. Healthcare dollars did not correlate with better outcomes.¹⁰

The idea of a competitive provider model as an adjunct to capitation and FFS payment methodologies began to gain popularity during the period of the Reagan administration. This model was assumed to be able to use market forces to “contain the rising costs of healthcare and allow for the proper distribution of healthcare resources.”¹¹ Providers, being forced to compete for patients would respond with quality and efficiency. Health maintenance organizations (HMOs) were described as a vehicle for advancing this competitive model, and it was asserted that they could control costs by integrating the delivery of healthcare and financing of healthcare under one organizational umbrella.¹² In fact, however, physicians perceived the HMO approach as simply a vehicle to deprive them of fair compensation, and patients perceive them to be vehicles to deprive them of the freedom of choosing their own physician. The popularity of “gatekeeper” physician models again seems to add layers of bureaucracy.

The 1990s saw the dramatic growth of networks of providers, mostly consisting of physician-hospital organizations (PHOs) and independent physician associations (IPAs). Physicians perceived HMOs and large payors as using their market strength to impose significant reductions on physician compensation and to impose various utilization controls that increased their costs and reduced their freedom to practice. Additionally, one aspect of the HMO/managed care approach was to refuse to admit many physicians to a physician panel, a feature that physicians perceived as particularly threatening. During this period, it was assumed that the steerage of numbers of patients to particular physicians or particular institutions could result in efficiencies and lower costs. Both physicians and hospitals, however, perceived this process as

essentially a tool to reduce their compensation while simultaneously burdening them with numerous administrative controls for pre-certification, retrospective review, and similar features. Physicians realized that a single physician or a single practice had no voice in the system and could be excluded by a payor at will. The formation of PHOs and IPAs therefore was a natural response to attempt to give physicians some voice in a payor system that was becoming increasingly intrusive in the delivery of the care itself. However, as these organizations grew, they came under the attention of the federal antitrust regulators at the Department of Justice (DOJ) and the Federal Trade Commission (FTC).

On September 15, 1993, the DOJ and the FTC jointly issued their Statements of Enforcement Policy, describing ways in which provider organizations would be permitted to operate, particularly with respect to payor relationships.¹³ These statements were revised in 1994 and again in 1996. Essentially, these statements offer three different options to provider organizations. The first option is an economic risk model, where the providers have material economic risk connected with the relationship with the payor (i.e., a capitation or percentage-of-premium contract is deemed to be a risk-bearing contract). A second option is “clinical integration.” The federal regulators have never sufficiently defined clinical integration, but in any event, this will be addressed in more detail below. The third option involved the use of the so-called “messenger model” which has become a widely-used mechanism for a PHO or IPA to enter into payor contracts, not involving financial risks or clinical integration, through the use of a neutral third party.

The summary of where all of the foregoing has brought the healthcare system is indeed troubling. Employers, federal and state governments, and individual patients complain of excessive costs in the system. Hospitals and physicians complain of reimbursement rates that at times are below cost and perceive both governmental and private payors as having no interest other than paying less and less for more and more. Perhaps a critical feature of essentially every payment system is that it pays the same thing for the same procedure, test, or office visit, regardless of the effectiveness, quality, or outcome of that event. Indeed, as governmental and private payors push down the rate of payment, they have succeeded in commoditizing medical services for the American public. The quality of the care has simply not been an issue in these systems. All of that may be changing, however, as a result of the Institute of Medicine report of March 2001¹⁴ and initiatives referred to below by the Leapfrog Group and other actions.

THE NEW COMPETITIVE LANDSCAPE

FTC actions over the past year signal the demise of networks operating using the “messenger model” without adding market efficiencies. Healthcare competition has become a high priority for the FTC. The FTC has recently conducted public investigations of groups for antitrust violations in Colorado, California, Maine, Missouri, New Mexico, Texas, Georgia, and Louisiana. In July of 2003 alone, the FTC charged five groups with price-fixing or conspiring to fix prices.¹⁵ One such action was against Brown and Toland, a network manager in San Francisco, for fixing the terms and the prices under which the network’s doctors would contract with payors in connection with preferred provider organization (PPO) contracts.¹⁶ According to the FTC, Brown and Toland “directed its physicians to terminate pre-existing contracts with payors, and invited them to enter into horizontal agreements regarding prices or other elements of competition.”¹⁷ Almost 1,500 physicians in the San Francisco area had contracts with Brown & Toland. The FTC alleged that the physicians in the Brown and Toland PPO network did not integrate their practices in any significant respect.¹⁸ The complaint alleged that “Brown and Toland has no ongoing mechanism to ensure that those potential efficiencies are replicated in services provided by its PPO network. Brown & Toland *does not monitor practice patterns and quality of care, or enforce utilization standards regarding services provided by its PPO network.*”¹⁹ The FTC contended that the network was not clinically integrated.

On July 11, 2003, the FTC settled price-fixing charges against Washington University Physician Network (WUPN). The FTC contended that WUPN successfully “coerced” a number of health plans to increase the fees they pay to the group’s physicians and that the challenged conduct *was not related to efficiency-enhancing clinical integration.*²⁰ To meet the FTC definition of a “qualified clinically-integrated joint agreement,” physician participants must “participate in active and ongoing programs to evaluate and modify clinical practice patterns in order to control costs and ensure the quality of services provided.”²¹ The clinical integration agreement “must create a high degree of interdependence and cooperation among physicians.”²² Although a “qualified clinically-integrated joint arrangement” need not involve any sharing of risk, any agreement concerning price or other terms of dealing must be “reasonably necessary” to achieve the goals of the joint arrangement.²³ However, the FTC does not define what constitutes “reasonably necessary.”

On July 18, 2003, the FTC extended its attack to include a network of doctors *and* hospitals in northeast Maine.²⁴ In the FTC news release about the action, Joe Simons,

Director of the FTC’s Bureau of Competition stated, “The Maine Health Alliance fixed prices not in just one health-care sector, but two—hospital services and physician services.”²⁵ According to the business records of the Alliance, the organization was formed to negotiate payor contracts that contain “higher compensation” and more “advantageous” contract terms than the physicians and hospitals could obtain if negotiating individually.²⁶ Again, the FTC determined that the Alliance had not undertaken any efficiency-enhancing clinical integration sufficient to justify its challenged conduct.

Less than a week later, the FTC announced a proposed consent agreement with Baton Rouge, Louisiana IPAs. The Professional Orthopedic Services group consisted of twenty-eight doctors who provided approximately 70% of the orthopedic medicine services in the area.²⁷ The FTC claimed that “[t]hese physicians violated fundamental antitrust principles by agreeing to demand common price terms, and their agent crossed an impermissible line by participating in the price-fixing activity.”²⁸ Once again, the FTC charged that the IPA failed to comply with the messenger model, and that its conduct did not meet the criteria either as a “qualified risk-sharing joint arrangement” or a “qualified clinically-integrated joint arrangement.”²⁹

As a result of these enforcement actions, the FTC has essentially killed the messenger model. Although it remains true that a messenger may “messenger” terms between the physicians and payors, IPAs without clinical integration or meaningful additions of market efficiencies have no place in the new competitive environment. To survive, network ventures must be either a “qualified risk-sharing joint arrangement” or a “qualified clinically-integrated joint arrangement.” A qualified risk-sharing joint arrangement would exist if at least one of the following four structures is present:

- “capitated” reimbursement arrangements;
- “percentage of premium” reimbursement arrangements;
- the use of significant financial incentives to achieve specified cost-containment goals for the entire group, either by: (a) using withholds to incentivize compliance with the cost-containment goals of the network as a whole; or (b) establishing overall cost or utilization targets for the network as a whole, with the provider participants subject to subsequent financial rewards or penalties based on group performance in meeting the targets; and
- case rate reimbursement for certain courses of multidisciplinary treatments.³⁰

A qualified clinically-integrated joint arrangement must address these four issues:

- Monitoring of practice patterns and quality of care, or enforcement of utilization standards;
- Evaluation and modification of clinical practice patterns in order to control costs and ensure the quality of services provided;
- Creation of a high degree of interdependence and cooperation among physicians; and
- If sharing of financial risk is involved, any agreement concerning price or other terms of dealing must be “reasonably necessary” to achieve the goals of the joint arrangement.

THE CASE FOR QUALITY AS AN INTEGRATING FACTOR

Communities, patients, and employers are asking for openness regarding clinical performance. Physician groups are in a prime position to take the lead in collecting and sharing quality data that relates to clinical performance. Specifically, IPAs have the fundamental foundation upon which a large-scale quality improvement effort can be rapidly incorporated, launched, and sustained: an agreement to act in a collaborative fashion. With appropriately identified initiatives, clinically based quality indicators, and meaningful measurement and reporting systems, physicians can raise the bar on the standard of care. By reducing the variation in decision-making, we will see a long term reduction in healthcare costs, fewer complications and errors, and an overall improvement in the health of patients.

Were quality a significant enough goal to motivate change on its own, the American healthcare system would enjoy an extraordinary level of care. However, history shows this is not the case. We offer two observations in support of this statement. First, becoming known as the quality leader in a community has typically not resulted in increased reimbursement for a provider. Governmental programs and commercial payors treat medicine as a commodity and offer the same compensation for all varieties of quality. Second, improving patient care outcomes likely will not result in lower malpractice premiums due to the prevailing practice of malpractice insurers to rate specialists using national experience data or other cost reductions.

GAINSHARING

A recent example of an initial attempt of reward for quality initiative is gainsharing. The term “gainsharing” is used to refer to types of financial arrangements between physicians and hospitals that are intended to motivate or encourage the physicians to improve quality of care while accomplishing cost reduction.³¹ The savings from gainsharing partially result from reductions in practice variations. Such arrangements are “designed to align incentives by offering physicians a portion of a hospital’s cost savings in exchange for implementing cost saving strategies.”³² Usually, the burden of implementing cost saving strategies falls on the hospitals, not the physicians, but since physician decisions determine as much as 70% of inpatient costs, physician involvement in cost saving activity is crucial.

Hospital cost savings programs may implicate (1) civil money penalties for reductions or limitations of direct patient care services provided to federal healthcare program beneficiaries,³³ and (2) the Anti-Kickback Statute³⁴ and the federal “Stark” statute.³⁵ However, in January of 2001, the Department of Health and Human Services Office of Inspector General (OIG) issued an advisory opinion in which it concluded that it would not impose civil money penalties or impose anti-kickback sanctions on a gainsharing arrangement. The arrangement involved a non-profit hospital that participates in federal programs and a group of cardiac surgeons practicing at the hospital.³⁶ If the surgeons implemented certain cost saving measures, the hospital proposed to share a percentage of the cost savings.³⁷ The percentage the physicians were to be paid was 50% of the cost savings over a period of one year. There were nineteen recommended cost saving procedures that were divided into the following areas: open as needed,³⁸ substitution,³⁹ and apyrotin use.⁴⁰

Gainsharing remains a viable pay for performance alternative, has specifically been approved by the Internal Revenue Service,⁴¹ and represents a focus on costs in the hospital setting and usually involves a specific focus on patients and procedures in a specialized area. Although it can be very effective in rapidly reducing costs and increasing quality in such a specialized area (and, indeed, much more rapidly in its area(s) of focus than can a system-wide quality effort), it does not address the patient population generally and is not intended to produce integration among various physicians.

CURRENT INITIATIVES

The federal government and commercial payors are also beginning to explore types of pay-for-performance models. In July 2003, the Centers for Medicare and Medicaid

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Services (CMS) announced the Premier Hospital Quality Incentive Demonstration project that will increase Medicare reimbursement to hospitals providing superior care for five conditions: heart attack, heart failure, pneumonia, coronary artery bypass, and hip and knee replacements.⁴² CMS intends the effort to be a massive restructuring of the current payment system into one that rewards for clinical quality performance.⁴³ CMS is not alone in this effort, however. In February of 2003, Anthem Blue Cross and Blue Shield of Virginia also implemented a program in partnership with the American College of Cardiology that will pay nine participating hospitals up to \$3 million in incentive awards over three years for superior performance in cardiac care.⁴⁴ In addition, Empire Blue Cross and Blue Shield of New York created pay-for-performance programs with contracting hospitals in its markets.⁴⁵

A PROPOSAL

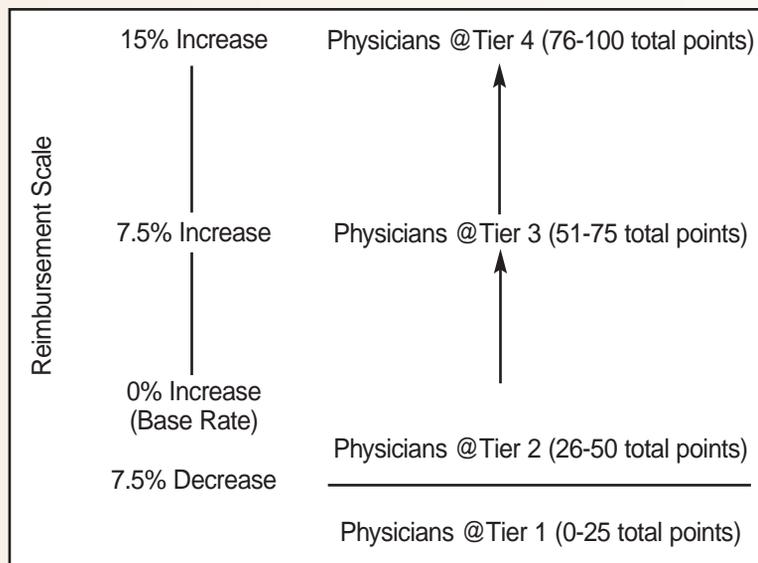
An era of improved physician reimbursement methodology is potentially available. Changes are occurring rapidly and have set the stage for a substantial overhaul to current reimbursement strategies. We propose a methodology for physician reimbursement based on quality measurement and performance. Using available metrics, a sliding scale can be utilized that results in the ability to reward quality. Although American healthcare remains significantly below achievable high-level results,⁴⁶ this model will promote a shift toward higher quality performance. More fundamentally, this model will also foster clinical integration, encourage the reduction of barriers, and promote a team-based, cooperative approach to improving healthcare. As a result, the patient community benefits through the collaboration of the hospital and physicians in designing the quality improvement program. And, as will be discussed below, we also think a very strong argument can be made that this new model will meet the FTC's new requirements for economic and clinical integration.

A series of steps should be taken before the sliding scale is put into play. These steps are critical to the process:

- A steering committee of physician *and* hospital leadership should first be formed.
- Develop clinical groups whose goals are to establish the quality goals for a particular contract or contracts. We recommend using measurements at the system or hospital level as well as at the practice level. Keeping these quality indicators straightforward makes communication to various stakeholders much easier to understand. The system and physician factors

are *weighted* (for example, system goals requiring intense collaboration between the hospital and multiple physician specialties could comprise 60% of the targets and practice-level physician goals 40%) and *cumulative* (so that achieving the top reimbursement tier is impossible without both components making significant progress).

- Invite local employer groups (both insurance consumers and self-insured employer plans) to have an inside view of and sign off on these quality goals. Employers and providers may form a powerful market force if they buy in to these factors and advocate with payors for these initiatives. Employer support is also critical because only employers have a long term exposure to changes in utilization patterns (and corresponding premium adjustments).
- Have a "dry run" with the measurements. Allow *everyone* to see where he stands before the pay-for-performance scheme takes effect. Create excellent communication concerning these results and help the providers see how they can improve.
- Over a pre-determined time frame that is agreed upon with the payor, measure the designated performance indicators and create a provider owned spreadsheet of the results.
- Finally, place the providers on a sliding scale. The scale is based on current fee-for-service reimbursement schedules. Differential reimbursement is achieved through a tiered fee schedule based on the weighted quality performance points earned for achieving the agreed-upon targets. You could, for example, divide the tiers into quartiles as follows:



The proposed model prevents individual physician effort alone from being sufficient to create increased reimbursement: at best, the physician can keep his own reimbursement the same; at worst, he can lose reimbursement if he fails to achieve a majority of his own quality goals. Likewise, the system as a whole cannot experience the top rate of reimbursement if physicians do not meet approximately half of their quality goals. And, importantly, no physician in Tier 1 on the above chart can participate in any gains recognized by the rest of the system.

WHY THIS SHOULD WORK

In order for our pay for performance model to avoid antitrust violations on all fronts, the model must offer both real financial risk sharing and real clinical integration. DOJ's and FTC's Statement 9 (Multiprovider Networks) describes the legal analysis that the applicable enforcement agencies apply to "networks involving more than one type of provider."⁴⁷ Agreements that are *per se* illegal such as naked agreements to fix prices or allocate markets are simply condemned as illegal on their face.⁴⁸ The courts have generally imposed *per se* liability involving three types of conduct: price-fixing, market division, and group boycotts.⁴⁹ However, when "competitors economically integrate in a joint venture, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason."⁵⁰ In a rule of reason analysis, a court must examine the competitive effects of the agreement.⁵¹

The compensation system for providers in the proposed model, even though based on achieving clinical quality targets, constitutes a real sharing of financial risk. Provider compensation is at risk should the actions of the provider group as a whole fail to meet the clinical targets. According to Statement 8, "[r]isk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians."⁵² The Statement permits substantial financial risk to be shared among competitors in a multiprovider network in one of four methods. The proposed model uses "*significant financial incentives for its provider participants, as a group, to achieve specified cost-containment goals.*" Specifically, the venture "*establishes overall cost or utilization targets for the network as a whole, with the provider participants subject to subsequent financial rewards or penalties based on group performance in meeting the targets.*"⁵³ The proposed model fits within the FTC's concept of market efficiency by reducing the total cost of patient care by increasing near term positive health outcomes, shortening recovery times, and avoiding repetitive expensive treatment. Because awards are based on increased quality, not cost-cutting initiatives calculated on a per-procedure basis

alone, the fear of denying needed care is eliminated. And, because the reimbursement of the participating providers, as a whole, is affected by the system reaching the quality and cost targets, individual achievement without systemic change has no reward.

A legitimate financial risk-sharing system can be structured around clinical quality improvement. However, as the recent FTC decisions indicate, the FTC is also placing greater emphasis on clinical integration and "efficiency enhancing integration."⁵⁴ Statement 9 recognizes that "multiprovider networks that do not involve the sharing of substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies."⁵⁵ Significant integration can be evidenced by "*the network implementing 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.*"⁵⁶ In the proposed model, attributing significant weight to systemic quality factors means that, for example, internists in a network lose money if the network's surgeons prevent the network from meeting its system quality goals, and vice versa. According to the MedSouth advisory opinion addressing some degree of clinical integration, the FTC and DOJ will be looking for utilization review, quality assurance, and medical management programs that (1) *will be implemented* and (2) *will have a strong probability of reducing utilization and costs, and increasing quality significantly.*⁵⁷ Linking financial reward to quality achievement has this strong probability.

Two other points need to be made. First, wellness programs have failed because the savings are realized only in the long term and the insured population is transient. Pay for performance can demonstrate savings to payors within one fiscal year, thereby achieving the dual goals of decreased utilization and improved quality. A simple example will illustrate this point. A network may implement a two-step protocol to (1) administer beta-blockers to every ER patient with acute myocardial infarction, and (2) prescribe a year-long course of beta-blocker therapy. Studies have shown that beta-blockers can reduce both the risk of death and the risk of recurrent heart attack if administered promptly (within hours) following the onset of a heart attack,⁵⁸ and that a continued course of beta-blocker therapy (at least six months) is required for maximum benefit.⁵⁹ Further suppose that the cost of the beta-blocker prescription is \$5 per month.⁶⁰ Now, if you consider that the Medicare DRG reimbursement for hospital treatment for an acute myocardial infarction without complications or co-morbidities is \$4,899.51, the payor has real savings of \$4,839.51 to share with the providers in the current year if the beta-blocker therapy prevents the second

heart attack. Everyone wins in this example. Clinical quality of care will not be compromised, patient outcomes are improved, total healthcare costs are lowered, utilization of system resources is lowered, and payors have additional reserves to share with the providers. The cost drivers and quality drivers work hand in hand.

Second, although the achievement of clinical integration, increased reimbursement, and improved healthcare are salutary goals by themselves, hospitals have an additional incentive to consider such a program. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standard P.I. 3.20 requires that an “ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients [be] defined and implemented”⁶¹ in accredited hospitals. So, a hospital could build into its pay for performance indicators some factors required to be measured in this mandatory process. Such an approach would create more efficiencies and more collaboration between physicians and hospitals on a clinical level, and would further the non-financial integration the FTC desires.

END NOTES

¹ DARTMOUTH ATLAS OF HEALTHCARE; Elliott S. Fisher, et al., *The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care*, ANNALS OF INTERNAL MEDICINE, 138(4):273-287 (2003).

² Wing et al., THE LAW AND AMERICAN HEALTH CARE, Aspen Law and Business (1998).

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.* By the end of the 1940s, almost one out of five Americans had enrolled in Blue Cross hospital “service-benefit” plans.

⁷ See www.cms.gov/about/history.

⁸ A provider payment method in which an insurer pays a fee for each service performed.

⁹ Capitation is defined as a type of risk sharing reimbursement method whereby providers in a plan’s network receive fixed periodic payments for health services rendered to plan members.

¹⁰ DARTMOUTH ATLAS OF HEALTHCARE, *supra* note 1; Fisher, *supra* note 1.

¹¹ Wing, *supra* note 2, at 55.

¹² *Id.* at 69.

¹³ U.S. Dep’t of Justice and Federal Trade Comm’n, *Statements of Antitrust Enforcement Policy in Health Care*, (1996), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,153. The Federal Trade Commission has antitrust enforcement authority under the FTC Act, 15 U.S.C. § 41 *et seq.* The Department of Justice has antitrust enforcement authority under the Sherman Act, 15 U.S.C. 1 *et seq.*

¹⁴ “Crossing the Quality Chasm: A New Health System for the Twenty-First Century,” Institute of Medicine report, March 2001 ([available at www.iom.edu/includes/dbfile.asp?id=4124](http://www.iom.edu/includes/dbfile.asp?id=4124)).

CONCLUSION

We believe that all segments of the healthcare system, including payors as well as providers, must take an interest in the quality of the service provided to the American public. A key feature should be a move toward rewarding physicians for delivering quality increases. Fortunately, physicians, when organized and contracting appropriately, will be authorized under current antitrust guidelines to combine and coordinate their efforts on clinical issues, while simultaneously gaining better compensation from payors. This may be a rare situation where additional payments will not be made in the hope of something positive happening but will be made only on the delivery of an improvement, and one of the rare situations where an advantage flows to patients, physicians, and payors simultaneously.

Toby Watt and Barry Herrin are partners in the health care practice group of Smith Moore LLP. Jennifer Pritzker Sender is an associate in the health care practice group of Smith Moore LLP. Dr. Robert Ryan is a principal in The Strategy Group based in Richmond, VA, and is the former chief medical officer and interim chief executive officer of the Promina Health System in metropolitan Atlanta, GA. Laura Cook is a consultant in The Strategy Group.

¹⁵ See the FTC’s Web site for a current list of enforcement actions, www.ftc.gov/ftc/formal.htm

¹⁶ *California Pacific Medical Group, Inc., dba Brown and Toland Medical Group*, FTC Complaint, Dkt. 9306, July 8, 2003, *available at* www.ftc.gov/os/2003/07/caadmincmp.pdf.

¹⁷ *Id.*

¹⁸ *See id.*

¹⁹ *Id.* (emphasis added).

²⁰ *In the matter of Washington University Physician Network*, FTC Order, File No. 021 0188, July 11, 2003, *available at* www.ftc.gov/os/2003/07/wupndo.htm.

²¹ *See California Medical Group, supra* note 16.

²² *Id.*

²³ *Id.*

²⁴ *In the matter of The Maine Health Alliance and William R. Diggins*, FTC Order, File No. 021 0017, July 18, 2003, *available at* www.ftc.gov/os/2003/07/mainedo.pdf. The Maine Health Alliance, which was formed in 1995, consists of 325 physicians and 11 hospitals.

²⁵ In September, the FTC settled price-fixing charges against South Georgia Health Partners, L.L.C., whose membership included 15 hospitals and approximately 500 physicians. *In the matter of South Georgia Health Partners, L.L.C., et al.*, FTC Order, File No. 01 1 0222, Sept. 9, 2003, *available at* www.ftc.gov/os/2003/09/sgeorgiado.pdf.

²⁶ *Id.*

²⁷ *In the matter of Physician Network Consulting, L.L.C., et al.*, FTC Order, File No. 021 0178, July 22, 2003, *available at* www.ftc.gov/os/2003/07/physiciando.pdf.

²⁸ *Id.* at www.ftc.gov/opa/2003/07/pnc.htm, citing Joe Simons, Director of the FTC’s Bureau of Competition.

- ²⁹ *Id.*
- ³⁰ See *supra* note 13, at Statement 8.
- ³¹ Karl A. Thallner, *OIG approves hospital-physician gainsharing*, PHYSICIAN'S NEWS DIGEST, July 2001, available at physiciansnews.com/law/701.html.
- ³² *Id.*
- ³³ A civil money penalty may be imposed against any hospital that knowingly makes a payment directly or indirectly to a physician (and any physician that receives such a payment) as an inducement to reduce or limit items or services to Medicare or Medicaid beneficiaries. 42 U.S.C. § 1320a.
- ³⁴ The Anti-Kickback Statute provides criminal penalties for "Whoever knowingly and willfully offers or pays [or solicits or receives] any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—to refer an individual to a person for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program. . . ." 42 U.S.C. § 1320a-7b.
- ³⁵ 42 U.S.C. § 1395nn.
- ³⁶ OIG Advisory Opinion 01-1, available at oig.hhs.gov/fraud/docs/advisoryopinions/2001/ao01-01.pdf.
- ³⁷ See Thallner, *supra* note 31.
- ³⁸ See OIG Advisory Opinion No. 01-1, *supra* note 36. The recommended actions involved opening certain pre-packaged items only as needed.
- ³⁹ *Id.* Substituting less costly items than those currently being used by surgeons.
- ⁴⁰ *Id.* Only for patients at elevated risk for pre-operative hemorrhage.
- ⁴¹ Prior to the OIG's initial crackdown on gainsharing in 1999, the Internal Revenue Service had issued multiple private letter rulings approving of gainsharing activities. See, e.g., PLR 9112006 (Dec. 20, 1990).
- ⁴² www.cms.gov/quality/hospital/PremiereFactSheet.pdf
- ⁴³ *Id.*
- ⁴⁴ www.anthem.com. The announcement details the Quality-In-Sights Hospital Incentive Program, which focuses on improving health outcomes in patients with heart disease, pneumonia, and pregnancy, and tracks patient safety and patient satisfaction indicators.
- ⁴⁵ www.empireblue.com. The initiative rewards hospitals that adopts two of the three Leapfrog Group initiatives to improve patient care. The Leapfrog Group is a coalition of more than 90 public and private organizations that provide healthcare benefits to more than 26 million Americans. Their initial focus is on practices relevant to urban area hospitals. In the future, they plan to focus on other aspects of healthcare, such as doctor office visits. The three practices the Leapfrog Group has identified for initial focus are Computerized Physician Order Entry (CPOE) systems, Intensive Care Unit (ICU) Staffing (both part of the Empire Blues program), and Evidence-Based Hospital Referral.
- ⁴⁶ *Health, United States, 2003*, Table 111. Total health expenditures as a percent of gross domestic product and per capita health expenditures in dollars: Selected countries and years 1960-2000, available at www.cdc.gov/nchs/products/pubs/pubd/hus/listables.pdf.
- ⁴⁷ See *supra* note 13, at Statement 9.
- ⁴⁸ *Id.* The Supreme Court has described *per se* unlawful conduct as conduct that has a "pernicious effect on competition and lack of any redeeming virtue, has "no single purpose except stifling of competition" or is "plainly anticompetitive." *Northern Pac. Ry. Co. v. U.S.*, 356 U.S. 1, 5 (1958); *White Motor Co. v. U.S.*, 372 U.S. 253 (1963). Characterization of conduct as *per se* unlawful generally requires (i) identifying a restraint's likely anticompetitive effect, (ii) determining whether it also has a likely procompetitive potential and, if so, (iii) ascertaining that the connection between the suspect conduct and any benefit is sufficiently close or necessary to justify rule-of-reason analysis. William E. Cohen, *Per se illegality and truncated rule of reason: the search for a foreshortened antitrust analysis*, FTC Staff Discussion Draft, Nov. 1997, available at www.ftc.gov/opp/jointvent/persepap.htm.
- ⁴⁹ *Id.*
- ⁵⁰ *Id.*
- ⁵¹ *Id.*
- ⁵² See *supra* note 13, at Statement 8.
- ⁵³ *Id.*
- ⁵⁴ See the discussion, *infra*, regarding "The New Competitive Landscape," in particular, the WUPN settlement, *supra* note 20.
- ⁵⁵ See *supra* note 13, at Statement 9.
- ⁵⁶ *Id.* Credentialing and peer review programs are not enough to achieve clinical integration.
- ⁵⁷ *MedSouth*, FTC Staff Advisory Opinion, Feb. 19, 2002, available at www.ftc.gov/bc/adops/medsouth.htm. MedSouth's clinical integration program had two parts. MedSouth intended to develop a web-based electronic data system permitting its physician members to access and share clinical information about their patients. Second, MedSouth intended to develop and implement between 100-150 clinical protocols. At least 48 guidelines were under development when the FTC opinion was issued. *Id.* MedSouth believes "it will be able to improve and standardize members' treatment of specific diagnoses and their fulfillment of standards of care; reduce medical errors and improve patient care outcomes; permits its members to provide their services more efficiently and to reduce the aggregate long-term costs of physician services; and demonstrate to payers, employers and others that integrated and coordinated delivery of services by primary care and specialist physicians can improve the quality and delivery of physician services." *Id.*
- ⁵⁸ Nicolas Danchin, et al., *Acute myocardial infarction*, CLINICAL EVIDENCE, (7):11-35 (2002).
- ⁵⁹ Cathie Sudlow, et al., *Secondary prevention of ischaemic cardiac events*, CLINICAL EVIDENCE, (7):124-160 (2002).
- ⁶⁰ Charlotte Grayson, *Opinion: The time has come to emphasize beta-blockers for heart failure*, WebMD Medical News Archive, May 30, 2001, available at my.webmd.com/content/article/32/1728_80672?y=1.
- ⁶¹ JCAHO, *Comprehensive Accreditation Manual for Hospitals*, Standard P.I.3.20 (2003 rev. ed.).