

**Statement  
of the  
American Hospital Association  
on the  
Importance of Clinical Integration to the  
Nation's Hospitals and their Patients**

**Federal Trade Commission  
“Clinical Integration in Health Care: A Check-Up”  
May 29, 2008**

I am William Petasnick, chairman of the American Hospital Association (AHA) and president and CEO of Froedtert and Community Health in Milwaukee. On behalf of the AHA and our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, I want to thank the Federal Trade Commission (FTC) for holding this important workshop. Across the country, clinical integration arrangements have the potential to help hospitals and physicians improve the quality and efficiency of care provided to patients. Hospitals increasingly recognize clinical integration's potential and many of us have been impressed by the upsurge in interest in these programs that is sweeping the field. We hope that today's hearing will help the Commission provide improved guidance into how antitrust laws will be applied to these arrangements so that their potential can be fully realized.

Federal agencies can and should do more to remove actual and perceived barriers to clinical integration. The antitrust agencies in particular have been keenly aware of the role they can play in facilitating or chilling marketplace conduct. This awareness spurred the agencies to issue the original *Statements of Antitrust Enforcement Policy in Health Care* and to update that important publication several times. The hospital field remains grateful to the antitrust agencies for their leadership then, and we look forward to their continued leadership on clinical integration.

Our statement will focus on the forces in the health care field driving clinical integration, the current federal regulatory barriers to clinical integration and examples from hospitals that are attempting to forge ahead on various integration projects in the face of these barriers.



## **THE FRAGMENTATION OF HEALTH CARE DELIVERY**

The AHA's most recent work on clinical integration began with a Task Force on Delivery System Fragmentation, which I chaired. We based our efforts on this framework:

*Health care is about teamwork and requires the talent and dedication of many – doctors, nurses, technicians and many others. Hospital care is especially dependent on the ability of hospital leaders and physicians to work together to improve the efficiency of patient care and to get patients the right care, at the right time, in the right setting.*

The task force spent many months studying the problems with our health care system that lead to persistent and unproductive fragmentation. The task force received input from providers around the country as well as from legal counsel familiar with the field. Based on its work, the task force made a comprehensive set of recommendations to reverse fragmentation and facilitate alignment that was approved by the AHA's board of trustees in November 2005.

Recognizing that achieving better alignment among providers was the key to improving patient care and enhancing productivity, the task force's recommendations centered on the tools needed by hospitals and physicians to achieve those goals. The task force encouraged hospital and physician arrangements that would achieve improvements in care delivery, sustain community access to essential services, adopt and integrate information technology linking hospitals, physicians and other providers, and enhance productivity across providers and settings.

Central to the task force's work was identifying and recommending ways to remove the impediments to better alignment created by various federal laws and policies. To that end, the task force issued a challenge for federal agencies to:

*Establish a simpler, consistent set of rules for how hospitals and physicians construct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting hospital-physician arrangements is a significant barrier. Few arrangements can be structured without very significant legal expense.*

The recommendation applies to a number of federal laws and policies, not just to antitrust laws. Those other laws and policies are discussed later in this statement. However, because of their complexity and potential consequences, the antitrust laws are among the most significant barriers to clinical integration.

While the AHA's Task Force on Fragmentation ended its work in 2005, the work of the AHA in promoting clinical integration has not ended. In 2008, the AHA created a new advisory group on clinical integration to provide input to its *Health for Life* initiative. *Health for Life* is a framework for change – a set of goals and ideas for creating better, safer, more affordable care and a healthier America. The framework was developed with

the support and advice of the AHA Board of Trustees, hospital leaders across America, regional and metropolitan hospital associations, and many others with a stake in our nation's health care system, including consumers, businesses and health care professionals. A key component of that effort is eliminating barriers to greater collaboration and teamwork between hospitals and other providers.

### **THE QUALITY IMPERATIVE**

Many believed that the introduction of diagnosis-related-groups (DRGs) in the 1980s would prove to be a catalyst for clinical integration. Arnold Milstein, M.D., currently medical director of the Pacific Business Group on Health, attributed the failure of DRGs to ignite lasting clinical integration to the fact that the government was “paying based on individual units of service, rather than excellence in quality and economy over a longer-period than single-service events.”

In 2000, the drive toward clinical integration took on renewed urgency, in part, because of the heightened focus on identifying and reporting patient care quality measures sparked by the Institute of Medicine's (IOM) seminal report, *To Err is Human*. That report, and the work it spurred, focused the health care field on the need for a rededication to quality. The IOM's subsequent publication, *Crossing the Quality Chasm*, highlighted impediments to quality improvement, and made recommendations to bridge that chasm. The authors recognized that fragmentation of the health care delivery system was a major contributor to quality problems, noting, for example, that those who deliver health care often do so in “silos,” without access to all the information that may be needed about a patient's current treatments or medical history.

The IOM established six “aims” that are now the touchstone for many quality policies in the field: health care that is safe, effective, patient-centered, timely, efficient and equitable.

The quality imperative has created nearly unprecedented collaboration between the private sector, including hospitals, insurance companies, businesses and consumer organizations, and the public sector, including the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ). The goal of this collaboration, known as the Hospital Quality Alliance, is to provide greater transparency and accountability for the public. For example, to help consumers make more informed decisions about their care, hospitals report quality measures to CMS; those measures are then displayed for consumers to use on the collaborative *Hospital Compare* Web site.

Examples of the types of information collected and made available to consumers include: whether hospitals administered aspirin on arrival for heart attack patients, whether patients with pneumonia received smoking cessation counseling and whether patients understood the instructions they received from their doctors. Today, hospitals report some 30 different quality measures and the number continues to grow.

While it is hospitals that report their quality measures, the success of that reporting is entirely dependent on their ability to enlist physicians, nurses and other medical professionals in the quest for quality. Clinical integration is important to that effort. You will hear from Advocate Health Care today about its nearly historic journey to achieve integration between the hospital and its physicians, and the enormous successes that effort has yielded. Countless other hospitals around the country are anxious to follow in Advocate's footsteps – if they are assured that their journey won't be impeded by intractable regulatory challenges.

### **THE EFFICIENCY IMPERATIVE**

According to a poll conducted in April by the Robert Wood Johnson Foundation, Americans view the state of the economy and the need to improve access to health care as closely linked, and believe that 'making health care more affordable' should be the top priority for improving the U.S. economy. The key to achieving greater affordability is improved efficiency.

Both the public and private sectors are experimenting with payment policies that encourage greater quality and efficiency. Two of those efforts involve pay-for-performance and value-based-purchasing, which link payment with certain quality and efficiency outcomes. According to the Agency for Health Care Policy and Research:

*The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers.*

CMS last year issued a report to Congress outlining options for moving ahead with a value-based purchasing incentive program that would reward hospitals for meeting certain performance thresholds. Recognizing that the development of successful incentive-based programs is complex, the hospital field supported the concept of aligning payment incentives with the provision of high-quality care. Among the AHA's recommendations for achieving a successful outcome for value-based purchasing programs:

- align hospital and physician incentives to encourage all to work toward effective and appropriate care;
- develop the programs collaboratively with all stakeholders;
- provide rewards that will motivate change;
- recognize and reward both high levels of performance and substantial improvements;
- use measures that are developed in an open and consensus-based process and selected to streamline performance measurement and reporting; and

- use measures that are evidence-based, tested, feasible, statistically valid and recognize differences in patient populations.

CMS recently announced a “Demonstration to Encourage Greater Collaboration and Improve Quality Using Bundled Payments.” The announcement stated that the goal of the demonstration, called Acute Care Episode, “is to use a global payment to better align the incentives for both types of providers [doctors and hospitals] leading to better quality and greater efficiency in the care that is delivered.” CMS and other government agencies recognize that the key to efficiency improvements is greater alignment and, therefore, are experimenting with ways to achieve that goal, including relaxation of regulatory impediments, in this case, the gainsharing restrictions attendant to the Civil Monetary Penalty law. It only stands to reason that government efforts to achieve greater alignment would be facilitated by lowering other regulatory barriers, thereby encouraging more experiments with clinical integration.

A recent report in the May/June 2008 edition of *Health Affairs* underscores the point. A five-year study involving hospitals and physicians in six cardiac catheterization labs received federal approval to improve alignment through gainsharing. The study of more than 222,000 patients found cost savings of 7 percent per patient and no corresponding decline in quality or patient access; in fact, the study showed an increase in the use of recommended therapies for coronary stent patients. The authors of the study suggested that gainsharing decreased costs and increased the use of recommended therapies because it “provides physicians with information about other physicians’ practice patterns and increases their incentive to collaborate in defining and adopting best practices.”

In the same vein, but from a different perspective, a recent study by Citi, shared at the National Quality Forum: “establishe[d] a clear financial positive link between the degree of [provider] integration and financial performance.” The Citi study provides some additional evidence that greater integration, especially clinical integration, improves efficiency and productivity in the health care field that redounds to the benefit of hospitals, physicians and their patients.

### **ADDRESSING IMPEDIMENTS RAISED BY ANTITRUST LAWS**

To address one of the regulatory impediments to clinical integration, the AHA took the rare step of asking former FTC officials, including an award winning former commissioner, to help us craft guidance for the hospital field on antitrust and clinical integration. The result was *Guidance for Clinical Integration*, a well-received working paper that is being submitted with this statement. We shared the paper and our hopes for how the antitrust agencies would use it with the FTC’s leadership in meetings last year. We received encouragement from FTC leaders as well as from those on Capitol Hill who oversee antitrust policy.

Senators Herb Kohl (D-WI), Arlen Specter (R-PA), Charles Grassley (R-IA), Richard Durbin (D-IL) and Sheldon Whitehouse (D-RI) sent the agencies a letter, also being submitted with this statement, stating:

*The [agencies] could make a significant contribution to furthering clinical integration by working with the hospital field to provide guidance to providers who are eager to undertake clinical integration programs. The success of the Statements of Antitrust Enforcement Policy in Health Care in addressing providers' concerns about the requirements of the antitrust laws, suggests a similar effort that is more focused on clinical integration would be of substantial benefit to providers as they explore innovative approaches to improving quality and lowering the cost of health care.*

In addition to making the case for more agency guidance on clinical integration, the AHA's working paper provides proposed guidance on establishing clinical integration programs and a proposed legal analysis of how clinical integration fits within established antitrust analysis.

The heart of the working paper is the proposition that, while one size will never fit all in the hospital or health care field, legitimate clinical integration programs would not run afoul of antitrust laws and policies. To that end, the paper discusses steps hospitals will likely need to take to develop a clinical integration arrangement. These include: establishing goals for the program; determining its clinical approach and participants; developing mechanisms to monitor and control utilization and enhance quality and efficiency; developing an infrastructure; and determining when negotiations with payors can begin.

The goal of our work was to foster discussion with the antitrust agencies that would lead to guidance similar to that provided by the *Statements of Antitrust Enforcement Policy in Health Care*. In other words, comprehensive guidance directed to health care providers, not just antitrust lawyers – guidance that can be understood by those in the field who will be responsible for fashioning clinical integration arrangements.

For example, the working paper discusses developing mechanisms to monitor and control utilization of health care services to enhance quality and safety:

*A key component of most CI programs will be the gathering and monitoring of data regarding provider performance. Providers might receive feedback on how their performance has changed over time, how it compares to other providers in the CI program, or how it compares to external benchmarks, such as national or regional norms. There are advantages and disadvantages with each of these approaches. Some measures may focus on process, that is whether the providers are performing certain procedures or taking specific steps that the medical literature or experience suggest are associated with better outcomes or lower costs. Alternatively, some measures may actually focus on outcomes themselves – that is, measuring the actual costs or clinical outcomes of the provider practices. Reliable outcomes measures, however, are the most difficult to obtain and interpret, because there are many variables that can explain patient outcomes other than physician performance, and it may be difficult or impossible to control*

*for such variables. Again, there are advantages and disadvantages of each approach, and often a combination may be employed.*

Before releasing the working paper, we vetted it with a group of hospitals interested in undertaking clinical integration programs or, in a few instances, hospitals that had taken some steps in that direction. These hospitals provided practical advice about how to make the working paper more useful to hospitals. Since the paper was released in spring 2007, AHA has had a great deal of feedback from hospitals – all of it has been complimentary and has encouraged us to move ahead in seeking agency guidance.

Our working paper demonstrates it is possible to provide clear guidance on clinical integration that is consistent with the antitrust laws. We urge the agencies to act with dispatch to work with the health care field to embrace guidance that is clear and concise, and therefore of great assistance to those in the health care field likely to be involved in developing clinical integration programs.

### **IMPEDIMENTS RAISED BY OTHER FEDERAL LAWS AND POLICIES**

We think it is important for the Commission to recognize that, currently, the parameters of any clinical integration arrangement will be affected by other federal laws and policies. We believe that the impediments raised by these laws and policies also need to be addressed. In some instances doing so could involve guidance, similar to what hospitals are seeking from the antitrust agencies; in other instances legislation or other policy changes may be needed to completely remove the impediment. In any case, the existence of these regulatory impediments should not deter the antitrust agencies from moving forward and even from becoming a force for needed changes to those regulations as well. A few hospitals have already been successful in overcoming these impediments. Our collective goal should be to increase the number of hospitals that are successful by lowering or eliminating all of these barriers to integration.

In addition to the antitrust laws, four federal statutes have a significant impact on hospitals' ability to form financial relationships with physicians: the *Ethics in Patient Referrals Act*, known as the "Stark law;" the antikickback statute; the Civil Money Penalty (CMP) law; and the tax-exemption provisions of the Internal Revenue Code. Each has a unique purpose, and is implemented largely independently of the others.

By design or effect, each of these statutes creates a tension around hospital and physician financial relationships. Under the Stark and antikickback laws, payments from hospitals to physicians are almost always suspect – presumed by policymakers to be a means to induce referrals, interfere with clinical decisions, or increase payments from federal health care programs. Under the CMP law, the concern is that hospitals might encourage doctors to limit or reduce services provided to program beneficiaries by offering a share of the resulting financial gains. Under the Internal Revenue Code, the suspicion is that payments to physicians will be for the private benefit of the physicians and not to advance the charitable purpose of the hospital.

Under each statute, the litmus test of a payment's legality is typically whether it is "fair market value" for a service provided by the physician. In the new world of health care delivery, where payments are increasingly conditioned on a combination of work and outcomes, measuring a fair market rate for services rendered is ill-suited to aligning hospital and physician interests.

### **Civil Money Penalty (CMP) law**

Under the CMP law, hospitals are prohibited from paying physicians to reduce or limit services to a Medicare or Medicaid beneficiary. Both the hospital that knowingly makes such a payment and the physician that knowingly accepts it are subject to financial penalties. Enacted soon after Medicare adopted the prospective payment system, the CMP law was an attempt to ease concerns that the new system might lead hospitals to pay physicians to reduce services.

The CMP law is enforced by the Department of Health and Human Services Office of the Inspector General (OIG). In 1999, the OIG surprised the field by issuing a Special Advisory Bulletin interpreting the statute to prohibit any payment that has the effect of reducing or limiting services without regard to whether they were medically necessary or appropriate. At the time, requests for advisory opinions were pending on the legality of various so-called "gainsharing" arrangements in which hospitals and physicians agreed on certain practices that would lead to cost savings, with those savings shared with the physicians based on their efforts to achieve them. In its bulletin, the OIG commented that, while it "recognizes that appropriately structured gainsharing arrangements may offer significant benefits where there is no adverse impact on the quality of care received by patients, [the law] clearly prohibits such arrangements."

Beginning in 2001, the OIG backed away from its absolutist approach and began issuing advisory opinions on a case-by-case basis, exercising its enforcement discretion and permitting certain arrangements to go forward. However, those opinions protect only the person submitting the request, and cannot be relied upon by others. Also, the specifics of the approved arrangements are very narrow, limiting the time period for which they are approved and the nature of the activities that are permitted. The OIG effectively takes the position that any change in practice or routine is subject to the prohibition.

### **The *Ethics in Patient Referrals Act* (Stark law)**

The Stark law prohibits a physician, or his or her immediate family member, from making referrals for certain designated health services paid for by Medicare, including inpatient or outpatient hospital services, to an entity with which the physician or immediate family member has a financial relationship (self-referral), unless an exception applies. The physician is subject to a civil money penalty if he or she knowingly makes a noncompliant referral, as is the entity, a hospital, for example, which knowingly makes a claim for services provided pursuant to a noncompliant referral. In addition, a hospital is liable for any reimbursement related to services ordered by the self-referring physician, regardless of whether the hospital knew the referral was noncompliant.



The statute also creates exceptions under which arrangements that otherwise would be prohibited may go forward. These include a general exception for payments that are fair market value, another for personal service arrangements and another for employment, both of which also include a fair market value criterion. The personal service arrangements and other compensation exceptions are also subject to more specific rules that require that a year's worth of payments be set in advance and not take into account the volume or value of referrals or other business generated between the parties.

### **Antikickback laws**

The antikickback statute prohibits, among other things, knowingly or willfully offering or accepting any benefit or "remuneration" in exchange for, or to induce the referral of, patients for services, or the purchase, lease, or order of any good, facility, service, or item paid for by Medicare, Medicaid, and most other federally funded health care programs. These carry both civil and criminal penalties. The breadth of the statute places any financial arrangement under scrutiny.

Initial guidance from the OIG and the Department of Justice was limited to regulations that merely repeated the statutory language. Faced with concerns about potential liability and the lack of meaningful guidance, Congress directed the OIG to establish regulatory "safe harbors" for arrangements that would not be subject to prosecution. OIG also was directed to establish a process for issuing advisory opinions as a means for an individual or entity to seek advance clearance for an arrangement. As with other advisory opinion processes, only the person making the request is protected, and the opinion is limited to the precise facts provided in the request. Like the Stark law, the antikickback statute inhibits the use of incentives to implement the clinical protocols and practices that are needed to improve quality and efficiency.

### **Tax-Exemption laws**

The Internal Revenue Code, specifically the provisions controlling charitable tax-exempt organizations, also comes into play for not-for-profit hospitals. One of the fundamental conditions of tax exemption is that the organization's assets may not "inure to the benefit of any private shareholders or individuals." The standard is strictest for those who are board members or in a position to control or significantly influence the decisions of the organization, sometimes referred to as "insiders". The Internal Revenue Service (IRS) no longer takes the position that all physicians on a hospital's medical staff are insiders, and instead uses a case-by-case, "facts and circumstances" approach. Nevertheless, relationships with physicians are given particular scrutiny.

Under certain circumstances incentive compensation can be seen as constituting inurement of the hospital's net earnings to private individuals. An example would be where the arrangement transforms the principal activity of the organization into a joint venture between it and a group of physicians, or is merely a device for distributing profits to persons in control. The IRS uses a variety of factors to assess whether incentive compensation could jeopardize a hospital's tax-exempt status, such as whether the compensation is approved by an independent board, is negotiated at arm's length, is reasonable, and does not adversely affect performance of the hospital's charitable

activities, among others. When issuing the equivalent of advisory opinions, the IRS typically includes a condition that an arrangement is not in violation of the Stark and antikickback laws.

### **How these regulatory impediments can impact hospitals**

Per-patient payments, particularly payments attributable to patients admitted by the physician, can run afoul of the antikickback statute and the Stark laws because they are volume-sensitive payments that can induce physicians to refer to one hospital over another. Opportunities to earn additional revenue on a particular case, and the additional revenue itself, can be remuneration triggering the antikickback statute if offered or received with the intent to influence or reward referrals to one hospital over another. For example, incentive payments tied to a physician adhering to practice protocols, like the administration of antibiotics within a certain number of hours, could implicate the antikickback statute as payments intended to induce the ordering of a covered item. Similarly, if the protocol were also to encourage physicians to order the generic equivalents of higher-cost antibiotics, this incentive could be viewed as payment intended to induce the ordering of particular items, in this case, the generic antibiotics. In this way, the antikickback law chills hospitals from offering legitimate incentives to physicians.

Payments to physicians can also trigger the Stark law's prohibition on referrals, the definition of which specifically includes the ordering of services – the very act to which many of the quality incentives are tied – and its resulting prohibition on hospital billing, unless those payments are fair market value for defined services. Similarly, productivity bonuses paid by a group practice can only be for services personally performed by their physicians; any share of cost savings would not meet this standard. CMS has recently stated in proposed regulations that the agency is considering an even narrower rule that would allow percentage-based physician compensation arrangements only for services provided personally by the physician, and based solely on the revenues directly resulting from physician services rather than on some other factor such as the savings of a hospital department. As a result, opportunities for implementing standards such as antibiotic administration protocols are dwindling, not expanding.

Under both the antikickback and Stark laws, law enforcement agencies and CMS have indicated that payment to a physician for services for which that physician has already received fair market value compensation by a patient or a payer, such as Medicare Part B physician services, is likely to be prohibited. Paying a physician a second time, the argument goes, cannot be fair market value for that service, so it is assumed to be a payment for something else, such as the referral of patients, even when the compensation is actually to reward achievement of a quality or efficiency goal that improves patient care.

Similar notions apply to the assessment of payments made by non-profit hospitals to physicians. Splitting payments with those physicians where the payer views the payment as earned by the hospital for its services, *e.g.*, successfully meeting treatment protocol benchmarks, could be viewed by the IRS as prohibited "private inurement" or "private

benefit.” Where a private benefit is viewed as more than “incidental,” *i.e.*, more than a mere byproduct of the public benefit, it can jeopardize the organization’s tax exempt status and/or put the entity at risk for intermediate sanctions. So long as any incentive arrangement is tied to an improvement in an organization’s delivery of its health care services, it should be permissible under the tax laws and should not be seen as an impermissible equity-sharing in the net income of the tax-exempt organization. However, without favorable guidance, establishing clinically based treatment protocols and structuring incentive payments to physicians to encourage the adoption of these protocols, is a challenging proposition for any tax-exempt entity.

Finally, the CMP law prohibits hospitals from offering payments that provide physicians an incentive to reduce or limit services. Administrative interpretations of the CMP law have it covering any incentive that impacts the delivery of services, regardless of whether the services were medically necessary or would improve quality of care. For example, the formulary compliance component of the incentive program noted above could implicate the CMP law as an incentive to reduce services, even where none of these reductions were inappropriate. More generally, the CMP law has a chilling effect on any specific practice protocols, even where such protocol is recognized as a best practice based on the clinical evidence, if the OIG elected to argue that it was an incentive to reduce or limit services.

### **WHAT MIGHT BE ACHIEVED?**

There is widespread interest throughout the hospital field in greater clinical integration. While only a very few have achieved fully integrated clinical programs others are experimenting around the edges. Most are discouraged from undertaking the effort because of the myriad of regulatory impediments. The following are examples of experimentation in clinical integration that is ongoing in the field. They illustrate the high degree of interest in the field in greater integration and suggest the accompanying high interest in experimenting with innovations and other improvements in quality and efficiency that greater clinical integration would help hospitals achieve.

- ***Multi-Hospital/Physician Program***

A physician-hospital arrangement in the Midwest, representing three metropolitan hospitals and 1,600 physicians, began developing a clinically integrated system several years ago.

Physician leadership was instrumental in developing the organization and education was necessary to gain physician participation.

Guidelines were established for the collection of data on 30 disease categories known to be the most common conditions in the service area. Existing evidence-based research was used with some refinements made by a multi-specialty clinical quality committee. The group monitors performance on clinical quality through periodic reporting. Reports are shared with physicians and plans are developed to

improve both data collection and performance. Policies place providers at risk for non-participation in clinical data submission and for poor performance.

Initial reports indicated that compliance was at or above national benchmarks for comparable measures, although they also demonstrate the need for change and improvement in some areas.

- ***West Coast Hospital's Integration Efforts***

Since 1985, a large regional health system in the West has been developing information systems that bring all the constituents of the organization together.

Quality is considered to be a management function requiring infrastructure. The information systems and management structure led to the use of an advanced clinical computer system, an interactive Web site, electronic medical records, clinical workstations, advanced clinical practice tools, bedside computers, a robotic pharmacy system, and more.

Incentives and resources for physicians and hospitals are aligned to help people stay well and improve medical outcomes through collaboration, teamwork, and care process improvement initiatives.

Integration has led to better medical outcomes and reduced costs. Health care costs at this system have increased at half the rate of those across the nation. Patients help manage their own care by accessing their medical records online, where they may also view billing and benefit information.

System leaders say that culture change, driven by advanced training of quality improvement leaders, was crucial, as was having a strategic plan that focused on process analysis, outcomes tracking, and a management structure that would function in various settings.

- ***East Coast Community Health System***

An independent physician organization working with an East Coast community health system provides services to link and integrate a network of physicians, physician groups, and a community hospital.

The organization provides the tools and management necessary to develop and demonstrate the best possible patient care in an ever-changing environment. In collaboration with a not-for-profit community hospital, the group practice is engaged in a demonstration project aimed at improving the coordination of care across inpatient and outpatient settings. Nearly all physicians on the hospital's medical staff are participating.

This demonstration project addresses quality measures for the management of Medicare patients with select chronic diseases, and the physician group has the potential to earn financial incentives if it demonstrates that it has delivered high-

quality, efficient health care to this population. The physician group and hospital have not established an electronic medical records system in which they all contribute information and measure quality goals. Instead, quality and efficiency determinations are based on established demonstration criteria. The physicians and hospitals have, however, established a record of innovative collaboration. For example, the hospital has been building a comprehensive data repository on its patients that is accessible to all of its affiliated physicians.

### **CONCLUSION**

We again thank the Commission for providing this important forum. We look forward to leadership from the antitrust agencies in removing the apprehension and confusion about antitrust laws and policies that are preventing too many hospitals and physicians from working together to provide improved quality and efficiency for their patients.

We believe that leadership by the antitrust agencies will have a ripple effect that can lead to better care across the health care field.