Clinical Integration Task Force Interim Report

I. Introduction

The members of the Clinical Integration Task Force are:

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Cornelius Foley, M.D…….…...….Queens
Mark L. Fox, M.D…….…..Westchester
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David T. Hannan, M.D…….…..Wayne
Munish Khaneja, M.D…….……Kings
Rob Mackenzie, M.D…….…….Tompkins
John Paul Mead, M.D…….…....Tompkins
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Richard Stechel, M.D……..…….……..Nassau
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The Clinical Integration Task Force was formed as a result of Resolution 2006-52 which states:

RESOLVED, That the Medical Society of the State of New York create a task force to study the opportunities and risks involved with physicians developing clinically integrated groups, and educate physicians regarding the same, including (1) defining clinical integration (2) researching Federal Trade Commission and Department of Justice advisories on clinical integration; (3) monitoring the progress of clinically integrated groups; (4) making policy and legislative recommendations (5) developing a program to educate physicians about the benefits to physicians and patients, as well as the threats, concerning creating clinically integrated physician practices; and be it further

RESOLVED, That MSSNY ask the American Medical Association to work with State Medical Societies to develop a white paper to educate physicians regarding the benefits and risks of clinical integration; and be it further

RESOLVED, That this resolution be transmitted to the American Medical Association for consideration at its 2006 Annual House of Delegates meeting.

II. Clinical Integration Background

A. Antitrust Basics

The principle antitrust law is the Sherman Act which became law in 1890. Section 1 of the Sherman Act, in pertinent part provides:

> *Every contract, combination in the form of a trust or otherwise, or conspiracy in restraint of trade or commerce among the states … is declared to be illegal.*

Section 1 of the Sherman Act cannot be violated by one person acting alone. To violate the Sherman Act, there must be concerted action by two or more competitors. Physicians who are in separate medical practices that are not financially and clinically integrated are considered to be "competitors of each other". Concerted agreements among competitors on price, or concerted agreements to refuse to deal or boycotts have been held to be per se violations of the antitrust laws.

Rule of Reason and Per Se Rule

There are, generally, two standards to determine whether concerted action is unreasonable, and a violation of section 1 of the Sherman Act. Most conduct is examined under the "Rule of Reason". Some conduct is examined under the Per Se rule.

Under the Rule of Reason analysis, the plaintiff has the burden of establishing that a particular practice unreasonably restrains trade. The defendant does not have the initial burden of proving that a challenged practice is reasonable. The impact of the particular practice is evaluated in the context of the relevant market. The Rule of Reason requires a weighing of all the relevant circumstances of a case to decide whether a restrictive practice constitutes an unreasonable restraint on competition in the relevant market. This requires a thorough investigation of the industry under review and a balancing of the conduct's positive and negative effects on competition. The essential test of the legality of a business practice under the Rule of Reason is whether the conduct promotes or suppresses competition.

The Per Se Rule is the exception to the general Rule of Reason. The Per Se rule involves a limited analysis as to whether the alleged conduct actually occurred and, if so, whether the type of conduct in question falls within the category of conduct that has been condemned under the antitrust laws as per se illegal. If the conduct under review is subject to the per se rule, it is presumed to be illegal without elaborate inquiry as to the precise harm it may have caused or the business justification for its use.

Specific practices that have been condemned by the courts as per se illegal include price fixing, horizontal allocation of customers, certain tying agreements and certain group boycotts.

Obviously, an antitrust defendant prefers to be under the Rule of Reason rather than the Per Se Rule. Under the Rule of Reason, not only does the plaintiff have a difficult burden of proof, but the defendant has the opportunity to show, on balance, the conduct promoted competition.

B. Department of Justice and Federal Trade Commission Statements of Antitrust Policy in Health Care – August 1996

The Federal Trade Commission and Department of Justice have jointly issued policy statements in order to provide guidance to the health care profession. The Statements on Health Care

Antitrust Enforcement – August 1996[1], provided revisions to guidelines that were issued in 1994. In earlier versions of the Policy Statements the agencies discussed only financial integration as a means of structuring collaborative physician joint ventures through which physicians could negotiate prices without running afoul of the antitrust laws. The 1996 policy statements included discussion of a new concept - clinical integration.

The revised statements provide guidance on how the agencies determine whether agreements among competing providers on the prices they will charge through a network should be condemned as "per se" illegal price fixing or analyzed instead under Rule of Reason. The Revised Statements also provide additional guidance on "safety zones" for certain types of physician networks. A safety zone describes conduct that the two agencies will not challenge under the antitrust laws absent "extraordinary circumstances".

In the joint statement, the DOJ and FTC acknowledge that many physician network joint ventures promise significant pro-competitive benefits for consumers of health care services. Statement 8 of the DOJ and FTC Statements on Antitrust Policy describes the Agencies' antitrust analysis of physician network joint ventures and provides examples of certain types of joint ventures that the two agencies would not challenge.

<u>Statement 8 - Antitrust Safety Zones – Sharing of Substantial Financial Risk</u>

Statement 8 provides somewhat differing safety zones depending upon whether the network is "exclusive" or "non-exclusive". In an exclusive network, the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans. In a non-exclusive venture, the physician participants in fact do, or are available to, affiliate with other networks or contract individually with health plans. Networks that are truly non-exclusive generally are viewed as posing substantially fewer antitrust risks than exclusive networks because payors can contract independently with network physicians and bypass the network. As a result, the Policy Statements provide more latitude for non-exclusive networks. For example, a financially integrated physician network that is non-exclusive may receive safety zone treatment if it includes no more than 30 percent of the physicians in each specialty in the relevant geographic market while a financially integrated physician network that is exclusive must include no more than 20 percent of the physicians in each specialty in the relevant geographic market. Regardless whether the network is exclusive or non-exclusive, however, there must be the sharing of substantial financial risk in order to qualify for a safety zone. According to Statement 8:

> *To qualify for either antitrust safety zone, the participants in a physician network joint venture must share substantial financial risk in providing all the services that are jointly priced through the network. The safety zones are limited to networks involving substantial financial risk sharing not because such risk sharing is a desired end in itself, but because it normally is a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies. Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians.*
>
> *The following are examples of some types of arrangements through which participants in a physician network joint venture can share substantial financial risk:*

[1] www.ftc.gov/bc/healthcare/industryguide/policy/into.hta

1) *agreement by the venture to provide services to a health plan at a capitated rate;*

2) *agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;*

3) *use by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:*
   (a) *withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting 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 network's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and*

4) *agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.*

Physician Network Joint Ventures That Do Not Involve Sharing of Substantial Financial Risk But Involve Clinical Integration

Statement 8 reiterates that naked price agreements among competitors is illegal per se, but states that a physician network joint venture that does not involve the sharing of substantial financial risk may nevertheless involve sufficient clinical integration, and, accordingly, will merit evaluation under the Rule of Reason standard. According to Statement 8:

> *Physician network joint ventures 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. Such 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. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.*
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> *The foregoing are not, however, the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis, and the Agencies will consider other arrangements that also may evidence such integration. However, in all cases, the Agencies; analysis will focus on substance, rather than form, in assessing a network's likelihood of producing significant efficiencies. To the extent that agreements on prices to be charged for the integrated provision of services are reasonably necessary to the venture's achievement of efficiencies, they will be evaluated under the rule of reason.*

The above stated clinical integration elements are stated as examples, not requirements. Statement 8 provides that the agencies will make a case-by-case assessment of whether a clinically integrated network possesses the likelihood of producing significant efficiencies in order to justify joint price setting.

Statement 8 makes clear that a clinically integrated network does not qualify for an antitrust safety zone (which still requires financial integration). However, Statement 8 offers the benefit that a clinically integrated network will be evaluated under the Rule of Reason.

C. The Federal Trade Commission and the Department of Justice provided further guidance regarding clinical integration in the jointly issued report Improving Health Care: A Dose of Competition (July 2004).[2]

The report stated that the four indicia of clinical integration are: (1) the use of common information technology to ensure exchange of all relevant patient data; (2) the development and adoption of clinical protocols; (3) care review based on the implementation of protocols; and (4) mechanisms to ensure adherence to protocols.

Other indicia listed in the report include physician credentialing, case management, preauthorization of medical care, and review of associated hospital stays.

In response to requests for further guidance on clinical integration the Agencies stated:

> *Commentators and panelists asserted that there is uncertainty regarding the nature and extent of clinical integration that would, in the Agencies' view, avoid summary condemnation of collective price setting or other horizontal agreements on competitive terms among physicians who participate in clinically integrated joint ventures. Several panelists and commentators requested that the Agencies provide additional guidance to address such uncertainty. The Agencies are committed to eliminating unlawful restraints on vigorous price and non-price competition in physician markets, but not to any particular model for financing and delivering health care. The Agencies do not suggest particular structures with which to achieve clinical integration that justifies joint pricing, because it would risk channeling market behavior rather than encouraging market participants to develop structures responsive to their particular efficiency goals and the market conditions they favor. Nonetheless, to help further guide practitioners and counsel on the on the issue, below is a broad outline of some of the kinds of questions that the Agencies are likely to ask when analyzing the competitive implications of a physician network joint venture that justifies joint action involving price or other competitive implications of a physician network joint venture that justifies joint action involving price or other competitively significant terms on the grounds that it is clinically integrated. The Agencies emphasize that this list is not exhaustive, and that these questions may be more or less relevant, depending on factual circumstances. Other questions, not listed here, may be important, again depending on the facts at issue.*
>
> *1. What do the physicians plan to do together from a clinical standpoint?*
> - *What specific activities will (and should) be undertaken?*
> - *How does this differ from what each physician already does individually?*
> - *What ends are these collective activities designed to achieve?*

[2] www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf

2. *How do the physicians expect actually to accomplish these goals?*
   - *What infrastructure and investment is needed?*
   - *What specific mechanisms will be put in place to make the program work?*
   - *What specific measures will there be to determine whether the program is in fact working?*
3. *What basis is there to think that the individual physicians will actually attempt to accomplish these goals?*
   - *How are individual incentives being changed and re-aligned?*
   - *What specific mechanisms will be used to change and re-align the individual incentives?*
4. *What results can reasonably be expected from undertaking these goals?*
   - *Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?*
   - *To what extent is the potential for success related to the group's size and range of specialties?*
5. *How does joint contracting with payors contribute to accomplishing the program's clinical goals?*
   - *Is joint pricing reasonably necessary to accomplish the goals?*
   - *In what ways?*
6. *To accomplish the group's goals, is it necessary (or desirable) for physicians to affiliate exclusively with one IPA or can they effectively participate in multiple entities and continue to contract outside the group?*
   - *Why or why not?*

D. FTC Advisory Opinion to MedSouth, Inc.

The staff of the Federal Trade Commission issued an advisory letter dated February 19, 2002 to MedSouth, Inc.[3] stating that it has no present intention to recommend a challenge to the organization's proposed operation as a non-exclusive physician network joint venture. MedSouth requested a staff advisory opinion concerning its proposed clinical integration program. MedSouth's proposed program consists of two major parts. First, the physicians will use an electronic clinical data record system that will permit them to access and share with one another clinical information relating to patients. Second, the organization will adopt and implement clinical practice guidelines and measurable performance goals relating to the quality and appropriate use of services provided by MedSouth physicians.

The FTC staff opinion letter concluded that the proposed program taken as a whole "appears to be capable of creating substantial partial integration of the practicing physicians' practices and to have the potential to produce efficiencies in the form of higher quality or reduced costs for patient care services". The staff letter also concluded that the collective negotiation of payer contracts appears to be reasonably related to the physicians' integration through the network and reasonably necessary to the accomplishment of the network's objectives.

The staff opinion also advises MedSouth that the FTC staff will closely monitor MedSouth's activities and those of its physician members for indications of anticompetitive effects, and will recommend that the FTC take appropriate action in the event that those indications arise.

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[3] The MedSouth Inc. Advisory Opinion is available at www.ftc.gov/opa/2002/02/

See Exhibit 1 for a more detailed summary of the MedSouth Advisory Opinion.

E. Messenger Model

The "Messenger Model" is discussed in Statement 9 of the Statements of Antitrust Policy in Health Care. Statement 9 provides that some networks that are not substantially integrated (whether financially or clinically) can use "messenger model" arrangements to facilitate contracting between health care providers and payors and avoid price fixing agreements among competing network providers. According to the FTC and DOJ, a messenger model is an arrangement designed to reduce transaction costs associated with negotiation of contracts between providers and payors. It is not a device for facilitating collective contract agreements among providers on price or price related terms. In a messenger model, a physician network uses the agent to convey to payors information obtained individually from the providers about the prices or price related terms that providers are willing to accept, but the agent does not negotiate on behalf of the provider. The agent may convey to the providers all contract offers made by purchasers, and each provider then makes an independent, unilateral decision to accept or reject the contract offers. Alternatively, the agent may receive authority from individual providers to accept contract offers that meet certain criteria as long as the agent does not negotiate on their behalf.

The FTC and DOJ have warned that it is illegal to use a messenger model in a way that facilitates collective decisions among providers on prices or price related terms.

Some activities that can tip the balance toward illegality are: agent coordination of provider responses to a particular proposal, dissemination to network providers of the views or intentions of other network providers of the views or intentions of other network providers about the proposal, expression of an opinion on the adequacy of price terms offered, or collective negotiations of price terms for the providers.

At the request of a payor, the messenger may discuss with the payer such potentially competitively significant non-price issues as utilization review, credentialing, and quality assurance standards.[4] However, the messenger may not negotiate or agree to any standards on behalf of the members or in any way attempt to require a payor to adopt any particular standards.

F. North Texas Specialty Physicians

An example where the FTC held that the improper use of a messenger model arrangement resulted in the orchestration of illegal price fixing agreements among physicians is North Texas Specialty Physicians.[5] In a unanimous administrative decision and order issued by the FTC on December 1, 2005 the FTC held that the North Texas Specialty Physicians (NTSP), an association of independent physicians in the Forth Worth, Texas area, illegally fixed prices in its negotiations with payors, including insurance companies and health plans. NTSP is the first case which the FTC took a physician network involving allegations of unlawful price fixing to trial. The FTC ordered NTSP to cease and desist from the illegal conduct and to terminate pre-existing contracts with payors for

[4] For example, see DOJ letter to Alexander's Home Health www.usdoj.gov/atr/public/busreview/0942.htm

[5] www.ftc.gov/os/adjpro/d9312/051201opinion.pdf

physician services.

According to the FTC at the time of trial in April 2004, NTSP had approximately 480 physician members representing 26 medical specialties as well as primary care physicians. NTSP's main functions, according to the FTC, were to review contract proposals and negotiate on behalf of its members. NTSP negotiated both financial risk-sharing contracts and non-risk contracts, although the non-risk contracts far outnumbered the risk sharing contracts. Typically, the financial risk sharing contracts involved reimbursement to physicians on a dollar amount per patient basis, whereas the non-risk contracts involved fee for service patients. The conduct challenged by the FTC solely involved the negotiation of non-risk contracts.

The FTC held that NTSP made no effort to justify its negotiation of non-risk contracts on the basis that the physicians had sufficiently clinically integrated their practices. FTC stated that, as a matter of fact, NTSP admitted that its administration of the non-risk contracts did not constitute clinical integration. The FTC stated that NTSP's president stated "NTSP 'isn't there yet' in terms of clinical integration of the care of non-risk patients".[6]

The FTC opinion stated that NTSP deviated from the accepted parameters of a lawful messenger model in a manner that amounts to horizontal price fixing. The FTC stated that in a lawful messenger model, a physician network uses the agent to convey to payors information obtained individually from providers about the prices or price-related terms the providers are willing to accept, but the agent may not negotiate on behalf of the providers. If the agent acts in a way that creates or facilitates collective decisions on price or price-related terms then the arrangement is an unlawful price fixing agreement.

The FTC order does not prohibit NTSP from entering into any agreement involving conduct that is in furtherance of a qualified risk sharing joint venture or a qualified clinically integrated joint venture. The FTC order also allows NTSP to follow a lawful messenger model on behalf of physicians, but for three years, NTSP will be required to notify the FTC in advance before doing so.

NTSP is seeking judicial review of the FTC decision. As of the date of this report, oral arguments are scheduled to be held before the United States Court of Appeals for the Fifth Circuit in March 2007.

A summary of the FTC North Texas Specialty Physicians decision is annexed as Exhibit 2.

G. FTC Staff Advisory Opinion to Suburban Health Organization Inc. – Not Enough Clinical Integration

The FTC Advisory Opinion issued to Suburban Health Organization Ind. ("SHO")[7] on March 28, 2006 is a "negative opinion" where the FTC advised that a proposed clinical integration joint venture would violate the antitrust laws.

Under the proposed program SHO, an Indiana non-profit corporation, would be the exclusive bargaining and contracting agent with most insurers for 192 primary care physicians

[6] Id at p. 30

[7] www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf

employed at SHO's eight member hospitals. Under the proposed plan, SHO hospitals would deal only through SHO, at prices set by the group, when selling their employed physicians' services to insurers. The FTC advisory opinion letter concluded that the plan would eliminate price competition that otherwise would exist among the hospitals for the physicians' services.

SHO's proposed program would involve: joint development of practice protocols and disease specific treatment parameters regarding a limited set of medical conditions; centralized collection and use of data to monitor physician behavior and outcomes with respect to the treatment protocols and parameters; jointly produced educational materials for the participating physicians; and a commitment by the SHO hospitals to have their physicians abide by the program requirements, reinforced by a bonus pool to reward financially desirable behavior and results.

The FTC staff advisory opinion stated, however, that the proposed program's limited nature and scope appeared to limit significantly its potential benefits. Because it would only involve the SHO hospitals' employed primary care physicians, the program would not apply to the full range of medical services that a patient might need. Consequently, anyone referred to a specialist physician, or any other provider not in the program, would lose the benefits of the program. In addition, the FTC staff observed, most of the program's integration and efficiencies would only be informational in nature – relating to developing and disseminating information, and collecting information regarding performance – and would not involve integration or interdependence among the participating physicians in the actual provision of their medical services.

Finally, the FTC staff concluded that the price agreement in SHO's proposal was not reasonably necessary to achieve any of the potential efficiencies or consumer benefits.

H. Brown & Toland Medical Group

Brown & Toland Medical Group is a comprehensive multi-specialty independent practice association in the San Francisco area. In 2003, the FTC sued the medical group for alleged price fixing. The FTC alleged that the medical group organized a horizontal agreement under which its competing member physicians would agree collectively on the price and other competitively significant terms on which they would enter into contracts with health plans. The FTC and Brown & Toland entered into a consent decree in February 2004. The terms of the consent decree barred Brown & Toland from: (1) negotiating with any payor on behalf of any physician; (2) dealing or refusing to deal with any payor based on price or other terms; and (3) jointly determining price or other terms upon which any physician deals with payors.

The Consent Decree stated that Brown & Toland may engage in the above conduct if such conduct is reasonably necessary to the formation of qualified risk-sharing joint arrangement or a qualified clinically integrated joint arrangement.

On June 17, 2004 Brown & Toland submitted a proposed PPO clinical integration program to the FTC for review. Based upon questions raised by the FTC in regard to the proposed clinical integration program, Brown & Toland submitted a Follow-Up PPO Submission on October 7, 2004, and then a Second Follow-Up PPO Submission on December 2, 2004. These submissions provide a detailed program for planned clinical integration features and the efficiencies that are expected to be achieved as a result. The Brown & Toland submissions may be a helpful resource to identify the level of specificity that the FTC will require in reviewing a proposed clinical integration program, and, moreover, may give examples of some of the questions that may be raised by the FTC in

reviewing a proposed program[8].

The FTC staff responded in a letter dated April 5, 2005. The FTC staff stated that based upon the information provided by Brown & Toland, the FTC staff will not recommend that the FTC take any action regarding Brown & Toland's PPO product at this time. The FTC staff cautioned that it will continue to monitor the implementation of the PPO product.[9]

[8]Brown & Toland PPO Submission is found at

http://www.ftc.gov/os/adjpro/d9306/040617followuppposub.pdf

The Follow-Up PPO Submission is found at: http://www.ftc.gov/os/adjpro/d9306/041007followuppposub.pdf

The Second Follow-Up PPO Submission is found at

http://www.ftc.gov/os/adjpro/d9306/041202secfollowupsub.pdf

[9] The FTC staff letter is available at

http://www.ftc.gov/os/adjpro/d9306/050405cpbresponsetbtnotice.pdf

III. Clinical Integration Task Force Meeting – January 23, 2007

The Clinical Integration Task Force met on Tuesday, January 23, 2006. The Task Force received presentations from Eric T. Nielsen, M.D., Chief Medical Officer of the Greater Rochester Independent Practice Association (GRIPA), and Christi Braun, Esq. of the law firm Ober Kaler. Ms. Braun is outside counsel to GRIPA. GRIPA is a physician organization which presently has 610 "owner" physicians including 150 employed physicians. GRIPA contracts with multiple payers for risk contracts. GRIPA is developing a clinical integration program to administer non-risk contracts.

In June 2006, GRIPA requested an Advisory Opinion from the Federal Trade Commission regarding its proposed clinical integration program. An Advisory Opinion from the FTC is expected in the near future.

The presentation of Ms. Braun is attached as Exhibit 3 and the presentation of Dr. Nielsen is attached as Exhibit 4.

IV. Next Steps

A meeting of the Task Force will be held on March 26, 2007. The Long Island Health Network (LIHN) headquartered in Melville N.Y., which is a clinically integrated joint venture of 10 hospitals, will make a presentation regarding its clinical integration program. The Task Force has requested LIHN to provide information regarding the role of physicians and medical staffs in the clinically integrated hospital network. In addition, a representative of the American Medical Association will make a presentation regarding some of the efforts of the AMA to provide guidance and education pertaining to clinical integration.

V. Interim Recommendations

The Task Force should continue to monitor developments that may provide additional guidance regarding clinical integration. GRIPA has requested the FTC to issue an advisory opinion regarding GRIPA's clinical integration program, and it is believed that the FTC will issue an advisory opinion to GRIPA in the near future. The Task Force hopes to review the advisory opinion to determine whether it will contain guidance that expands upon the guidance provided in the MedSouth advisory opinion. The Task Force is also awaiting the ruling of the United States Court of Appeals, Fifth Circuit In the Matter of North Texas Specialty Physicians to determine whether any lessons can be learned from the appellate court ruling with respect to what role (if any) a physician network can play in the negotiation of non-risk contracts on behalf of its physician network members if the network is not sufficiently clinically integrated.

The Task Force believes that clinical integration offers substantial potential benefits to many members of the medical profession and may lead to innovative approaches that will improve clinical performance and enhance efficiencies. The Task Force should continue to evaluate how clinically integrated networks including MedSouth, GRIPA, LIHN and others are meeting the challenge of implementing and realizing their stated goals of improving quality and enhancing efficiency.

The Task Force believes that in order to successfully develop and implement a clinically integrated joint venture, there must be substantial investment of capital – both monetary and human. To the extent that a physician network promises that its clinical integration program will achieve improved clinical performance and will enhance efficiencies – in the end, key players, including the government, private health plans employers and the patient community, must be satisfied that the promises of clinical integration have been met.

Physicians who view clinical integration solely as a "simple" way to facilitate the collective negotiation of contracts with payors do not understand the concept of clinical integration and will be disappointed when it is learned that clinical integration requires serious commitments. Not only must there be a substantial investment of time and capital to develop a clinically integrated physician network, but even upon the successful implementation of such a program, the network must be able to demonstrate that any joint negotiations by the network is "ancillary" to the network's clinical integration, and reasonably related and necessary to achieve the network's clinical integration benefits. Clearly, any collective negotiation unrelated to the clinically integrated product would still be subject to per se condemnation.

Despite the substantial benefits offered by clinical integration, and the recognized opportunities that a clinically integrated network may offer to many physicians, the Task Force realizes that clinical integration may not be a suitable option for every physician. Some physicians may not be willing to make the investments of time and effort required by the network. Other physicians may view that certain clinical integration features may lead to a curtailment of clinical independence. The role of the Task Force should be to provide education regarding clinical integration so each physician can make an informed decision whether to participate in a clinical integration network.

MSSNY has advocated for legislation to allow independently practicing physicians to collectively negotiate contract terms with managed care plans. The Task Force believes that MSSNY should continue to pursue the objective of pursuing legislation that would allow collective negotiations by independently practicing physicians, while also pursuing the objective of providing education regarding clinical integration. The two objectives are separate and distinct, and each objective has different benefits. Both objectives should be pursued concurrently.

The Clinical Integration Task Force looks forward to continuing its role in developing educational material pertaining to clinical integration.

Respectfully Submitted,

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MSSNY Clinical Integration Task Force

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