I. The Future. No discussion of physician alignment strategies would be complete without a discussion of what people see as the future of health care. Clearly we, lawyers, are not futurists. But an awareness of what people are saying about healthcare and its structure can help us to better understand our clients and prepare them for the inevitable changes that will come. The need to improve quality is the backdrop of much of the discussion about how health care should and will be delivered. Many health care experts see quality as the area that will be the focus of future competition.

A. Part of that debate has been carried on in the *Harvard Business Review* as evidenced by recent articles on competition at the diagnosis level and competition at the integrated system level. Both approaches focus on competition although neither view competition in the same way that anti-trust lawyers do. If competition were effective in the way traditionally espoused by the FTC then, but for small pockets of the industry where there is inadequate competition, there would be relentless improvements in processes and methods that would be improving quality and driving down costs. That, of course, is not happening. In fact, most significant improvements in metrics and processes appear to be occurring in areas where there is not intensive competition, e.g., at organizations such as Intermountain. The type of competition needed to transform health care is seen very differently by the two sides to this debate.
1. Competition at the diagnosis level. In June of 2004, Michael Porter and Elizabeth Olmsted Teisberg published an article in the *Harvard Business Review* in which they argued that health care competition has “become a zero-sum: The system participants divide value instead of increasing it. In some cases, they may even erode value by creating unnecessary costs. Zero-sum competition is manifested in several ways: First, it takes the form of cost shifting rather than fundamental cost reduction…. Second, zero-sum competition involves the pursuit of greater bargaining power…Third, zero sum competition restricts choice and access to services instead of making care better and more efficient.” They advocate moving the level of competition to prevention, diagnosis and treatment of individual health conditions. They correctly note that the more experience physicians and teams have in treating patients with a particular disease or condition, the more likely they are to create better outcomes. In order to achieve their goal they advocate the ability of patients to chose any provider; there would be no differences in rates charged by a provider to different insurers.

2. Competition at integrated delivery system level. A response to the suggestion that competition should be at the level of diagnosis was disputed in the September 2005 issue of the *Harvard Business Review*. In an article by Alain Enthoven and Laura Tollen entitled
“Competitions in Health Care: It Takes Systems to Pursue Quality and Efficiency” they argue that the solution to health care competition is markets that encourage integrated delivery systems with incentives for teams of professionals to provide coordinated, efficient, evidence-based care, supported by state-of-the-art information technology. Enthoven and Tollen advocate per capita prepayment as a way to reward providers to keep patients healthy. They also note that IDS which are at least partially prepaid are far ahead of small groups and individual doctors in their use of quality enhancing decision support tools, disease registries, guidelines, automated reminders, performance feedback, patient self-management, linkage to community resources, and electronic medical records. IDS would also have the resources to develop teams to focus on the patient rather than the procedure as well as develop and implement evidence based guidelines (neither of which can be achieved by an individual practitioner). They could also determine the best least costly site of care since all sites of care would be controlled by the IDS. In addition, all providers would share comprehensive patient records. They advocate competition that is designed to encourage evolution toward “systemness.” Thus, consumer choice would be exercised at the delivery system level.
B. In addition to the academic discussions regarding the key role competition will play in the future, carriers and the Federal Government are focusing on quality through P4P programs that were discussed in the plenary session. But, like productivity improvement measures, you are likely to get results in the area you are measuring but you may have little effect on the overall level of quality.

C. Consumer directed health care is designed to increase quality while reducing costs by shifting more costs to consumers and providing them with information on quality and cost so that they can make better informed choices. This solution, while helpful, also has limitations since many consumers engage in little study before seeking treatment for urgent or emergent health problems. In addition, substantial portions of our society are unable or unwilling to use the available information on quality. See “Consumers Don’t Know What They Don’t Know” in the December 2005 edition of Managed Care Magazine. They noted “that a quarter of all adults can’t read at the fifth level”…and “the situation with health literacy is far worse.”

D. There are some futurists who see entities that employ physicians and own hospitals as the “end game”. They think that Kaiser type models will be the winning strategy to improve quality and meet the needs of the younger generation of physicians.
E. Stronger physician/hospital alignment is needed under all of these scenarios. What follows is a discussion of ways in which alignment can be achieved.

II. Employment.

A. The value of employing physicians is being reevaluated. For the past several years hospitals have been divesting themselves of physician practices. Physician practices often lost money and were seen as a drain on hospital resources. The reevaluation is due in part to the different pressures in the market place and the change from the old system of paying substantial premiums when purchasing practices and compensating physicians without regard to productivity.

B. Competitive Advantage. Hospitals in volatile markets are employing physicians in order to assure the viability of the hospital. What better way to increase the number of vascular surgeries performed in a hospital than to employ all the vascular surgeons in a community? When competing hospitals employ all the physicians in a given specialty in their community they cripple their competitor, at least temporarily. The only truly effective way to preclude the loss of a vital product line is to employ physician who provide that service.

C. Recruitment. Traditional recruitment of physicians by a hospital must meet the requirements outlined below. However, those requirements do not have to be met in order for a hospital to employ a physician. Thus, hospitals will often employ physicians when one or more of the
requirements for recruitment cannot be met. For example, when community need cannot be established but the hospital believes that it “needs” a specialty or when a hospital wants to engage in what otherwise would be an across town recruitment, hospitals can use employment instead. The following is a brief outline of the requirements that must be met in order to for a hospital to recruit a physician. The inability to meet these criteria can often be overcome by using the employment model instead of the private practice model.

1. The threshold requirement is the establishment of community need. In those instances in which the need is an institutional vs. a community need, employing the physician may be a viable option.

2. In order to recruit a physician into an existing group a number of requirements must be met:
   a. No non-compete;
   b. The subsidy can only cover the incremental costs added by the newly recruited physician; and
   c. Employing a physician, who then leases office space, shares call and purchases services from the existing group can often have many of the benefits of recruiting into a group.

3. The downside of this approach is that it is difficult to allocate the revenue from patients who are seen by both the private practice physicians and the physician who is employed by the hospital.
Another issue that must be considered is any non-compete required by the hospital. If the hospital’s non-compete is too short the Government could allege the employment was simply a ruse to circumvent the recruitment regulations. In addition, once the non-compete has terminated there is no guarantee that the physician will join the group with whom he has been sharing an office.

D. Access to Critical Services. Employed physicians can also assure a hospital that it will have access to critical services. This is the other side of the demand for call pay. The costs associated with call pay can exceed the costs of employing physicians particularly in such areas as orthopedics and neonatology. When employing specialists a hospital will have to make a determination as to whether those specialists will also have outpatient practices which will compete with the other specialists on its medical staff. That determination is fraught with both political and financial ramifications.

E. Tax-exempt considerations are still present in an employment situation. Private inurement allegations can be made if the employed physicians continually result in a flow of red ink. Both productivity requirements, instead of just a guaranteed salary, and more realistic valuations of existing practices where a purchase is involved have greatly assisted the hospital in at least breaking even.

III. Medical Directors.

A. Some hospitals are looking at ways to phase out traditional Medical
Director contracts. Medical Directors have traditionally been individuals who were responsible for essentially making a department run on an even keel but too often were thinly disguised payments to reward a major admitter. The Medical Director was paid on a per hour or per annum fixed fee basis. Payments were based upon hours worked not outcomes. Medical Director contracts have rarely achieved marked increases in quality of care or efficiencies of operations. Payments to medical directors represent a substantial sum of money that some hospitals feel could be better directed toward improving quality. Those agreements are now evolving into agreements with groups of physicians based on the achievement of predetermined goals. Incenting physicians to provide better quality of care is a laudable goal that is in keeping with changes in the market place. Unfortunately, making the change from traditional Medical Director contracts to the new quality focused group agreements faces a number of operational and legal hurdles.

1. Who should be paid? All physicians with a given specialty on a medical staff? Only those who can influence changed behavior in others? Physicians in multiple specialties who influence the outcome of a particular quality measure?

2. How should the money be divided up? If a physician is paid for the number of times he treats a patient in accordance with a protocol are you indirectly paying for referrals?
3. Gainsharing. In effecting true quality improvements the recent Gainsharing opinions provide little help in achieving true quality improvement. However, they need to be reviewed when establishing a quality improvement program in order to determine if they could negatively impact the implementation of the program.

4. How do you determine what to measure? Should it be adherence to evidence based protocols? If so, what is the cost of the infrastructure needed to track adherence? Should it initially be simple easily measured things? The difficulty in identifying useful evidence based quality measures is seen in “A Process for Measuring the Quality of Cancer Care: The Quality Oncology Practice Initiative” in the *Journal of Clinical Oncology* in which they describe monitoring care in a number of oncology physician practice locations.

IV. Paying Physicians to Participate in the Quality Revolution. This is essentially the same concept as that discussed above although it could potentially include more physicians and is more likely to include programs focused on multiple specialties working toward the same quality goal. A number of groups, including the VHA, are discussing ways to incentivise physicians to participate in the quality evolution. The preference would be to pay physicians each time they follow a protocol. This is a line of sight reward for performance and would have the greatest likelihood for success in terms of changing physician performance. Unfortunately, it would be all too easy for the Government to allege that such
payments are disguised payments for referrals. Thus, VHA has been advised to seek an advisory opinion. Another slightly less risky approach would be to have the division of the maximum payments based on the number of admissions in a prior based year, instituting criteria that would preclude gamming the system by admitting only selected patients while still basing payments on the percent of patients who were treated in accordance with the protocol.

V. Management Agreements. Physicians form an entity that contracts with a hospital to manage segments of the hospital. Such an agreement can, in addition to the standard requirements of a management agreement, contain quality and performance goals. The following are examples of management agreements:

i. Management of a hospital’s Gastroenterology service;

ii. Management of the hospital’s outpatient surgery center; and

iii. Management of the hospital’s whole cardiovascular program, including inpatient and outpatient services, screening and detection, and community education.

A. Among the benefits of the management agreement model are:

1. Physicians gain substantial input into operation of the program;

2. Compensation can be performance based;

3. It does not involve the creation of a new provider;

4. It does not require physician equity contribution; and

5. Participating physicians can be prohibited from owning, operating or managing a competing program.
B. The primary drawback of the management agreement model is that compensation must be consistent with the fair market value for the services provided so it is unlikely the physicians will “hit a home run” in compensation under this model.

C. Ideally this type of transaction will be structured to fall within a Stark exception such as the personal service exception or the management contracts exception. These exceptions provide that the ban on self-referral does not apply to remuneration from an entity for the provision of physician services if:

1. The arrangement is in writing, signed by the parties, and specifies the services it covers; ¹

2. The arrangement covers all the services to be provided by the physician (or an immediate family member of such physician) to the entity;

3. The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement;

4. The term of the arrangement is for at least one (1) year;

5. The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business arrangement or other activity that violates any state or federal law; and
6. The arrangement meets any other requirements the Secretary of HHS may impose as needed to protect against program patient abuse.

D. Management agreements that provide for a percentage based bonus or penalty will not meet the requirement that the aggregate compensation must be set in advance, be consistent with the fair market value and not be determined in a manner which takes into consideration the volume or value of referrals. Nonetheless, the OIG or a court may well find such an arrangement was not the type of arrangement that Congress intended to prohibit given the prevalence of such compensation historically existing in the industry.

E. **Anti-Kickback Safe Harbor.** One of the keys to making sure the transaction will stand legal muster is to make sure that when physicians have a management contract they actually manage the function. Therefore, determining not only what the staffing level should be but also who will staff the managed unit is a physician obligation that must be set forth in the contract. Generally, most believe a joint venture can be structured and operated in a fashion that would be found to comply with the Anti-Kickback Act. The final analysis, of course, depends on the intent of the parties and the details of the particular arrangement. In such an analysis, the parties should focus on the “Recommended Preliminary Questions and the Supplementary Information for Addressing Requests for

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1 42 U.S.C. § 1395nn(c)(3)
OIG Advisory Opinions,” in which the OIG has identified the following “risk” factors that any arrangement should address:

1. Will the arrangement reduce access to health care services?
2. Will the arrangement decrease the quality of health care services?
3. Will the arrangement affect patient freedom of choice among health care providers?
4. Will the arrangement have a negative impact on competition among health care providers?
5. Will the arrangement affect the ability to provide services to medically underserved populations?
6. Will the arrangement increase the cost to federal health care programs?
7. Will the arrangement influence the clinical judgment of any health care professionals?

With respect to management agreements, safe harbors are potentially applicable, including the personal services and management contracts safe harbor, 42 C.F.R. § 1001.952(d), the equipment rental safe harbor, 42 C.F.R. § 1001.952(c), and the space rental safe harbor, 42 C.F.R. § 1001.952(b). As noted above, failure to fit precisely within a safe harbor, however, does not necessarily mean that an arrangement is unlawful. The requirements of the personal services and management contracts safe harbor are as follows:

1. The agreement must be set out in writing and signed by the parties;
2. The agreement must cover all of the services provided between the parties and specify the services to be provided;

3. If the services will be provided on a periodic, sporadic or part-time basis, rather than on a full-time basis, the agreement must specify the exact schedule of the intervals, their precise length, and the exact charge for such intervals;

4. The term of the agreement must be for not less than one (1) year;

5. The aggregate compensation under the agreement must be set in advance, be consistent with the fair market value in arms-length transactions, and not be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made under Medicare, Medicaid, or other Federal health care programs;

6. The services performed under the agreement must not involve the counseling or promotion of a business arrangement or other activity that violated federal or state law; and

7. The aggregate services contracted for may not exceed those that are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

VI. Hospital Based Physicians.

A. Hospital based physicians have traditionally been paid (if at all) essentially to show up. Payments were often based on the theory that hospitals were paying physicians for additional services that were helpful to the hospital
but were not economically sound from a physician perspective, e.g., staffing twenty-four (24) hours per day operations. Payments are now moving toward being at least in part based on outcomes and/or meeting pre-determined goals, e.g., turnaround time in the ER. Once again, setting the goals and measuring the achievement of goals are the major operational difficulties. Often the initial year or two (2) years of the agreements are used to set the baseline against which future performance will be measured. In the case of hospital based physicians the goals can include revenue and volume related goals. Of course any service that could have been performed as a result of a referral from a member of the group must be excluded. Hospital based physicians can impact volume in many ways. For example, how fast test results are reported to the attending physician and whether the tests are accurate have impacts on quality.

VII. Quality Institutes. Some commentators are suggesting the establishment of local independent quality institutes that are distinct entities lead by physicians and focused on improving clinical performance, patient and employee safety and consumer understanding and satisfaction. (See “The Quality Institute” published in the CareCompanion). These independent organizations would be lead by physicians who have a keen interest in improving quality. They would be set up as non-profit independent entities. It is envisioned that in this way physicians could be compensated without “creating legal entanglements or undesirable precedents.” (Although I think that if the institute has too close a relationship
with a hospital, the Government could view the Institute as an alter ego of the hospital thus invoking Stark, anti kickback etc.) The Institute could be tasked with measuring performance, monitoring scientific literature in order to develop evidence-based protocols and coordinating participation in P4P programs. They could have a full time staff or could share staff with a health system (researchers, health statisticians and nurses). Financing such entities remains a major open issue.

VIII. Hospital/Physician Clinical Integration. This can be a more robust version of the Quality Institute. The primary difference is that the level of integration is such that hospitals and physicians can jointly negotiate with payors. This would unite hospitals and physicians in their approach to both quality and the market place. However, doing so requires programs and infrastructure aimed at improving care. Only with adequate integration can the new entity can go to the market place and negotiate agreements with third party providers. Those negotiations have the ability to focus on how the new organization can demonstrate its value to patients and third party providers.

A. Components

1. Multi specialty group MDs.
2. Single specialty MDs.
3. Chronic disease focused MDs.
4. Institutions/systems.

B. Attributes

1. Self sustaining.
2. Dedicated mission.

3. Contracting entity.

C. Strategy

1. Organized to improve quality.

2. Goals are set objectively – evidence-based science and data is used to make decisions and recommendations.

3. Membership is open to all physicians who wish to participate.

4. Decision making is transparent.

5. Proactive - focused on quality improvements not just incentives offered by third parties or other special interests.

6. Focus on appropriate standards and processes for the community in which it is located.

7. Rely on national evidence-based consensus measures.

8. Use electronic medical records, computerized order entry and protocols.

D. Funding

1. MDs need to see real returns not merely the promise of future returns.

2. Varying levels of leadership/participation will require varying levels of payment. The difference in payment between the leadership and the participants can be readily handled but the difference between participants is a far more difficult distinction.
E. Potential Sources of Funding. In order to generate interest by third party payors and to incent hospitals to contribute capital the initial areas of focus should include areas likely to generate substantial financial rewards for both the hospitals and payors. Focusing initially on inpatients is also a necessity until a robust electronic outpatient medical record system is implemented. Those can include (i) focusing on the use of generics (substituting generic drugs for a branded drug can result in savings of sixty-seven percent [67%]); (ii) instituting treatment protocols designed to avoid emergency room visits and hospitalizations for asthma; (iii) requiring participating physicians to participate in supply chain initiatives, e.g., using preferred orthopedic implants; and (iv) documentation of smoking cessation counseling so as to decrease the number of smokers.

1. Integrated delivery systems can monetize the start up and help to under-write the needed IT support.

2. Health insurance providers that are owned or controlled by the institutional members can be valuable participants. They can fund some of the IT costs and they can base their payment rates on participation and achievement of goals.

3. Grants

4. Third party payors through joint negotiations and P4P programs

5. Preferred malpractice rates can be achieved for physician participants if the institutional providers own or control
malpractice carriers and adherence to protocols can be shown to reduce exposure to malpractice claims.

6. Potentially, office practice efficiencies can accrue to physician participants through participating in the IT initiatives and sharing of processes.

F. Challenges

1. Particularly during the start up phase it is difficult to assign a value to achievement of evidence based results.

2. Long term funding by third parties is not guaranteed.
   a. The cost of putting this structure in place is greater than P4P rewards.

G. Anti-trust. In order for health systems and physicians to join together to negotiate with payors and not run afoul of the anti-trust law they must be integrated financially or clinically. Financial integration is fairly straightforward. Clinical integration requires further definition. To meet the Government’s test, clinical integration can be evidenced by a “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.”

1. Clinical integration can be achieved through:
   a. The use of common information and technology to ensure the exchange of all relevant patient data;
b. The development and adoption of clinical protocols;

c. Care review based on the implementation of protocols; and

d. Mechanisms to ensure adherence to protocols;

2. The FTC may use the following guidelines in reviewing purported integration of physician groups and physician groups and hospitals:

a. What do the parties plan to do together from a clinical standpoint?

   (1) What specific activities will (and should) be undertaken?

   (2) How does this differ from what each physician already does individually?

   (3) What ends are these collective activities designed to achieve?

b. How do the parties expect to actually accomplish these goals?

   (1) What infrastructure and investment is needed?

   (2) What specific mechanisms will be put in place to make the program work?

   (3) What specific measures will there be to determine whether the program is working?

c. What basis is there to think that the individual physicians will actually attempt to accomplish these goals?
(1) How are individual incentives being changed and realigned?

(2) What specific mechanisms will be used to change and realign the individual incentives?

d. What results can reasonably be expected from undertaking these goals?

(1) Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?

(2) To what extent is the potential for success related to the group’s size and range of specialties?

e. How does joint contracting with payors contribute to accomplishing the program’s clinical goals?

(1) Is joint pricing reasonably necessary to accomplish the goals?

(2) In what ways?

f. To accomplish the group’s goals, is it necessary (or desirable) for physicians to affiliate exclusively with one entity or can they effectively contract outside the group?

IX. Joint Ownership of Real Estate. The joint ownership of real estate can be used to permit primary care physicians to participate in joint ventures that would otherwise only be open to specialists, for example, Ambulatory Surgery Center transactions. It is legally problematic to have primary care (referring) physicians
own an interest in an ambulatory surgical center. However, a way to permit limited participation by them is to have them participate in the real estate portion of the transaction. Thus, the primary care physicians would be part of a joint venture that would own the real estate that would then be leased to the ASC joint venture. In addition, physicians can joint venture medical office buildings that can then be leased to themselves or to third parties.

A. These transactions must be at fair market value. Since medical office buildings generally have a rate of return of approximately eight to nine percent (8%-9%) this will effectively limit the rate of return for this type of transaction.

B. Strip Center Type Lease. Some attorneys are advocating the use of the type of leases that are common in strip centers. These leases, while common in general industry, are uncommon in health care and have characteristics which could cause concern for some regulators. The characteristics of this type of lease are:

1. Rent is based on a percentage of profits. This effectively permits the lessor to increase his profitability based on volume.

2. Rent can also be based on a percentage of gross revenue which will also effectively permit the lessor to increase his profit as volume increases

X. **Click Fee Leases.** A joint venture composed of a hospital and physicians or a group of physicians can lease equipment to a hospital and the hospitals can pay for the use of the equipment on a click-fee basis.
A. This will permit the hospital to bill for the service as a provider-based service. In general, provider-based services are reimbursed at a higher rate than similar services performed in a physician’s office.

B. A joint venture for ownership of equipment does not face the same difficulties valuing the contribution of the parties to the joint venture as the creation of a freestanding joint venture, which requires valuing the stream of revenue being contributed. Physicians will argue that since they made the referrals the revenue stream currently being enjoyed by the hospital should be valued at zero. Normally that is not an argument that will be accepted by a valuation expert, and thus, physicians will be required to contribute substantial capital to a freestanding joint venture. Unlike a freestanding joint venture the valuation of the parties’ equity contributions in an equipment lease transaction is straightforward. Each party’s equity is equal to the value of assets used to purchase the equipment. The fee charged for each use of the equipment must be a fair market value fee. Fair market value can best be determined by a third-party valuation expert.

XI. Lease of Ancillaries.

A. Non-Stark Covered Ancillary Services

1. Practices without sufficient patient volume to justify full-time use of expensive imaging facilities may choose to share a facility.

   a. A number of medical groups form an entity that acquires the imaging equipment and, on an as-needed basis,
provides various aspects of the technical component to each member group.

b. The groups, in turn, pay the entity for their share of the expenses of the jointly owned entity based on their use.

c. Each medical group bills for tests performed for its patients.

d. The technical and professional revenue is not pooled or shared.

B. Ancillary services covered by Stark. A shared facility should qualify for the Stark law’s in-office ancillary services exception as long as it and all the medical groups occupy the same building. Each medical group must also supervise tests for its patients.

1. The Stark in-office ancillary exception is also available for procedures covered by Stark but which are performed on portable equipment. The joint venture can own the equipment, own a van, and employ the technician. The equipment could be driven to each practice site and moved to the physician’s office where the test will then be performed under the supervision of the physician.

2. These arrangements should not violate the Anti-Kickback Act because the shared entity allows each medical group to provide tests to its patients rather than making referrals to a jointly owned entity and receiving a profit distribution.
a. Example: The preamble to the final regulations states that when a physician furnishes a physician service, including a visit to a home health patient, the physician service is billed as a physician service and is not considered to fall with the Stark II category of home health services constituting DHS.

b. If, however, the physician orders a service such as physical therapy, durable medical equipment and supplies, or outpatient prescription drugs that would otherwise constitute a DHS under Stark II, then the Stark II ban will be implicated and, accordingly, any financial relationship that the home care physician has with the entity billing Medicare or Medicaid for the service must fall within an exception to the ban.

3. Another alternative is to provide Stark type services only to private pay patients (non-governmental patients). While this is an attractive concept, it can be very difficult to implement since it is not always clear if a patient has a secondary coverage or if a patient correctly understands who provides their primary coverage.

4. Finally, some groups are finding the use of shared treatment offices within the ancillary space in which the physician provides care at least six (6) hours per week to not be all that onerous in view of the financial reward.
XII. **Maximizing Physician Productivity.** Except when performing procedures, time spent in hospitals is often the least financially productive time of a physician’s day. Hospitals are beginning to recognize that fact and institute processes designed to make physicians more productive. When physicians are more productive, they increase their revenue and the hospital’s revenue. Many programs that increase the time physicians can spend in their office practices also decrease inpatient length of stay in a hospital. The following are examples of practices that maximize physician productivity:

i. **Physician Extenders.** For example, when hospitals hire surgical nurse practitioners to make rounds on surgical patients, those patients will be discharged faster.

ii. **The advent of the use of Hospitalists to provide care to hospitalized medical patients and the use of Intensivists in critical care units also frees physicians of the need to spend time traveling to and from hospitals and making rounds.**

iii. **Remote Access to Patient Information** can also make physicians more productive. When physicians can have up to the minute access to their patients’ charts, diagnostic images and test results, they can give more timely orders and are freed from the obligation to come to the hospital to review images or test results.

XIII. **Reality.** The historical reality is everyone wants to improve quality but no one wants to pay for improved quality. We are now seeing a small but evident shift in the right direction. The myriad of statutes and regulations within which all
transactions between hospitals and physicians must be structured have not gone away. Yet even the most recent Stark regulations have recognized the theoretical world of the government’s view must meet the realities of the marketplace. Cooperation in a financially beneficial model which improves quality is the wave of the future.