UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Health Care Division

April 13, 2009

Christi J. Braun, Esquire
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1401 H Street, N.W., Suite 500
Washington, D.C. 20005-3324

Re: TriState Health Partners, Inc. Advisory Opinion

Dear Ms. Braun:

This letter responds to your request for an advisory opinion on behalf of TriState Health Partners, Inc., a physician-hospital organization based in Hagerstown, Maryland. TriState proposes to "clinically integrate" its members' provision of health care services, and to contract jointly with health plans and other payers on a fee-for-service basis on behalf of its members to provide services to plan beneficiaries.[1]

As is discussed in detail below, it appears that, if implemented as you have described, TriState's proposed program would be a bona fide effort to create a legitimate joint venture among its physician and hospital participants that has the potential to achieve significant efficiencies in the provision of medical and other health care services that could benefit consumers. After evaluating the proposal, we have concluded that, if implemented as you have described, we would not recommend that the Commission challenge the program. This opinion rests on three central conclusions:

> TriState's proposed program, while still in the early stages of development in some respects, appears to have the potential to create substantial integration among its participants, with the potential to produce significant efficiencies, including both improved quality and more cost-effective care.
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> Joint contracting with payers on behalf of its competing physician members appears to be subordinate and reasonably related to TriState's plan to integrate its members' provision of services to deliver coordinated care by a group of providers committed to the program,

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[1] The Federal Trade Commission and the Department of Justice ("the Agencies") first discussed "clinical integration" among health care providers in their joint *Statements of Antitrust Enforcement Policy in Health Care* (August 1996), 4 Trade Reg. Rep. (CCH) ¶ 13,153 (hereinafter referred to as "*Health Care Statements*"), available at http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm. *See also Improving Health Care: A Dose of Competition, A Report by the Federal Trade Commission and the Department of Justice* (July 2004) (available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf) at Ch. 2, pp. 36-41.

and reasonably necessary to effectively implement the proposed program and achieve its potential efficiency benefits. Accordingly, TriState's collective negotiation of contracts with payers in connection with the proposed program, including the prices to be paid for the services of the physician participants, should be evaluated under the antitrust rule of reason.

While TriState's physician members as a group, and TriState's hospital member, may have market power in their respective markets, it appears that the program as described is unlikely to enable them to exercise or increase any such power. Critical to this determination is the representation that physician members and the hospital member will remain available to contract individually outside the proposed program. If participants were to operate in ways different from what TriState has proposed, TriState's program could raise serious competitive concerns.

As is customary with FTC advisory opinions, our conclusions are based on your representations and the information that you have provided.[2] As a prospective assessment based on limited information, the advisory opinion is necessarily tentative and expresses the staff's current enforcement views, which likely would change if implementation of the proposed program proved to have anticompetitive effects.

I. Description of TriState and Its Current Operations

TriState is a physician-hospital organization ("PHO") based in Hagerstown, Maryland, whose more than 200 physician members and one hospital member are located in Washington County, Maryland. TriState is organized as a Maryland non-stock membership organization, and was incorporated in 1995.[3] It has two classes of membership[4]: Class I members are physicians;[5] and

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[2] This advisory opinion letter is based on the information that you have provided to us on behalf of TriState, plus some additional information provided by other parties. We have not conducted an independent investigation to confirm, or supplement, the information that has been provided to us.

[3] TriState is governed by a board of directors that includes five representatives of its hospital member, and eight physician member representatives, including four primary care physicians, two surgeons, and two medical specialists, one of whom must be a hospital-based practitioner.

[4] Under TriState's bylaws, an act to be taken by the board requires that each class of board members have a quorum (i.e., a majority of the board members representing that class of TriState members) present, and requires approval by a majority of those present for each class. TriState's operations are managed by an administrative staff of eight.

[5] TriState's member physicians include primary care physicians (identified as including pediatricians, family practitioners, general practitioners, and internists, excluding those practicing in internal medicine sub-specialties), specialty care physicians, hospital-based physicians, and oral surgeons, all of whom are licensed to practice in Maryland, as well as medical group practices whose individual physician members meet that requirement.

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the sole Class II member is Washington County Hospital Association, a non-profit corporation that operates Washington County Hospital and which, in turn, is a member of the Washington County Health System, Inc., also a non-profit corporation.[6] TriState's physician members provide medical services to patients located in western Maryland, southern Pennsylvania, and northern West Virginia,[7] although you state that their primary service area essentially is Washington County, Maryland.

TriState began as a risk-sharing joint venture to enter into capitation contracts with payers. It, however, offered such risk-sharing arrangements for only one year. Since 1998, TriState and its physicians have offered their services through InforMed, L.L.C.[8] TriState members who wish to participate in the InforMed provider network, Community Health Partners, each separately and individually agree to accept InforMed's fee-for-service reimbursement rates, and sign participation agreements with TriState evidencing their agreement to participate in InforMed's network through TriState.[9] Under this arrangement, TriState has contracted with InforMed for

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Approximately 40 of these Class I physician members are employees of TriState's Class II member – Washington County Hospital Association – or one of its subsidiaries. These employed physicians practice in eight specialty areas. The remainder of TriState's Class I members are independently practicing physicians practicing in a variety of specialty areas. Currently, TriState also has approximately 70 non-members, including physicians, nurse midwives, and clinical social workers, with whom it contracts for the provision of health care services.

[6] Washington County Hospital Association operates the 292 licensed acute care bed Washington County Hospital, which "offers a full range of adult and pediatric inpatient and outpatient services including intensive and progressive care units, a family birthing center, mental health services, cancer therapy, surgical care, cardiac catherization, physical and occupational rehabilitation, and diagnostic imaging." The hospital's licensed beds include 218 medical/surgical, 18 obstetric, 10 pediatric, 18 psychiatric, and 28 acute rehabilitation beds, and the facility is designated by the State of Maryland as a Level III Trauma Center. Washington County Hospital Association also operates a variety of related diagnostic, treatment, and support facilities and services covering virtually every area of medical service need, including inpatient, outpatient, and home-based services. Washington County Hospital Association also owns a minority interest in Maryland Physicians Care, a Medicaid HMO with approximately 90,000 members in Maryland, about 9,000 of whom are located in Washington County. Washington County Hospital Association's parent organization, Washington County Health System, Inc., also owns Antietam Health Services, a for-profit subsidiary that operates or joint ventures in a variety of business enterprises related to the provision of outpatient health care services, such as diagnostic imaging, outpatient surgery, endoscopy, medical transport, medical supplies, and management services.

[7] Specifically, you have identified Washington and Frederick counties in Maryland, Franklin and Fulton counties in Pennsylvania, and Morgan, Jefferson, and Berkeley counties in West Virginia as the areas served by Washington County Hospital and TriState.

[8] You describe InforMed as "an Annapolis, Maryland health-care consulting and information technology company that provides third party administrator ('TPA') services, medical management, health information reporting, health information technology, and a regional network of physicians, hospitals, and ancillary providers."

[9] You state that "TriState physicians deal directly with InforMed on any issues related to fees or payment of

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TriState's providers to participate in the Community Health Partners network, and for TriState to provide certain administrative services for InforMed, including physician credentialing, network management, clinical oversight, and utilization review. TriState also has agreed to obtain certain information technology services from InforMed, including "management of TriState's claims information database, design and support of an interactive website, and internet-based software for eligibility verification and medical referrals."

TriState currently sells an employee wellness program and provides medical management services, including case management, disease management, and pharmacy management services. These programs are operated primarily by TriState's administrative staff, and are sold separately from the services of TriState's physicians. The proposed program will include these services,[10] along with the various components that directly involve the provision of services by TriState's physicians.

II. The Current Market Environment in Which TriState Operates

You describe TriState as currently having 212 member physicians, including about 40 member physicians employed by Washington County Hospital, itself also a TriState member, with the remaining 172 physician members being privately practicing physicians in 78 separate practices. You also note that there are about 50 additional "contracted" physicians and 19 contracted non-physician health care providers who, while not formally members of TriState, nevertheless currently provide services to persons covered under TriState's existing contracts through InforMed.[11] Finally, you state that Washington County Hospital – the only hospital in the county – has a medical staff of 319 physicians. It therefore appears that TriState physicians represent a very substantial majority of the physicians practicing at the hospital and in Washington County, which you identify as both TriState's and the hospital's primary service area; that is, the area from which the hospital draws more than 80 percent of its admissions.[12]

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claims. When fee schedule modifications are made, practitioners are free to accept, reject, or negotiate modifications with InforMed directly. TriState is not involved in these discussions." We have not reviewed this aspect of TriState's current operations, and offer no opinion regarding TriState's or its physician members' current activities involving InforMed.

[10] Under the proposed program, however, utilization management will be under the supervision of physicians, rather than the TriState staff, and be done by the Quality Assurance/Utilization Management Committee and the Quality Improvement Committee.

[11] TriState's contracted non-physician providers include four nurse-midwives employed by Washington County Hospital Association, and fifteen clinical social workers, who are not eligible to be Class I members of TriState.

[12] You state that TriState's primary service area, which includes and extends slightly beyond Washington County, Maryland, has a population of about 145,000. TriState's secondary service area, which includes parts of

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A. Alternatives to TriState or Its Members in TriState's Service Area

1. Provision of Medical Services by TriState Physicians Other Than Through TriState

TriState physicians provide their professional medical services through a variety of arrangements. TriState physicians who participate in InforMed's Community Health Partners network provide their services to persons covered under contracts that InforMed has entered into with self-insured employers in Washington County. InforMed contracts with self-insured employers to offer access to its provider network, which includes physician and hospital providers.[13] InforMed currently has contracts with three self-insured employers in the area, covering a total of about 5,650 lives. The largest InforMed contract for which TriState provides medical services is with the employee benefits plan for the Washington County Health System, Inc., the parent organization of TriState's sole Class II member, the Washington County Hospital Association.[14]

Besides offering their medical services through InforMed's provider network, you state that TriState physicians also participate in a variety of programs involving other payers. You identify various government programs and several commercial payers operating in TriState's service area. You state that TriState member physicians participate in these payers' programs through individual contracts entered into between the physicians and each payer and, while you provide no specific statistics in this regard, you state that TriState's members "contract directly with most payers."

2. Other Providers and Networks in TriState's Service Area

TriState appears to include a substantial majority of the physicians practicing in Washington County, TriState's primary service area. And, as you acknowledge,"[t]here are no other IPAs or PHOs other than TriState operating within Washington County."

You also state, however, that TriState physicians represent a considerably smaller percentage of physicians within TriState's (and Washington County Hospital's) much broader secondary

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Pennsylvania and West Virginia, as well as Frederick County, Maryland, has a population approaching 350,000.

[13] InforMed provides third-party administrator services, such as claims processing, to the contracting employers, and offers utilization and medical management services to employers that want those services.

[14] The Washington County Health System, Inc., employee benefit plan covers about 5,000 lives. The two other self-insured employer programs that TriState and its physician members serve through InforMed together cover about 650 lives.

service area, which accounts for an additional 14.5 percent of hospital admissions.[15] Within this broader service area, you identify three other health systems and two related provider networks. These include Summit Health, with hospitals in Waynesboro and Chambersburg, Pennsylvania, and the Cumberland Valley Health Network – a PHO "aligned with Summit Health;"[16] City Hospital in Martinsburg, West Virginia, and the Eastern Panhandle Integrated Delivery System, a "provider-sponsored, vertical arrangement of physicians and hospitals serving nine counties in eastern West Virginia," through which "many of . . . [City Hospital's] medical staff members contract with payers;"[17] and Frederick Memorial Hospital in Frederick, Maryland, which you state no longer has a contracting physician network dealing with payers.[18]

B. Payers Operating in TriState's Service Area

In addition to InforMed's Community Health Partners network, through which TriState physicians provide services under its self-insured employer contracts, you identify a variety of third-party payers and programs that operate in TriState's combined primary and secondary service areas. Government payer programs include Medicare, Medicaid, and Tricare, which you estimate together cover approximately 48 percent of all patients in the area, with worker's compensation covering slightly more than one percent of area patients. About four and a half percent of patients are identified as self-paying, not covered by any third-party payer program. The remaining roughly 46 percent of area patients are covered by non-governmental health plans. The largest commercial payers in the area are CareFirst Blue Cross Blue Shield, and United Health Care/MAMSI, which together cover almost 71 percent of those with private coverage. In addition, Aetna and Cigna do business in the area. While you did not provide statistics specifically addressing payer market shares in the health system's and TriState's smaller primary service area, you state that TriState "has no reason to believe . . . that the statistics would be different if it looked only at patients residing in Washington County, Maryland, which is roughly its primary service area."

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[15] You note that there are about 1,200 physicians in TriState's secondary service area, of which TriState physicians represent only about 16 percent. You have not, however, specified what percentage of physicians in TriState's primary service area – essentially Washington County, Maryland – TriState's physicians represent.

[16] You describe Waynesboro Hospital as "a 62-bed hospital . . . (about 20 minutes north of Hagerstown)," and identify "the 232-bed Chambersburg Hospital . . . [as] located about 30 minutes from Hagerstown."

[17] You describe City Hospital as "a 144-bed hospital . . . [located] [t]hirty minutes to the south [of Hagerstown]."

[18] You describe Frederick Memorial Hospital as "a 253-bed hospital located about 30 minutes east of Hagerstown." You state that "Frederick County's only physician contracting organization ceased operations on December 31, 2006, and most of its former members now contract directly with payers."

III. TriState's Proposed Program

A. Purpose and Description of the Proposed Program

TriState now proposes to develop and implement a program through a "multi-provider network joint venture that will integrate its members clinically as described in Statements 8 and 9 [of the joint FTC and Department of Justice *Health Care Statements*]." Under the proposed program, TriState's members would provide medical and other health care services, including hospital services, to persons covered under health benefits programs offered by self-insured employers and other payers in TriState's service area. TriState identifies three main objectives for its proposed program: (1) to "facilitate and assure cooperative interaction and collaboration among TriState's member physicians" so as to "align the efforts of the physicians to improve their patients' health and their delivery of services, resulting in the right care being rendered in the right setting at the right time;" (2) to "engage every TriState stakeholder – physicians, case managers, administrators, payers, and patients – in a cohesive and comprehensive program of care management," that "should result in identifiable quality improvements for patients and significant financial benefits for payers;" and (3) to allow TriState to offer payers "an integrated set of services . . . not previously available in the market," which "will be desirable to self-insured employers looking to control their rising cost of providing health care coverage to employees," and "will also offer a competitive advantage to health plans and other payers seeking to distinguish their products on the basis of quality or quality-adjusted cost."[19]

TriState broadly describes itself and its proposed program as

> offer[ing] payers a network of primary care and specialist physicians whose services will be integrated through a formal and stringent medical management program that includes protocol development and implementation, performance reporting, procedures for corrective action when necessary, and aggressive management of high-cost, high-risk patients. The program will offer payers a network of coordinated services from physicians committed to improving outcomes by working together to achieve quality improvements not possible by working independently. TriState's physicians will actively collaborate in the development of all facets of the program, ensuring the cooperative delivery of high-quality, cost-effective care.

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[19] In contrast to TriState's current contracts with self-insured employers through InforMed, under TriState's proposed program, InforMed will no longer serve as the third-party administrator for self-insured employers. InforMed will, however, continue to serve as the data warehouse, software developer, and technical vendor for TriState.

More specifically, you identify a variety of activities that TriState plans to undertake or expand from its current activities, as part of its proposed program.[20] Central to the proposed program is TriState's plan to implement a web-based health information technology system that will help identify "high-risk and high-cost patients," and "will facilitate the exchange of patients' treatment and medical management information" in order to "more aggressively manage . . . [TriState's] patients' care than . . . [the providers] could achieve working independently."[21] TriState believes that this "aggressive care management should result in identifiable quality improvements for patients and significant financial benefits for payers."

TriState is in the process of developing clinical practice guidelines, and will monitor physicians' adherence to them, as well as more broadly seeking means of improving clinical efficiency through other changes in the program's policies and procedures.[22] TriState will use InforMed's software to review episodes of care; i.e., "all of the medical care and services a patient receives from the onset of an illness or disease through final treatment," to determine where performance improvement will have the greatest financial and quality benefits.[23] This information will be used to review and, as appropriate, modify specific clinical guidelines or "care protocols" used by TriState in the proposed program. The Quality Improvement Committee and TriState staff will seek to identify instances of both overutilization and underutilization of services, and work with physicians to address these issues.

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[20] This letter broadly summarizes our understanding of various major aspects of the proposed program whose components are described in greater detail in the materials you have submitted.

[21] You state that "[t]he main technology piece is InforMed's virtual electronic health record, commonly referred to by TriState as the Clinical Claims Chart ('Chart'). Incorporated into the chart are Ingenix's Symmetry family of products – Episode Treatment Groups ('ETGs'), Episode Risk Groups ('ERGs'), and Evidence Based Medicine Connect ('EBM Connect')." Episode Treatment Groups will collect data regarding claims and medical encounters or related services (e.g., pharmacy), and organize the data into episodes of care (similar to Medicare's diagnosis-related groups), which can be used for provider profiling, utilization management, clinical benchmarking, and disease management. Episode Risk Groups can be used to predict health risk and identify high-risk patients in various categories. Evidence Based Medicine Connect focuses on several important preventative screening procedures and 50 costly medical conditions for which there is strong evidence supporting documented guidelines. Evidence Based Medicine Connect allows assessment of both provider and patient compliance with certain guidelines and preventative screenings, flags non-compliers, and allows the plan to target interventions, such as disease management, medication adherence, patient safety, and care patterns.

[22] As of mid-July 2008, you reported that 18 clinical practice guidelines had been approved by TriState's Board of Directors, and that 30 others were in various stages of development and review. The functions of developing and monitoring compliance with clinical guidelines, both individual and for the entire program, are performed by TriState's Quality Improvement Committee, with involvement of multiple ad hoc committees of specialists in the areas to which the guidelines apply. TriState's stated goal is to have "at least 80 percent of the medical conditions comprising at least 80 percent of the cost of care in the community, covered by at least one clinical guideline."

[23] You note that typically about five percent of health plan beneficiaries account for 60 percent of claims expenses, and that 40 percent of beneficiaries file no claims in a given year, supporting the view that focusing on the treatment of the relatively few high-cost patients may be the most effective way to achieve program cost savings.

TriState also will develop, implement, and oversee policies and procedures related to the program's utilization management, case management, and disease management activities. As noted previously, TriState currently offers and sells medical management services, including case management, disease management, and pharmacy management programs, as well as employee wellness programs, which are provided by TriState's administrative staff. These services also will be part of TriState's proposed program. TriState will also continue to offer these services separately from its proposed program for those who are interested only in purchasing these specific services. However, when they are provided as part of the proposed program, these services will be under the direction of the physicians on the Quality Assurance/Utilization Management Committee and the Quality Improvement Committee, rather than just the TriState staff, and will be coordinated with the program's protocol development and implementation, quality monitoring, and patient management services.

As part of the proposed program, TriState will monitor achievement of physician performance targets, using peer, regional, and national benchmarks, and make recommendations for both individual and group performance improvement. Individual physicians' performance will be the subject of "report cards" and peer counseling and educational efforts, as needed, with eventual discipline and even expulsion from the program, if necessary, for those who fail or refuse to conform their practices to the established program parameters. TriState's stated goal, however, at least initially, is to "move the mean" in terms of the performance of its participants, rather than to winnow performance "outliers" from the program. Specific details of how TriState's performance measurement and evaluation processes will operate, both for individual TriState physicians and for the group as a whole, were not provided. You noted that TriState "is in the very early stages of determining which metrics initially will be measured, how they will be measured, and how this will be communicated to the membership."

B. Participants' Obligations and Commitments Under the Proposed Program

1. Membership and Financial Investment in TriState

While most of the physicians who provide their professional services under TriState's current contracts already are Class I members of TriState, a substantial number of physicians and other health care providers have been non-members who operated under "contractor" arrangements to provide services under TriState's payer contracts. In order to assure the necessary commitment to the proposed program and its requirements, you state that TriState is eliminating this form of participation status. Physicians who wish to participate in the proposed program will be required to be or become Class I members of TriState. After an initial, time-limited, opportunity to join TriState, physicians who subsequently wish to become members will be limited in their opportunities to do so.[24] For a multi-physician group practice to participate in the proposed

[24] The initial period for current non-members to join TriState is 60 days, after which there will be an annual 30-

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program, all of the practice's physicians – including any who subsequently join the practice – must become TriState Class I members and agree to all requirements of participation in the program. TriState's fifteen currently contracting licensed clinical social workers, who as non-physicians are not eligible for formal membership, will provide services through direct contracts with InforMed's Community Health Partners network.[25] The four nurse midwives currently providing services already are employees of TriState's hospital (Class II) member.

In order to become a Class I member of TriState, a physician must submit a written application, successfully complete TriState's credentialing process, be approved for membership by the TriState's board of directors, pay the required "joining fee" of $2,500, and sign a participating provider contract that TriState has designed especially for the proposed program, which spells out the obligations and requirements of both the physician and TriState regarding the program.

2. Participating Provider Contract

The "TriState Member Participating Provider Contract – Clinical Integration," which each physician member must execute, is the primary document formally evidencing TriState physicians' commitment to, and specifying their obligations regarding, the proposed program. One requirement of the agreement is that member physicians agree in advance to participate in all contracts that TriState enters into with payers for the proposed program, and to comply with the requirements of those contracts. Physicians cannot opt out of participating in individual contracts, or pick and choose among them regarding their participation. You state that this requirement helps to assure that the panel of physicians providing services under the program is stable and identifiable at the outset, and is not likely to vary from contract to contract. Having a stable, identified panel of physicians, in turn, is expected, among other things, to facilitate in-

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day open enrollment period for physicians who initially declined enrollment to join. Exceptions to this limitation on new members also will be made for physicians needed in "must-have" or limited access specialties and for physicians new to the community who join existing practices that already are members of TriState. You state that "[m]oving forward . . . [TriState] intends to be much more selective in allowing new physicians to join," although it appears that the substantial majority of physicians practicing in TriState's primary service area already are, or after the initial enrollment period will be, members of TriState.

[25] Apparently physicians and other health care providers who are not TriState members nevertheless may be allowed to provide services to patients covered under TriState's program contracts with self-insured employers or other payers if the employer or payer chooses to allow access to this supplemental provider panel, and separately contracts with Informed's Community Health Partners network or other providers or networks for such services. You anticipate that this type of arrangement may occur regarding the Washington County Health System, Inc., employee benefit plan that currently is TriState's largest contract. You go on to say that, in order to provide incentives for enrollees to stay within the program for their care, TriState will attempt to have payers designate these additional providers as part of a "second tier network," with higher co-payments and lower benefits (unless waived due to medical necessity) for enrollees using their services. You should be aware that the conclusions regarding TriState's and its members' joint negotiation and contracting with payers regarding the proposed program does not apply to any arrangements between payers and such supplemental provider networks, whose participants are not fully integrated into the proposed program.

network referrals, continuity of care, familiarity by physicians with the program's standards and requirements, and adherence to those standards and requirements.[26]

A second aspect of the proposed program contained in the participating provider contract is that TriState physicians generally agree to refer patients to other TriState network physicians "when medically appropriate," with the exception that this does not require the referring physician "to direct Enrollees to other Network providers from whom the Enrollee does not wish to receive treatment." Requiring in-network referrals as the default standard both helps to assure that referred patients will continue to receive care under the practice standards and requirements of TriState's program, and allows TriState to obtain more complete information regarding both the care provided to those patients and the performance of the treating physicians regarding that treatment. This information, in turn, facilitates TriState's monitoring and oversight activities, and thus achievement of the program's potential efficiencies in providing coordinated and appropriate patient care.

The participation agreement also generally obligates each physician member to comply with all of TriState's "policies, procedures, rules and regulations," and specifically identifies a number of areas where physicians must cooperate with the proposed program. For example, physicians must cooperate with the proposed program's requirements regarding utilization management, patient referrals, pre-authorization of services, use of clinical practice guidelines, provision of information to TriState for it to effectively monitor physician performance and patient care, and operation of various other oversight and review aspects of the program. Physicians also agree that they and their office staff will be trained in, and use, TriState's health information technology capabilities.

3. Personal Participation by TriState Member Physicians in the Development and Operation of the Proposed Program

You state that "every physician who agrees to participate in the clinical integration program will acknowledge their commitment to fully support the tenets of the program by assisting in the development of, and practice to, the clinical practice guidelines created in collaboration with their peers, utilizing the tools embedded in the EHR [electronic health record], and showing progress towards continual process improvement ('moving the mean')." You point out that

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[26] Regarding the situation, mentioned previously, where patients enrolled in the proposed program choose to seek care from providers who are not members of TriState, but who are part of the Community Health Partners provider network, you anticipate that "[i]n the event that Plan enrollees see CHP physicians, the [TriState] physicians, through monitoring of their patients' EHRs [electronic health records], should be able to determine whether or not their patients received guideline-directed care from the CHP physicians and, through follow-up care, make up for any omissions. Although its achieved efficiencies may not reach the level of a closed-panel product, [TriState] intends to do what it can to optimize the quality of care its patients receive, even if those patients self-select and receive some care outside [TriState's] network."

more than forty physicians "currently are participating in formal committees and governance" regarding TriState.[27] You also state that

> [m]any more physicians, although not formal committee members, have served on an *ad hoc* basis, assisting in the review of clinical practice guidelines that impact their specialty. It is expected that virtually the entire membership, at one time or another, will participate in the development of some component of the program. This not only is an expectation of continued membership in [TriState], but also an affirmation of commitment to clinical integration.

Under the participating provider contract, physician members agree to "cooperate with [TriState] in the development and implementation of [TriState's] clinical integration program." They also agree to "give due consideration to a request . . . to participate in" such activities as sharing clinical best-practice ideas and methods; developing, reviewing, or commenting upon clinical practice guidelines; leading a training session regarding a clinical practice guideline; reviewing patient files of a Network Practitioner and making recommendations for improvement; and mentoring a Network Practitioner.[28]

C. Mechanisms to Assure Physicians' Compliance with TriState's Program Requirements

TriState has established mechanisms to identify physicians who appear to be high-cost providers or over/under users of resources. As noted previously, to participate in the proposed program, TriState physicians will be required to execute a "TriState Member Participating Provider Contract – Clinical Integration," which identifies the various core aspects of the proposed program, and evidences the physicians' agreement to participate in the program and comply with its requirements. Among those requirements are providing TriState with patient and treatment information necessary to implement its programs, complying with TriState's clinical practice guidelines, assisting TriState in completing quality, safety, and cost assessments, serving on TriState clinical integration oversight subcommittees, cooperating in the development and implementation of the program, referring enrollees to other network practitioners, when medically appropriate, and accepting, being trained on, and using TriState's information technology hardware and software, and complying with TriState's rules and regulations.

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[27] In addition to its board, TriState has committees responsible for various non-clinical operational functions (Nominating, Bylaws, Communications, and Contracting Finance Administration), as well as committees and sub-committees for clinical operations. The Clinical Integration Oversight Committee, which is the body most directly responsible for overall supervision and oversight in this area, includes the chairs of five related sub-committees – Credentialing, Quality Assurance/Utilization Management, Quality Improvement, Pharmacy Benefits Management, and Care Coordination.

[28] Physicians may request that they be excused from such activities if they would "constitute a serious hardship or undue burden," including such justifications as "excessive demands of professional practice, personal or family health considerations, and service on committees or boards."

TriState will monitor each physician's compliance with its treatment protocols and other practice requirements. This process will include providing the physician with comparative data relative to the performance of the other TriState physicians, and using other benchmarks and peer counseling in order to generate performance improvement. You identify instances where, in the past, TriState had to deal with physicians or practices that were reluctant to accept certain monitoring or practice standard requirements, and where TriState was successful in convincing those physicians to embrace those requirements. Finally, you note that "[w]hen necessary, however, TriState will remove physicians from its network who refuse to improve ('culling the outliers')."

D. Measurement and Achievement of Efficiencies from the Proposed Program

TriState has not attempted to quantify the potential or likely overall efficiency benefits of its proposed program, or specified how overall cost or quality efficiency gains will be measured. However, as evidence of TriState's capability to achieve measurable efficiency improvements, you describe the results of a pilot "pay for performance" disease management program for diabetes that TriState implemented for Washington County Health System, Inc., employees from 2005 through 2008. Using 2005 data as a baseline, TriState reports achieving what appear to be significant improvements in population clinical results (e.g., hemoglobin A1c values, and frequency of several indicated tests), and reductions in several measures of use of expensive and potentially avoidable hospital and other medical resources (population utilization results). The pilot program was credited with achieving savings calculated at $159,898.00, which were evenly split between TriState and Washington County Health System, Inc.

Regarding measures of performance for the proposed program, you state that TriState "is in the very early stages of determining which metrics [of performance] initially will be measured, how they will be measured, and how this will be communicated to the membership." You state that TriState's proposed program will identify "best practices" and then identify both over-utilization and under-utilization of services by participating physicians. Through feedback, and promoting "best practices," TriState will seek to "move the mean" on key quality indicators, such as increasing rates of colorectal cancer screening, lowering hemoglobin A1c levels, and improving lipid profile scores. TriState will monitor the cost of care and use of resources by each physician and, through use of "report cards," provide performance feedback to each physician, including comparisons with both their peers' performance and regional and national performance benchmarks. You, however, have not provided details of this feedback process, such as the form and the frequency of the performance report cards, or how the system of applying remedial measures to improve performance will operate.

IV. Analysis

A. The Legal Standard

Tristate's proposed program will involve agreement on the levels of fees to be charged by its competing physician members for their professional medical services provided under contracts between TriState and various payers. TriState also will be collectively negotiating on behalf of its competing physician members the terms of dealing, including price terms, by those physicians under contracts between TriState and various payers. In the absence of adequate justification for this activity, such a course of conduct would be summarily condemned as *per se* illegal price fixing under long-standing antitrust law standards.[29] Further analysis as to competitive effects of this type of conduct is required, however, when it occurs in the context of a potentially efficiency-enhancing joint venture among otherwise competing market participants, and the competitive restraints are "ancillary" to the joint venture – i.e., subordinate to the primary purpose of the legitimate and potentially procompetitive joint venture, and reasonably necessary to its success and achievement of the efficiencies it makes possible.[30] We address TriState's proposed program under this standard for "clinical integration."

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[29] *See, e.g., Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982); *United States v. Trenton Potteries Co.*, 273 U.S. 392 (1927).

[30] *See United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *modified* 175 U.S. 211 (1899). This analytical approach was subsumed within the analysis that the Commission applied in *Polygram Holding, Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003) (available at www.ftc.gov/os/caselist/d9298.shtm, *aff'd. sub nom. Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005), and *North Texas Specialty Physicians*, 2005-2 Trade Cas. (CCH) ¶ 75,032, (available at http://www.ftc.gov/os/adjpro/d9312/index.shtm, *aff'd. sub nom. North Texas Specialty Physicians v. FTC,* 528 F.3d 346 (5th Cir. 2008). Likewise, this analytical approach was incorporated by the federal antitrust enforcement agencies in both the *Health Care Statements* and the Federal Trade Commission and the U.S. Department of Justice, *Antitrust Guidelines for Collaborations Among Competitors* (April 2000) (hereinafter *Competitor Collaboration Guidelines*) (available at http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf). The *Health Care Statements,* for example, specify how, consistent with general antitrust law principles, physician network joint ventures' negotiating and contracting with payers on behalf of their competing physician members will be analyzed by the antitrust enforcement agencies: "In accord with general antitrust principles, physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies." *Health Care Statements* at Statement 8, § B.1. *See also Health Care Statements*, Statement 9 at § A. (regarding multi-provider networks). The *Competitor Collaboration Guidelines* state (at § 3.2), "If . . . participants in an efficiency-enhancing integration of economic activity enter into an agreement that is reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits, the Agencies analyze the agreement under the rule of reason, even if it is of a type that might otherwise be considered per se illegal." *See also* Letter to Clifton E. Johnson, Esquire, and William H. Thompson, Esquire from David R. Pender, Acting Assistant Director, Bureau of Competition, Federal Trade Commission (March 28, 2006) (staff advisory opinion concerning Suburban Health Organization, Inc.) (available at http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf), at n. 14-17, and accompanying text.

B. Integration and Likelihood of Achieving Significant Efficiencies Through TriState's Proposed Program

The *Health Care Statements* address certain ways in which physician or other health care networks may be able to evidence that they involve sufficient integration among the participants so as to be likely to produce significant efficiencies. One type of arrangement through which integration may occur involves creation of a high degree of interdependence among the network's participants in the provision of care to patients served by the provider network. In networks involving significant clinical integration, the antitrust inquiry and analysis initially seek to ascertain whether the program's structure and operation have the capability, and the participants have the necessary motivation, to achieve the program's intended efficiency goals in the absence, for example, of the financial incentives and constraints typically provided by arrangements that involve the sharing of substantial financial risk by the network's participants.[31] In describing networks whose members clinically integrate, the *Health Care Statements* note that such integration can be demonstrated:

> 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.[32]

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[31] *See Health Care Statements* at Statement 8, § A.4. (Sharing of substantial financial risk "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."); Statement 8, § B.1. ("Where the participants in a physician network joint venture have agreed to share substantial financial risk . . . their risk-sharing arrangement generally establishes both an overall efficiency goal for the venture and the incentives for the physicians to meet that goal.").

[32] *Health Care Statements* at Statement 8, § B.1. The *Health Care Statements* emphasize, however, that these are only illustrative examples: they "are not . . . the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis [also assuming, of course, that the agreements eliminating competition among the participants in the arrangement are reasonably necessary to achieve the arrangement's potential efficiencies], and the Agencies will consider other arrangements that also may evidence such integration."

1. Selective Participation of Network Physicians in the Proposed Program

One aspect of provider network programs that is likely to affect their success in achieving integrative efficiencies is "selectively choosing network physicians who are likely to further . . . [the program's] efficiency objectives."[33] These physicians must agree to certain practice and business constraints, as well as to be subject to a variety of monitoring, oversight, and remedial activities by the network, in order to assure that the anticipated integration and efficiencies of the program can be achieved. There may exist a tension between a network arrangement's desire to include all interested or eligible providers, and its need to restrict participation only to those who are fully committed to accepting the significant limitations on their independent decision making that are necessary if the network is to succeed in controlling costs and improving quality. Moreover, the larger a network becomes, the more difficult it may be to establish the "high degree of interdependence and cooperation among the physicians to control costs and ensure quality"[34] that is the hallmark of clinical integration.

TriState has stated that participation in the proposed program is open to all current members who agree to the proposed program's requirements and to all contracting physicians who become TriState members and likewise agree to the program's requirements.[35] Thus, TriState is not initially being "selective" by excluding in any significant way local area providers from eligibility to participate in the proposed program. TriState's proposed program will, however, impose a number of requirements that are likely to discourage providers not fully committed to the program from seeking to join it, and thus assure that those who do choose to participate will be fully committed to its goals and requirements.

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[33] *Health Care Statements* at Statement 8, § B.1. *See also* Statement 9, § B.2.c.

> Most multiprovider networks will contract with some, but not all, providers in an area. Such selective contracting may be a method through which networks limit their provider panels in an effort to achieve quality and cost-containment goals, and thus enhance their ability to compete against other networks. One reason often advanced for selective contracting is to ensure that the network can direct a sufficient patient volume to its providers to justify . . . adherence to strict quality controls by the providers. It may also help the network create a favorable market reputation based on careful selection of high quality, cost-effective providers. In addition, selective contracting may be procompetitive by giving non-participant providers an incentive to form competing networks.

[34] *Health Care Statements* at Statement 8, § B.1.

[35] It is not clear whether other physicians practicing in TriState's service area, but who currently are neither TriState members nor contracting physicians, are also being given the opportunity to join TriState and participate in the proposed program.

Most important among the requirements of participation is that each physician must become a full member of TriState, and execute a participating provider contract, which obligates the physician to participate and cooperate in all of the various efficiency-enhancing aspects of the proposed program. With regard to membership, TriState is eliminating the category of "contracting physicians," whereby physicians previously could provide, and be paid for, services under TriState contracts, without becoming full members of the organization. Thus, to participate in the proposed program, physicians must commit to membership in TriState, incur the financial and other obligations of membership, sign the new provider participation contract for the program, and accept the obligations that agreement entails. Concurrently, TriState is restricting the circumstances under which physicians subsequently may join TriState and participate in the proposed program. These actions appear to be intended, and likely, to require both current physician members and contracting physicians to assess their willingness to commit to the requirements of the proposed program at this time. This, in turn, should result in TriState having a provider panel that will largely be "closed," and which will include only physicians who have fully and knowingly committed to both the organization and its proposed program.

2. Physician Investment of Monetary and Human Capital in the Proposed Program

The *Health Care Statements* note that "the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies" of a network joint venture may help evidence that it involves substantial integration that is likely to result in significant efficiencies.[36] Such "investment" by participants can evidence their stake in, and degree of commitment to, the successful operation of the venture, and therefore support the likelihood of the program achieving efficiencies as a result of the participants' joint activity through the enterprise. While not necessarily sufficient in itself, substantial financial or other investment by participants in a joint venture supports the view that the participants are likely to be motivated to work toward the venture's success in the market – which, in this case, requires it to succeed in improving the quality, and controlling the costs, of the health care services provided pursuant to the proposed program to their patients who are enrolled in the program.[37]

As mentioned earlier, physicians are required to pay an initial "joining fee" upon becoming members of TriState. Most of TriState's physician members presumably paid this fee around the time of TriState's establishment in the mid-1990s, with those joining since then paying the fee upon becoming new members. Physicians that previously were contracted

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[36] *See Health Care Statements* at Statement 8 at § B.1.; Statement 9 at § A. (referencing Statement 8 at § B.1.).

[37] While not specifically addressed in the *Health Care Statements*, nor readily quantifiable, we nevertheless are aware that many physicians, as responsible professionals, may be self-motivated to enthusiastically participate in innovative programs aimed at improving quality and reducing costs for their patients. This type of incentive for efficiency, however, may not apply or apply equally to all physicians. This particularly may be the case where the prevailing method of payment for physicians' services is on a fee-for-service basis, which creates financial incentives to provide more services, rather than rewarding the more efficient and effective provision of services.

physicians, rather than members, and who accept TriState's offer to now become members, also will be required to pay this fee as a condition of membership. There will, however, be no additional direct financial contributions or investments required of TriState members in order to fund or participate in the proposed program.[38] While you state that "[t]he program's success will require a portion of the members' capital contributions to finance the infrastructure and HIT [health information technology]," it is difficult to characterize using a portion of the initial joining fee paid by most TriState members many years ago as a significant financial investment in the proposed program, or as one that is likely to instill in long-time members a particular sense of commitment to the new proposed program's success. For new member physicians of TriState, however, the joining fee of $2,500 may provide at least some sense of financial investment in the proposed program, and a consequent degree of "buy-in" by them to the program's success.

In addition, you state that those physicians – for example, previously contracted physicians who newly become members of TriState in order to participate in the proposed program, likely will need to invest an estimated $2,600 in computer and related equipment in order to participate in the program. Finally, all participating physicians and their office staffs will be required to devote time to being trained in the program's operation, particularly those aspects related to use of its health information technology and electronic health records. You estimate that this will equate to a cost of about $2,500 in physician billing and office staff time for the average two-physician office.

These combined financial investments in the program – for joining TriState, for purchase of computer and related equipment, and for lost billing and staff time to receive training for the program – while not trivial, nevertheless appear relatively modest for many physician practices, particularly for the substantial majority of physicians who previously paid the $2,500 TriState joining fee, and may also have acquired the computer systems needed for the proposed program as part of their participation in TriState's previously existing programs. For physicians newly joining TriState to participate in the proposed program, the total investment, which by your estimate could be as much as $7,600, is a more substantial sum. Overall, in our opinion, while this financial investment may provide some sense of identification with TriState and its proposed program, it appears unlikely, by itself, to be sufficiently great to strongly motivate the majority of TriState physicians to work toward the success of the program.

However, financial investment is not the only form of investment in the proposed program by TriState's physician members. You state that "[t]he [proposed] program's success will also require the physician participants' to invest significant amounts of time and effort serving on TriState's formal and ad hoc committees, implementing guidelines and protocols in their practices, integrating medical management into their practices, collaborating in the care of their patients, and working together to achieve their quality and cost benchmarks." As mentioned earlier, a substantial number of TriState physicians already have contributed their time and effort

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[38] While no such additional fees currently are contemplated, TriState's board is empowered to levy additional assessments on the membership, if it deems such action to be necessary.

in developing various aspects of the proposed program and in serving on various formal and ad hoc committees. Moreover, you state that you expect that most physicians participating in the program will be called upon and expected, at one time or another, to contribute to the program's operation and success by doing any of a number of tasks related to the design and successful implementation of the program's specific aspects, and this expectation is specified in the Participating Provider Contract.

In our view, and as described above, a significant number of TriState physicians appear to have made, and likely will continue to make, non-trivial investments of time and effort in the development and ongoing operation of TriState's proposed program. In addition to many physicians participating in various committees and projects to develop the proposed program, most or all physicians will be required to incur significant opportunity costs in order to devote the necessary time for themselves and their staffs to be trained in use of the health information technology and electronic health records components of the program. TriState physicians also will be making some degree of financial investment in the program, particularly those physicians who newly become members of TriState, including previously contracting physicians who wish to participate in the proposed program. These various forms of "investment" by physicians in the proposed program together appear to evidence a substantial degree of commitment to the program's success. Likewise, Washington County Hospital Association will be contributing significantly to the proposed program through having hospital and hospital affiliate employed staff participate in various committees and provide their expertise in a variety of and positions, and through the matching of physicians' $2,500 joining fee for TriState membership.

3. Infrastructure and Program Capability for Integrating the Provision of Care and Achieving Efficiencies[39]

TriState appears to have included in its proposed program a variety of structural and operational aspects that seem likely to result in significantly increased interaction and cooperation among its physician members in the treatment of patients covered under the program. Among these are: (a) establishing a largely closed panel of providers committed to practicing consistently with evidence-based medicine standards and clinical guidelines developed or tailored by the program's

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[39] Regarding what the Agencies refer to as the necessary infrastructure and capability to achieve significant integrative efficiencies, knowledgeable commentators have emphasized the importance of systematized approaches – sometimes referred to as "organized processes" – in achieving the potential efficiency benefits of clinical integration arrangements among otherwise independently practicing physicians. *See*, *e.g.*, L. P. Casalino, *The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice*, 31 J. of Health Politics, Policy and Law 569 at 580-81 (June 2006) ("[T]here is ample evidence both that the use by physician groups of organized processes to improve quality is effective and that it is uncommon (citations omitted). The processes suggested by the FTC clinical integration policy are consistent with the literature on quality improvement . . . ."); L. P. Casalino, R. R. Gillies, et al., *External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients with Chronic Diseases*, 289 JAMA 434 (January 22/29, 2003); and S. M. Shortell and L. P. Casalino, *Health Care Reform Requires Accountable Care Systems*, 300 JAMA 95 (July 2, 2008) (an "accountable care system" is "an entity that can implement organized processes for improving the quality and controlling the costs of care and be held accountable for the results.").

participants; (b) maintaining continuity and coordination of care through a within-network referral policy; (c) requiring use of health information technology, including electronic health records, to coordinate care, effectively communicate among network providers, eliminate unnecessary duplication of tests, and collect performance data; (d) establishing mechanisms to collect and evaluate treatment and performance data, including data on appropriate use of health care resources; (e) requiring broad participation of the program's physicians in various aspects of the program's development, implementation, and ongoing operation; and (f) establishing procedures and mechanisms, including various committees that include participating physicians, to provide feedback on both individual and group performance, address performance deficiencies and, if necessary, impose sanctions for physicians whose performance is chronically deficient regarding program requirements and standards.

One potential area of concern regarding the program's ability to provide integrated care and achieve potential efficiencies, which you acknowledge, is the possibility of "leakage" of patients to non-TriState providers where a contracting employer or other payer allows enrollees to seek care out of network – for example by separately contracting for additional access to a broader network, such as InforMed's Community Health Partners network.[40] In addition to removing patients from TriState's integrated care systems, this may create gaps in the information available to TriState regarding the patients' treatment and health status. These types of potential gaps in care coordination and information for the proposed program, while perhaps unavoidable, nevertheless could prove to be problematic for TriState in achieving its integration and efficiency goals. TriState states that it intends to seek a tiering system in its payer contracts for the proposed program, providing financial incentives in the form of lower deductibles and copayments for enrollees who stay within the TriState network for their treatment. TriState also has arranged with InforMed to obtain access to data regarding enrollees' use of services from other Community Health Partners network providers, and hopes to do this with other contracting payers, such as CareFirst Blue Cross Blue Shield, as well. Whether patient leakage outside the TriState network proves to be a significant problem for the proposed program, whether these remedial approaches can and will be implemented effectively, and whether they will prove adequate to address the problem, all are questions that cannot be answered with any confidence at this time.

4. Measurement and Evaluation of Performance Results

The proposed program identifies a number of measures of physician performance, such as frequency of adherence to clinical practice guidelines, and both patient status and physician performance measures. But other than to generally state that individual and group performance on various as-yet-undetermined measures will be compared to peer, regional, and national benchmarks, you have provided very little information concerning how success or failure of the

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[40] Payers frequently seek to provide enrollees with access to a broad network of providers in response to consumer backlash against past restrictive provider panels under some managed care programs.

proposed program will be measured over time on a more macro level, such as in terms of cost or utilization of services by covered populations, or improvements in health status or outcomes.

TriState's pilot pay-for-performance program for diabetes treatment involving Washington County Health System, Inc., employees, which appears to have generated significant positive results – including financial savings from reduced hospital admissions and use resulting from the interventions – suggests that TriState already has some capability to measure and evaluate its and its members' performance. The information you have provided indicates that TriState is in the process of further developing this capability. Moreover, it seems likely that, as a business necessity, TriState will have to be able to provide this type of performance outcome data over time and on a broader scale in order to convince employers and other payers of the potential benefits of contracting with TriState for the program. Thus, we are reasonably confident that TriState is or will be capable of implementing, and will have the incentive to implement, appropriate mechanisms to measure and evaluate its and its participants' performance under the proposed program.

We also note that TriState has expressed its intention to further develop a pay-for-performance program regarding its services, although that future aspect of the program will require a period of time for accumulation of baseline data, and is not formally addressed in this opinion letter.

5. Effect of Washington County Hospital Association's Involvement on the Proposed Program's Ability and Likelihood of Achieving Significant Efficiencies

As noted previously, TriState is a physician-hospital organization that has as the sole member of one class of its membership Washington County Hospital Association, which operates the Washington County Hospital. Washington County Hospital Association has significant representation on the TriState board, and its representatives serve in numerous positions within the TriState organization. The potential effects of Washington County Hospital Association's involvement (and, indirectly, that of its related organizations) in the proposed program on the likelihood of its achieving significant efficiencies are not clear. On the one hand the hospital has considerable resources, including financial contributions, technical support, and infrastructure, that it has made and will continue to make available to the program.[41] These contributions to the joint venture by the hospital may help the proposed program to operate more effectively and may even have been essential for the program's development and establishment in the first place. The hospital's parent organization – Washington County Health System, Inc. – also is the largest employer in TriState's primary service area, and its employee benefits program is the potential source of the largest number of covered lives for the proposed program. Washington County

[41] The hospital has matched physicians' initial membership fee for joining TriState since TriState's inception, and continues to do so for new physician members. Several physicians employed by the hospital also serve in leadership positions in TriState, and several hospital and Antietam Health Services directors and managers serve on TriState committees.

Health System, Inc.'s related health care operations, such as lab and pharmacy, potentially also are positioned for effective use as part of the integration of care to enrollees under the proposed program.

As you acknowledge in your submission, however, there also is a potential conflict of interest between the hospital and the proposed program.[42] Under most current reimbursement systems, hospitals, as sellers of their services, often have an incentive to admit patients and fill available beds with paying customers, and to have them use diagnostic and treatment services for which the hospital receives additional payment.[43] Due to the unique rate regulatory system in Maryland, however, although Washington County Hospital Association has an economic incentive to ensure that incremental admissions come to its hospital, it does not appear to have the incentive, and may even have a disincentive, to provide diagnostic and treatment services or lengths of stay in excess of the regulated reimbursement per discharge set by the state. Under these circumstances, Washington County Hospital Association's financial incentives as a seller of services potentially could conflict with the proposed program's goal of rationalizing the use of services provided to patients, including keeping them out of the hospital through disease management, use of preventive services, and adherence to treatment protocols, or even providing certain services to admitted patients.

Any financial incentive of the hospital to increase admissions, however, may be tempered by the fact that Washington County Health System, Inc., as the area's largest employer and TriState's largest customer, pays for all the hospital services used by its employees and their dependents covered under its employee benefits program. Thus, in its role as a purchaser and payer of services on behalf of its employees, Washington County Health System, Inc., has a financial incentive to rationalize and more efficiently provide health care services, improve quality, and control its program costs, and to help TriState succeed in its efforts to do so. In sum, it is difficult to conclude one way or the other as to whether Washington County Hospital Association's and its affiliates' involvement in TriState's operation is likely to enhance, undermine, or have no net effect on the ability and likelihood of TriState's achieving significant efficiencies as a result of the proposed program.[44]

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[42] *See also, e.g.,* L. R. Burns and R. W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 The Milbank Quarterly 375-434 (2008) (discussing the differing and only partially overlapping goals of physicians and hospitals, and the implications for hospital-physician relationships). *See also* A. E. Cuellar and P. J. Gertler, "Strategic Integration of Hospitals and Physicians" (May 1, 2002) (available at http://faculty.haas.berkeley.edu/gertler/working_papers/hospital_VI_5_10_02.pdf) (paper examining whether efforts at hospital-physician integration leads to efficiency gains or is a strategy for the participants to improve bargaining power, and thereby increase prices.).

[43] This holds true where the price paid exceeds the cost of providing the service.

[44] Moreover, under TriState's bylaws, the board requires a majority vote of both the Class 1 Physician member representatives and the Class 2 hospital representatives in order to take any action. Thus, it does not appear that the

(continued...)

6. Conclusion Regarding Integration and Potential to Achieve Significant Efficiencies

Overall, it appears that TriState's proposed program is both intended and structured so as to be likely to create substantial integration among its participating providers, particularly its member physicians, in the provision of medical and other health care services. Operation of the program, as proposed, will involve a significant degree of participation by, and interaction among, many or most of the physician members of TriState regarding the services provided by each member under the program, and the group as a whole. Member physicians will no longer provide their professional services without a significant amount of reporting, observation, oversight, review, evaluation, and, if appropriate, intervention by their peers to assure that practices conform with evidence-based medicine "best practices." This integration among the participating physicians in the program, in turn, appears to have the potential to result in significant efficiencies, both in terms of cost and quality, in the delivery of medical services to patients covered under payer contracts for the program.[45] Moreover, it appears that achievement of those efficiencies, if it occurs, will be the result of the joint activities and infrastructure that TriState makes possible, and which could not occur absent the TriState participants' acting jointly and integrating their provision of services through the proposed program.

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[44](...continued)
hospital's involvement in TriState's governance could result in TriState being forced to adopt policies or undertake activities that would benefit the hospital at the expense of successful operation of the proposed program.

[45] This conclusion, of course, represents only our best prospective assessment of the proposed program's potential. Whether TriState's program in fact will create substantial integration among its physician participants, whether the program is capable of achieving significant efficiencies as a result of that integration, and whether the program's participants will bring the requisite commitment and rigor to its implementation so as to achieve that integration and resulting efficiencies, can only be determined by TriState's actual performance over time. While the potential benefits of a robust program appear intuitively obvious, the expected results of such efforts may not necessarily occur. *See, e.g.,* D. Peikes, et al., "Effects of Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries," 301 JAMA 603 (Feb. 11, 2009) (finding no reduction in hospitalizations or other cost benefits, and only modest or no quality improvements, resulting from care coordination programs in fifteen Medicare demonstration projects); C. L. Damberg et al., "Taking Stock of Pay-For-Performance: A Candid Assessment From the Front Lines," 28 Health Affairs 517 (March/April 2009) (evaluation after three years of the nation's largest pay-for-performance program, by the Integrated Healthcare Association in California, found that, despite physician organizations reporting "increased physician-level performance feedback and accountability, speeded up information technology adoption, and sharpened . . . organizational focus and support for improvement in response to P4P," investment in the program "had not translated into breakthrough quality improvements."). Moreover, while some components of clinical integration programs may have been the subject of study in particular contexts, we are unaware of any significant body of the technical literature that has looked at, much less conclusively demonstrated in any generalizable way, that physician or provider networks undertaking such programs can achieve significant efficiencies in terms of either quality improvement or cost containment, or that have identified the conditions or circumstances under which they are likely to do so.

C. Need and Justification for Joint Pricing and Collective Negotiation of Payer Contracts

We have concluded, as discussed above, that TriState's proposed program appears likely to involve substantial integration by its physician participants that appears to have the potential to achieve significant efficiencies in the physicians' performance and the care of patients covered by the program. We now consider whether the joint pricing of its physician members' services and collective negotiation of contracts with payers, are "ancillary" to – that is, related and subordinate to, and reasonably necessary to further – that integration and the proposed program's ability to achieve integrative efficiencies. Accordingly, we turn to TriState's explanations of why it believes that its program's competitive restraints are ancillary to the integration and achievement of efficiencies, and therefore warrant a more detailed inquiry into their likely competitive effects under the antitrust rule of reason.

1. TriState's Proffered Justifications for Joint Contracting

You state TriState's primary argument as to the need to jointly contract with payers for the proposed program as follows:

> For TriState to integrate its members' services with the quality improvement measures and medical management, it is important for all TriState physicians to participate, and be included, in the contracted network. . . . The success of Tristate's program depends significantly on its physicians participating in all its contracts. The only way to ensure that all TriState physicians participate in all TriState payer contracts is for TriState to negotiate payer contracts for its complete network and prohibit its members from "opting out" of its contracts. No other contracting methodology will ensure full participation.

You go on to identify several reasons why you believe that full participation of all TriState physicians in all payer contracts is reasonably necessary to the program's success, and how joint contracting on behalf of all physicians for all contracts will be "part of a larger endeavor whose success they [the restraint(s)] promote."[46]

First, you argue that, in order to effectively integrate the program's quality improvement initiatives and medical management services into the physicians' practices, it is necessary to maximize the number of patients in each physician's practice subject to those practice requirements.

> Each . . . patient is an opportunity for the physicians to collaboratively treat a patient, integrate guidelines and protocols into their practices, use the Clinical Claims Chart, and incorporate medical management into their practices. The more

[46] Citing *Polk Bros., Inc. v. Forest City Enterprises, Inc*, 776 F.2d 185, 189 (7th Cir. 1985).

> TriState physicians engage in integrative activities, the more interdependent they become, increasing the likelihood they will achieve the anticipated cost and quality efficiencies.

Thus, in addition to assuring that more patients will be subject to the potential quality and efficiency benefits of the program than would be the case if not every physician was a part of every payer contract, you assert that maximizing the physicians' activity under the constraints of the program will accustom the physicians to the program's system of integrating care, and maximize its effective operation.

Next, you assert that having all physicians in the program for all payer contracts and enrollees will reinforce the in-network referral requirement, again maximizing the potential effectiveness of the program, both in the provision of services and in the program's ability to obtain data and monitor both physician performance and patient treatment and status. "[E]ach time a TriState patient goes out of network, TriState loses an opportunity to gather information for the Clinical Claims Chart, to ensure [that] physicians have an accurate record of care, to improve the health of that patient, and to control the costs of that patient's care."[47]

You then argue that having all physicians in all payer contracts will provide greater incentive for those participating physicians to contribute their time and effort in developing and implementing the program than would be the case if physicians had less involvement due to participation in only a subset of contracts for the program. You state that "[w]ithout the physicians' investment of time in developing and implementing the clinical integration strategy, there will be no integrated product for TriState to sell," and note that physician participation in the program involves a range of activities such as "reviewing guidelines, developing protocols, teaching their peers about the guidelines and protocols, monitoring their peers' quality, developing medical management policies, reviewing prescription drug literature, or developing and maintaining a drug formulary." We understand this argument, in essence, to be that if physicians are not required to participate in all payer contracts, which will result from joint contracting with payers, their patient volume under the program may be too small for them to care sufficiently and devote the necessary time and effort toward its operation and success.

Finally, you make some more purely business-related justifications for joint contracting. You state that joint contracting allows TriState to offer a network of providers that is readily identifiable by payers and their subscribers in seeking services covered by the program. It also provides transaction costs efficiencies for payers in avoiding the need for individual provider contracts with each physician, as well as reducing TriState's administrative costs and burden, which would be considerably greater if different subsets of its physicians were participating under each payer contract.

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[47] In this regard, as noted previously, you have stated that TriState intends to seek to have included in all payer contracts a tiered coverage provision that rewards patients in terms of lower deductibles and co-payments for staying within the TriState provider network for their care.

2. Analysis of TriState's Ancillarity Arguments

TriState's primary argument of the reasonable necessity of joint contracting on behalf of all of its physicians, in essence, is two sides of the same coin: that not having all member physicians participating under all contracts would seriously undermine the ability of the program to function efficiently and achieve its hoped-for benefits; and that the various aspects of the proposed program, which require physicians to cooperate and interact in both their development and implementation, will be far more effective if all physicians are maximally involved because, through joint contracting, they are participating in all payer contracts under the program.

Without joint contracting, which will assure, and reinforce, TriState's membership requirement, that all physicians participate under all contracts, TriState potentially could have different provider panels representing a subset of its membership for each payer contract.[48] This, in turn, could make it difficult to effectively maintain the in-network referral requirement, since referring physicians might have to use different physicians for referrals under each contract. Likewise, with varying provider panels for each contract, the ability of TriState to coordinate the care provided to patients, and its ability to obtain information on both patients and providers would be more difficult and the results less robust. Reduced information on provider behavior could interfere with the program's evaluation of, and feedback regarding, physicians' practices in treating patients, again undermining a key component of the program's effort to improve efficiency. Thus, while it might be theoretically possible to have a program without joint contracting on behalf of all physicians in the program, such an approach appears likely to be far more difficult, and potentially could compromise TriState's ability to effectively integrate its physician members' provision of care, and to achieve the program's potential efficiencies.

On the positive side, uniform participation will facilitate the program's in-network referral requirement, which is central to the program's success in rationalizing and effectively providing evidence-based care to the program's enrollees. With a stable, defined network of participating providers, physicians will easily be able to make referrals to other network physicians, knowing that they also will be participating in the provision of coordinated care under the program's strictures. Likewise, maintaining a pre-set network makes it easier to assure that data and information on patient treatment and provider activity and use of resources – necessary for monitoring patient status and physician behavior, as well as the program's achievement of its efficiency goals – is available to the greatest extent possible. As noted above, achieving these operational necessities would be far more difficult if different physicians were participating in different payer contracts, referral patterns had to be adjusted accordingly to keep patients within the applicable network, and information on patient treatments and provider behavior were less uniformly available.

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[48] As likely would occur if TriState, for example, used a "messenger" arrangement to convey each payer offer to it physician members, who then individually would decide whether or not to participate in each payer contract.

Having complete provider participation as a result of joint contracting on their behalf also will maximize the number of patients each physician has that are subject to the program's various efficiency-enhancing mechanisms, thereby increasing the physicians' familiarity with, acceptance of, and efficient participation in those program aspects and requirements. In essence, the more physicians participate in the program, the faster they are likely to climb the learning curve in effectively treating patients under the clinical integration system and its required components.

Guaranteed uniform participation by all physicians under all contracts, through joint contracting, also is likely to contribute to the physicians' commitment to the success of the program. The greater the number of patients that a physician has who are under the proposed program, the more he or she is likely to care about its operation and success, and the greater is likely to be the physician's willingness to invest the necessary time and effort in the various aspects of its operation. Joint contracting on behalf of all TriState physicians will maximize each physician's opportunities to treat patients who are covered by the program which, in turn, should make them more committed to the program's success.

Having a stable provider network for all contracts also appears capable of enhancing TriState's effective business operations by helping to "brand" its product, and identify the program as a single entity with a stable provider panel and a reputation regarding its product, much like the way more highly integrated clinics are identified in the public's mind.

Joint contracting also can reduce administrative costs for the program, and reduce transaction costs for both its members and payers with which it contracts. Administrative and transaction costs efficiencies, by themselves, are unlikely to be of sufficient magnitude to offset the loss of competition from joint negotiation of prices by physicians in a provider network. Nevertheless, these types of efficiencies may be real, and are cognizable under the antitrust laws in the context of an integrated joint venture.[49]

We agree that having a predetermined, identified provider network for all services provided pursuant to contracts with payers for the proposed program appears likely to promote the program's intended integration of its physician members' provision of care, and the efficient operation of the various aspects of the proposed program. It also may help in the effective branding and marketing of the program. Increased physician participation and interaction, in turn, should further TriState's ability to achieve the program's anticipated efficiency benefits. Moreover, without such joint contracting on behalf of all member physicians, effective operation of TriState's proposed program is likely to be far more difficult and its effectiveness could well

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[49] *See, e.g.,* Statement 8 of the *Health Care Statements* at § B.2. (observing that while a physician network generally is likely to achieve more significant efficiencies from the integration of its participants, "the Agencies will consider [as efficiencies] a broad range of possible cost savings, including . . . economies of scale, and reduced administrative or transaction costs."). However, such "efficiencies," in the absence of integration, occur in any cartel, and alone do not justify rule-of-reason treatment of a price agreement. *See Competitor Collaboration Guidelines* at § 3.2 ("The mere coordination of decisions on price, output, customers, territories, and the like is not integration, and cost savings without integration are not a basis for avoiding per se condemnation.").

be compromised. Overall, such joint contracting appears to be subordinate to TriState's legitimate effort to improve efficiency and quality in the delivery of healthcare services through integration by its participants. We therefore conclude that, on balance, joint contracting with payers by TriState on behalf of its entire participating physician membership is an ancillary restraint – one that is subordinate to, and reasonably necessary to further or make more effective the potentially efficiency-enhancing and procompetitive integration that the proposed program represents.[50]

D. Likely Competitive Effects of TriState's Proposed Program

1. TriState's Position and Available Alternatives in the Market

We have not done an investigation or formal market analysis to define relevant geographic and product markets within which TriState and its physician and hospital members compete. Rather, our consideration of the likelihood that TriState would be capable of exercising market power in the sale of those services under the proposed program, or that the proposed program otherwise

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[50] TriState's justification for what otherwise would appear to be an anticompetitive and unlawful price agreement among its physician members rests on the proposed program's procompetitive potential to achieve efficiency benefits as a result of the participants' integration through the program. If, however, the proposed program ultimately were to fail to achieve significant integrative efficiencies, the anticompetitive effects of the program would likely dominate. A prospective assessment of the program thus does not ensure its legality for all time, and the *Competitor Collaboration Guidelines* make clear that assessment of the competitive effects of a joint venture is an ongoing process that occurs over the life of the venture:

> The competitive effects of a relevant agreement may change over time . . . . The Agencies assess the competitive effects of a relevant agreement as of the time of possible harm to competition, whether at formation of the collaboration or at a later time, as appropriate. However, an assessment after a collaboration has been formed is sensitive to the reasonable expectations of participants whose significant sunk cost investments in reliance on the relevant agreement were made before it became anticompetitive. *Competitor Collaboration Guidelines* at § 2.4.

Thus, absent the realization of significant efficiencies at some point, it might be difficult to sustain the justification that the arrangement's competitive restraints are necessary to achieve such efficiencies, and that the arrangement, overall, is not anticompetitive as a result of those restraints. We are not in a position to specify prospectively when those efficiencies must be achieved, or what level of efficiencies would be "significant." The best judges of that are likely to be TriState's customers "voting with their feet" if the program fails to achieve acceptable results within what they view as a reasonable period of time. If payers at some future date conclude that the program does not provide sufficient value, and decline to contract for it with TriState, this might signal the need for a prospective reassessment of the overall competitive effects of the program. However, absent the exercise of market power by the program or its participants, the market itself is likely to effectively address any competitive concerns that such a situation might raise.

might result in anticompetitive effects,[51] is based solely on the information that you have provided to us.

a. Physician Services

You state that TriState currently has 212 physician members who are expected to participate in the proposed program. While you represent that there are about 1,200 physicians in TriState's secondary service area, TriState physicians apparently represent a much higher percentage of the physicians within its primary service area – essentially Washington County, Maryland, which accounts for over 80 percent of admissions at Washington County Hospital. In fact, you state that TriState physicians comprise 64 percent of Washington County Hospital's medical staff, and half or more of the physicians in a large number of specialties in TriState's and the hospital's primary service area that have admitting privileges at the hospital.[52] Thus, TriState, as a combination of a substantial portion of the physicians in Washington County with privileges at the only hospital in that county, appears to have the potential to exercise market power in the sale of its member physicians' services.[53] This concern arises regarding the proposed program since, unlike TriState's current contracts, in which its physician members deal individually with InforMed and other payers regarding price and related contract terms of their participation in those networks and programs, TriState will be jointly contracting on behalf of its competing physician members under the proposed program, including negotiating and agreeing regarding the prices to be charged for those physicians' services under the program.

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[51] The *Health Care Statements* note that "a variety of factors may tend to corroborate a network's anticompetitive nature, including: statements evidencing anticompetitive purpose; a recent history of anticompetitive behavior or collusion in the market, including efforts to obstruct or undermine the development of managed care; obvious anticompetitive structure of the network (e.g., a network comprising a very high percentage of local area physicians, whose participation in the network is exclusive, without any plausible business or efficiency justification); the absence of any mechanisms with the potential for generating significant efficiencies or otherwise increasing competition through the network; the presence of anticompetitive collateral agreements; and the absence of mechanisms to prevent the network's operation from having anticompetitive spillover effects outside the network." *Health Care Statements* at Statement 8, § B.1.

[52] TriState physicians represent half or more of the physicians with admitting privileges in anesthesiology, cardiology, family medicine, internal medicine, nuclear medicine, obstetrics/gynecology, oral and maxillofacial surgery, orthopedics, pediatrics, physical medicine, plastic surgery, podiatry, radiation oncology, and radiology. TriState physicians comprise 100 percent of physicians with privileges at the hospital in the specialties of allergy, endocrinology, gastroenterology, infectious disease, neurosurgery, hematology/oncology, otolaryngology, pain management, and pathology. TriState notes that in many specialties the high percentages are the result of there being very few practitioners in the specialty that practice in the area, so that a relatively small number of TriState member physicians nevertheless may represent a significant percentage of area physicians in a particular specialty.

[53] A similar concern about the network including relatively high percentages of area physicians in certain specialties was raised in the MedSouth advisory opinion letter. *See* Letter from Jeffrey W. Brennan, Assistant Director, Health Care Services and Products, Bureau of Competition, Federal Trade Commission, to John J. Miles at 6 (Feb. 19, 2002), available at http://www.ftc.gov/bc/adops/medsouth.shtm.

You also state that "[t]here are no IPAs or PHOs other than TriState operating within Washington County," and it therefore is not clear that there are any competitively reasonable alternatives to TriState available to payers in TriState's primary service area.[54] Your submission mentions InforMed's "regional" network and certain networks used by some large private payers, which apparently cover a much broader area than just Washington County, as well as other providers operating within TriState's secondary service area. You, however, provide little information about these networks or providers, and it is not obvious that they represent realistic or practical alternatives to TriState and its members for payers to offer to their beneficiaries in order to obtain health care services within TriState's primary service area.

A potential concern may arise where a network's provider panel is over-inclusive – for example, comprising significantly more total physicians or physicians in particular medical specialties than is necessary for it to provide services effectively to its likely customers. Such over-inclusiveness may make it more difficult for, and lessen the likelihood that, other, potentially competing networks and programs will develop in the area. We are not in a position to do a detailed specialty-by-specialty assessment of TriState's provider needs, and none was provided to us. Nevertheless, TriState's non-urban geographic location and the limited total number of physicians in its primary service area, combined with the fairly modest absolute numbers of member physicians and physician practices in each specialty area, suggest that TriState's physician network may not be over-inclusive. This view is supported by TriState's historical operation, where its largest customer – the Washington County Health System, Inc., health plan – essentially required TriState to add a significant number of "contracting physicians" to supplement its provider panel of physician members.

TriState attempts to address these potential competitive concerns by providing assurances that its proposed program will be non-exclusive, "both *de jure* and *de facto*,"[55] and that payers who do not wish to contract for the proposed program will be able to contract individually with TriState's member physicians, as well as with Washington County Hospital, as they currently do.[56] While TriState will inform payers and its members of this non-exclusivity, and will counsel its members

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[54] This contrasts with the situation faced by the proposed network arrangement by the Greater Rochester Independent Practice Association (GRIPA), where other large provider networks appeared to be available to payers as alternatives to GRIPA. *See* Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Health Care Division, Federal Trade Commission to Christi J. Braun, Esquire, and John J. Miles, Esquire at 25-26 (of Sep. 17, 2007), available at http://www.ftc.gov/bc/adops/gripa.pdf.

[55] For a discussion of the Agencies' approach to determining the exclusivity or non-exclusivity of physicians' participation in a network joint venture, including an enumeration of several "indicia of non-exclusivity" that may weigh in that assessment, *see Health Care Statements* at Statement 8, § A.3. *See also Id.* at Statement 9, § B.2.b.

[56] You state that TriState "has not tied, and will not tie, hospital services and physician services in contracting with customers. WCHA also will not tie the sale of its hospital services to payers' purchasing [TriState's] physician services. . . . WCHA will not force any payer to buy [TriState's] clinically integrated product by conditioning the sale of WCHA's hospital services on the payer contracting with [TriState]."

about antitrust concerns regarding agreements to refuse to deal, it cannot guarantee that its members individually will decide to accept a payer's contract offer, or that payers choosing not to contract for TriState's proposed program will be able to secure an adequate physician network through such individual dealings, or obtain those services at prices that are not above market-determined levels as a result of the physicians' interaction through the joint venture.[57]

A payer's inability to obtain an adequate provider network through individual contracts, by itself, normally would not raise antitrust concerns where it was clear that this was the result of individual decisions by each provider as to the terms on which the provider was willing to deal with a payer. In the present circumstance, however, with TriState negotiating collectively on behalf of all of its members, and with TriState physicians representing a very significant percentage of both the total number of physicians and of those in several specialty areas within TriState's primary service area, the inability of a payer to attract sufficient individual TriState member physicians to contract outside of TriState likely would at least raise serious questions requiring further investigation and clarification.[58] Consequently, non-exclusivity in practice is of critical importance to our conclusion that TriState's proposed program is unlikely to create or allow it to exercise market power on behalf of its member participants, or to result in anticompetitive market effects.

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[57] The MedSouth advisory opinion raised similar concerns about possible anticompetitive effects – both in terms of physician participants not dealing individually with payers and regarding possible "spillover" price effects – potentially resulting from that program's having high percentages of available physicians in certain specialties, despite the program's "explicit policy of 'nonexclusivity'." The opinion letter noted that, despite the claimed non-exclusivity:

> MedSouth members may have the incentive and the ability to agree not to contract independently of the venture. They have incentives to seek higher fees to recoup their investments in developing and implementing the proposed program. Negotiation of fee-for-service rates for the group will involve identification of price levels that could become the focal point for collusion on individual contracts. To the extent that the program creates greater communication and interdependence among the doctors, the easier it likely would be for them to coordinate their activities. Particularly in light of the doctors' existing referral arrangements, MedSouth members may be able to discipline members of the IPA who might be inclined to break ranks and contract independently.

The letter went on to state, however, that:

> [w]e cannot conclude with certainty that MedSouth's physicians actually will contract outside the IPA; nor can we conclude . . . that MedSouth's operation will restrict competition unreasonably . . . We assume for purposes of this advisory opinion that your representations regarding the availability of MedSouth members to contract individually with health plans at competitive rates is accurate and will be borne out by the members' actual conduct.

[58] In considering the blanket license arrangement in *Broadcast Music*, the Supreme Court noted that "[t]he District Court found that there was no legal, practical, or conspiratorial impediment to . . . [customers] obtaining individual licenses [to use individual compositions]; . . . [customers], in short, had a real choice." 441 U.S. at 24. Assuming that TriState, in fact, operates in a truly non-exclusive fashion, payers likewise should have the option to purchase the services of individual TriState member physicians without having to deal through TriState.

b. Effect of Washington County Hospital's Involvement on Competition Regarding Physician Services, Hospital Services, and Related Services

As a physician-hospital organization, TriState and its proposed program involves the participation by Washington County Hospital. One possible competitive concern about this involvement is that the hospital – which is the only hospital in the primary service area served by TriState, and therefore likely possesses a degree of market power regarding hospital services – could act in ways that adversely affected competition for physician services in that area.[59] A "monopoly" hospital's involvement also could affect competition for related services provided by the hospital, but for which there are, or might be, competitive alternatives available. These types of competitive concerns are identified in the *Health Care Statements*' discussion of multiprovider networks:

> If there is only one hospital in the market, a multiprovider network by definition, cannot reduce any existing competition among hospitals. Such a network could, however, reduce competition among other providers, for example among physicians in the network and, thereby, reduce the ability of payers to control the costs of both physician and hospital services [for example, by aligning itself with a large share of physicians in the market, a monopoly hospital may effectively be able to insulate itself from payer efforts to control utilization of its services and thus protect its monopoly profits]. It also could reduce competition between the hospital and non-hospital providers of certain services, such as outpatient surgery.[60]

The latter concern is one that you acknowledge may be present in TriState's case. You note that many private physicians who have been expanding into the provision of outpatient services and seeking new business opportunities view the hospital as a competitor, and this is a particular source of tension insofar as Washington County Health System, Inc., insists that the care for which it pays for its health plan enrollees be provided within the Washington County Health System, Inc., including Washington County Hospital.[61]

While you have assured us that Washington County Hospital will continue to contract directly with payers independently of the proposed program where payers so prefer, this could be an area

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[59] Because of the ownership of numerous other related medical and health care providers and services by Washington County Hospital's parent organization – Washington County Health System, Inc. – Washington County Hospital may have, or be able to exercise, some degree of market power regarding health care services beyond just hospital services, as well. *See* n. 6, *supra*.

[60] *Health Care Statements* at Statement 9, § B.2.b.

[61] *See* discussion in Section IV.D.3, *infra*, re physician complaints regarding the proposed program.

of serious concern if the providers' relationship through TriState were to be used strategically to benefit either the physician participants or the hospital by reducing or eliminating competition that otherwise would exist in the absence of the participants' agreement through the joint venture.

Despite these concerns, it appears that if TriState operates as it has proposed, payers unwilling to contract jointly with physicians through TriState nevertheless should be able to deal individually, or perhaps through other regional networks, in order to obtain the services of some or all of TriState's physicians and hospital member at rates that are not artificially elevated due to the providers' coming together through the proposed program. If so, it is not apparent how TriState's proposed program would facilitate it or its physician members attaining or exercising market power or otherwise having anticompetitive effects in the market for physician services.

Likewise, it is not apparent how TriState's proposed program would enhance Washington County Health System, Inc.'s already existing leverage to insist that patients covered under its employee health benefits program be treated within its own system, a current policy that predates the proposed program. Consequently, it is not clear that its participation in the proposed program is likely to harm competition or increase Washington County Health System, Inc.'s, market power beyond that which it already possesses.

Should it, however, become apparent that TriState and its physician members in fact are not operating on a non-exclusive basis, that payers are unable to obtain access to physician services needed for their programs outside of TriState and at market-determined rates, or that TriState is being used strategically to undermine actual or potential competition for services provided by Washington County Health System, Inc., our initial view of TriState's market power and the proposed program's likely competitive effects would require reassessment. Under those circumstances, we might rescind this advisory opinion, and might recommend that the Commission institute appropriate law enforcement activity to remedy any anticompetitive conduct.

2. "Spillover" Price Effects

Another area of potential concern with a physician network relates to possible "spillover" effects on pricing by member physicians of their medical services sold outside the network.[62] The competitive analysis of a network considers whether the arrangement is likely to facilitate collusion, either overt or tacit, regarding activities by the participants outside the network.[63] For example, agreement by TriState physicians as to the fees they will charge outside of TriState, or

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[62] The Supreme Court, in *Broadcast Music*, alluded to this type of "spillover" concern through possible anticompetitive agreements by the participants in the blanket license arrangement regarding the sale of their individual compositions outside the joint venture, but found no evidence of the existence of any such agreements. 441 U.S. at 23-24.

[63] *See* discussion of "spillover effects" in *Health Care Statements* at Statement 8, § B.2.

any agreement only to deal with payers outside of TriState on collectively-determined terms, would raise antitrust concerns. We therefore would have serious concerns if the proposed program's operation facilitated any such agreements among its physicians in selling their services outside of TriState's proposed program.

TriState says that it will "take steps to prevent any anticompetitive spillover." Specifically, TriState "will limit its members' access to competitively sensitive information;" "will provide antitrust counseling to members of the committees responsible for dealing with competitively sensitive information, and antitrust guidelines to its members;" and "will require all board and committee members to sign confidentiality agreements and will use those agreements to enforce its confidentiality policy, which prohibits the disclosure of competitively sensitive information." When developing its fee schedule, a non-physician TriState staff person will survey the members' practices, and only non-physician staff will see actual physician prices.[64] After aggregating this information, the staff will destroy the information records from individual practices. Once a contract is in place, physicians overseeing the program's operation will "have access only to cost, not pricing, information as they perform utilization, quality, and cost-effectiveness reviews. TriState will make every effort to limit the competitively sensitive information reviewed by its committees." Finally, TriState's committee and board members "will receive antitrust counseling to keep competitively sensitive information confidential, not to use TriState's information for any business they conduct outside TriState, and not to discuss or exchange their own prices or competitive terms." Any board or committee member who breaches a signed confidentiality agreement will be removed from the committee or board.

One possible type of spillover effect that is not dependent on sharing of competitively sensitive information among competing physicians is that TriState physicians individually might seek to charge the potentially higher prices they receive for their services through the jointly negotiated contracts under the proposed program even when providing services outside of that program, without the quality and efficiency enhancements provided through the program's integrative aspects. This form of spillover would involve individual member physicians using the information they each necessarily would obtain about the program's negotiated reimbursement levels for their individual services (as evidenced by their payments under the program) in dealing with payers outside of the program. The concern would be that this information could influence the prices at which the physicians would offer their services outside the program, and potentially could allow some TriState physicians, particularly those practicing in specialty areas where there are few alternative providers in the area, to obtain higher fees from payers.

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[64] In discussing possible anticompetitive "spillover" effects, the *Health Care Statements* observe that "a network that uses an outside agent to collect and analyze fee data from physicians for use in developing the network's fee schedule, and avoids the sharing of such sensitive information among the network's physician participants, may reduce concerns that the information could be used by the network's physician participants to set prices for services they provide outside the network." *See* Statement 8 at § B.2. While not technically an "outside agent," TriState's proposed use of non-physician staff to survey its physicians, coupled with its other precautions to prevent that information from being conveyed to the physicians, may be adequate to achieve essentially the same result, if the proposed protections are adhered to rigorously.

While higher prices certainly are a concern, physicians generally know the payment levels they receive from various payers for their individual services, and presumably price their services as the market permits (or demands, in the case of certain government programs). Having information on their individual payment levels from payers under the proposed program would be no different from the type of information that they currently have from all other payers under all programs in which they participate. Payers would remain free to accept or reject those terms to the same extent that they currently are able, and any ability of particular TriState physicians to individually obtain higher fees outside of TriState would appear to be the result of supply and demand or other factors unrelated to TriState's operation. However, we would be greatly concerned if activity in the market suggested the possibility of coordinated interaction – either explicit or tacit – among TriState physicians regarding their dealings outside of TriState. This could become apparent if payers were unable to contract with physicians outside of TriState at market rates, which presumably would be lower than the TriState rates, since the latter would be based on the additional integrated systems, services, and value that the program promises to provide.

3. Competitive Concerns Expressed by Some Area Physicians

We received several letters from physicians who participate in TriState's existing programs, but who expressed concern that if TriState's proposed program were to receive a favorable opinion and proceed to operate, it would allow Washington County Hospital Association and its affiliates/subsidiaries "to gain such a great market share or monopoly on the privately insured patients of Western Maryland that all other competition would be effectively eliminated." The proposed program, they asserted, would create

> great potential for the PHO [i.e., TriState to] . . . control the majority of private insurance eligible patients in [the] . . . region thus leading to marked decrease in competition, the potential manipulation of reimbursement fees to favor [the hospital and its subsidiaries] . . . with the potential reduction in appropriate physician fees and the inability of physicians to adequately respond to these reductions due to the monopoly situation that would be created. This would certainly result in the diminution of services to the . . . people of the Washington County area, less efficient and less prompt service.

The letters and other accompanying memoranda submitted by the physicians raising concerns did not, however, explain how operation of TriState's proposed program would have these effects. As best we can ascertain from the submission, these physicians are concerned about the degree of market power they believe is already possessed by Washington County Hospital Association through operation of its subsidiaries, Washington County Hospital, TriState, and Antietam Health Services, and fear that TriState's proposed program would add to Washington County Hospital Association's market power, to the disadvantage of physicians who do not affiliate with Washington County Hospital Association and its programs. The materials they submitted also

indicate a concern that Washington County Hospital Association will use its market power to essentially require use by all area physicians of Washington County Hospital Association's health care facilities and capabilities, thereby making it impossible for independent practices to establish or successfully operate alternative outpatient services.

It is not evident, nor do the physicians' letters explain, how operation of TriState's proposed program would increase any market power that Washington County Hospital Association may already have due to its current position as the only hospital in Washington County or its ownership of certain primary care and other physician practices in the region. TriState's commitment to non-exclusive contracting with payers under the proposed program should allow payers to deal with any area providers, on an individual basis and without going through TriState, should the payers prefer to do so. Likewise, TriState has stated that access to hospital services from Washington County Hospital Association will not be tied to, or conditioned on, the purchase of physician services through TriState.

While it therefore is not apparent how the concerns expressed by these physicians would result from the proposed program or Washington County Hospital Association's involvement, as we have stated generally regarding the program, we would be greatly concerned if the program or the hospital's involvement somehow were to be used strategically, in order to increase Washington County Hospital Association's power in any area of the health care services market, or to otherwise disadvantage competitors or unfairly foreclose competition that otherwise might exist or develop in the market.[65] This could be of particular concern given that TriState physicians comprise 64 percent of Washington County Hospital's medical staff, and half or more of the physicians in a large number of specialities with admitting privileges at the hospital.[66]

V. Conclusion

TriState's proposed program, while still in the relatively early stages of development in certain respects, nevertheless appears to involve substantial integration by its physician participants that has the potential to result in the achievement of significant efficiencies that may benefit consumers if it is implemented as you have described. It also appears that TriState's joint negotiation of contracts, including price terms, with payers on behalf of its physician members who will be providing medical services to the payers' enrollees under those contracts is subordinate and reasonably related to TriState's members' potentially procompetitive integration

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[65] To the extent that Washington County Hospital Association, including its parent organization, subsidiaries, and affiliates, already may have market power or be a monopolist within a relevant geographic and product market, any activity by it to increase or maintain such market power by means other than competition on the merits – including through strategic use of its participation in TriState and its proposed program – could raise antitrust concerns.

[66] *See* n. 52, *supra*.

through the proposed program, and appears reasonably necessary to achieve the potential efficiencies of that program.

Because of the procompetitive potential of the proposed program, the apparent ancillarity of its joint contracting to furthering achievement of the program's potential efficiencies, and the indications that, if operated as you have proposed, TriState is unlikely to be able to attain, increase, or exercise market power for itself or its participants as a result of implementing the proposed program, we do not believe that the proposed program's operation should be summarily condemned *ab initio* under prevailing antitrust law standards.[67] We therefore would not recommend that the Commission challenge TriState's proposed program unless it became apparent that TriState in fact was able to increase or exercise its participants' market power, or otherwise have an anticompetitive effect in a relevant market. Because of TriState's interrelationship with Washington County Hospital Association, we also would be concerned if TriState or the proposed program, were used in a way that unfairly eliminated or restricted competition for the services provided by Washington County Hospital Association and its subsidiaries, divisions, or affiliates.

This letter sets out the views of the staff of the Bureau of Competition, as authorized by the Commission's Rules of Practice. Under Commission Rule § 1.3(c), 16 C.F.R. § 1.3(c), the Commission is not bound by this staff opinion, and reserves the right to rescind it at a later time. In addition, this office retains the right to reconsider the questions involved and, with notice to the requesting party, to rescind or revoke the opinion if implementation of the proposed program results in substantial anticompetitive effects, if the program is used for improper purposes, if facts change significantly, or if it otherwise would be in the public interest to do so.

Sincerely,

Markus H. Meier
Assistant Director

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[67] In *Broadcast Music* the Supreme Court observed that *per se* condemnation of apparently anticompetitive conduct first requires an inquiry focusing on "whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output . . . or instead one designed to 'increase economic efficiency and render markets more, rather than less, competitive'." 441 U.S. at 19-20 (quoting *United States v. United States Gypsum Co.*, 438 U.S. 422, 441 n. 16 (1978)).