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July 9, 2007

Mr. Donald S. Clark
Secretary
Federal Trade Commission
Room 172
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

Dear Mr. Clark:

Pursuant to Federal Trade Commission Procedure Rules 1.1 through 1.4, 16 C.F.R. §§ 1.1-1.4 (2007), TriState Health Partners, Inc. ("TriState") requests a staff advisory opinion. Recognizing the need of area employers to control health care expenses and ensure optimal care for employees and beneficiaries, TriState proposes to develop a non-exclusive multi-provider network joint venture that will integrate its members clinically as described in Statements 8 and 9 of the U.S. Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care (1996) ("Statements").[1] If TriState develops contract proposals that include performance bonuses, negotiates contract terms (including price), and enters into contracts with third-party payers for the sale of the integrated product described in this letter, what are the Commission's enforcement intentions and how would it analyze those activities under Section 5(a)(1) of the Federal Trade Commission Act?

TriState is a non-exclusive physician-hospital organization ("PHO") whose approximately 200 practitioner and one hospital system members are located in Washington County, Maryland and provide medical services to patients from Maryland, Pennsylvania, and West Virginia. Originally marketing its integrated product to the local business community, TriState intends to offer 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

[1] To maximize potential efficiencies, TriState intends to align the financial incentives of the joint venture partners, and further establish the interdependence of its practitioner members, through pay-for-performance ("P4P") risk agreements with payers. The amount of the risk funds, however, will be determined through negotiations with payers, and TriState cannot say at this time whether the financial risk sharing through its P4P contracts will qualify as "substantial," as that term is used in the Statements.

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.

I. TriState

A. Members

TriState, which is based in Hagerstown, Maryland, is a Maryland non-stock, membership organization that incorporated in June 1995. It has two classes of membership.[2] Class I members are primary care physicians ("PCPs"),[3] specialty care physicians ("SCPs"), hospital-based physicians, or oral surgeons licensed to practice in Maryland, or medical group practices whose physicians or surgeons meet that requirement.[4] The sole Class II member is Washington County Hospital ("WCH"), a member of the Washington County Health System, Inc. ("WCHSI"), located in Hagerstown.

1. Practitioners

To join TriState, physicians or oral surgeons (collectively "practitioners") must complete a written application for membership, meet TriState's credentialing criteria, and be approved by the TriState Board. TriState has no restrictions on the addition of new Class I members. Each new Class I member pays a joining fee of $2,500, which WCH matches.

There are currently 204 Class I physician members, 64 of which are PCPs practicing in the specialties of family practice, internal medicine, and pediatrics. The remaining members are SCPs who practice in 29 specialties.

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[2] See Exhibit 1, TriState's Bylaws.

[3] TriState defines PCPs as those physicians who specialize in family practice, pediatrics, general practice or internal medicine (excluding its subspecialties).

[4] Approximately 17 percent of TriState members are employees of Washington County Health System, Inc., through its subsidiaries Washington County Hospital Association and Antietam Health Services (a for-profit corporation), or Antietam's subsidiary Medical Practices of Antietam, LLC. These employed physicians must comply with all of TriState's clinical integration policies and rules, and they are subject to discipline deemed appropriate by their TriState peer physicians, including expulsion from TriState.

SPECIALTY	WCHSI EMPLOYED	TRISTATE MEMBERS[5]	TOTAL
Allergy, Asthma/Immunology	0	2 (1)	2
Anesthesiology	0	9 (1)	9
Cardiology	0	11 (4)	11
Dermatology	0	3 (2)	3
Emergency Medicine, Express Care	0	1 (1)	1
Endocrinology	2	1 (1)	3
Family Practice	9	18 (10)	27
Gastroenterology	4	2 (2)	6
General Surgery	1	7 (3)	8
Infectious Disease	0	1 (1)	1
Internal Medicine Primary Care	5	15 (13)	20
Internal Medicine/Pediatrics Primary Care	6	0	6
Nephrology	0	3 (1)	3
Neurology	0	5 (5)	5
Neurosurgery	0	4 (1)	4
Nuclear Medicine/Nuclear Cardiology	0	2 (2)	2
Obstetrics/Gynecology	5	9 (4)	14
Oncology	0	4 (2)	4
Ophthalmology	0	2 (2)	2
Oral & Maxillofacial Surgery	0	5 (2)	5
Orthopedics	0	12 (3)	12
Otolaryngology	0	6 (3)	6
Pain Management	0	3 (2)	3
Pathology	0	4 (1)	4
Pediatrics Primary Care	0	11 (4)	11
Physical Medicine/Rehabilitation	0	4 (3)	4
Plastic Surgery	0	1 (1)	1
Podiatry	0	7 (3)	7
Psychiatry	3	0	3
Pulmonary Disease	0	5 (2)	5
Radiation Oncology	0	1 (1)	1
Radiology	0	10 (1)	10
Urology	0	1 (1)	1
TOTAL	**35** **17%**	**169** **83%**	**204** **100%**

Historically, TriState has elected to contract with additional providers to fill geographic or specialty-coverage gaps in the network.[6] These medical providers do not pay membership fees and have no governance rights in the PHO. Although TriState will strongly encourage these contracted practitioners to be a part of its clinical integration

[5] The first numbers in the column represents the total number of TriState physicians in each specialty, and the number in parentheses represents the number of medical groups within which those physicians practice.

[6] See Exhibit 2, Chart of Professionals with privileges at WCHA, WCHSI employees, TriState Members, and TriState Contracted Providers.

program, it anticipates that some may choose not to participate. For payers (most of which are likely to be local employers) that need these non-participating providers in order to have a complete network but do not wish to contract directly with the providers, TriState will facilitate agreements with those providers through a messenger arrangement.

TRISTATE CONTRACTED PROVIDERS	
SPECIALTY	TOTAL
Emergency Medicine	3 (1)
Family Practice	5 (3)
General Practice	2 (2)
General Surgery	1 (1)
Hospitalist	7 (1)
Infertility/Reproductive Endocrinology	1 (1)
Internal Medicine	1 (1)
Mental Health (non-Physician)	15
Nurse Midwives	5
OB/GYN	1 (1)
Ophthalmology	4 (2)
Oral & Maxillofacial Surgery	2 (1)
Pediatrics	4 (1)
Plastic Surgery	1 (1)
Psychiatry	10 (6)
Rheumatology	2 (2)
Urology	4 (1)
Wound Care	1 (1)
TOTAL	**69**

2. The Hospital

WCH, TriState's Class II Member, is an acute-care hospital operated by Washington County Hospital Association ("WCHA"), a Maryland non-profit membership corporation that is a subsidiary of WCHSI.[7] WCH has a medical staff of 319 physicians who practice in 58 specialties and subspecialties through more than 120 group practices in Washington County and the surrounding area. WCHA is licensed to operate 292 acute care beds, including 218 medical/surgical, 18 obstetric, 10 pediatric, 18 psychiatric, and 28 acute rehabilitation beds. Designated a Level III Trauma Center by the State of Maryland, WCH 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 catheterization, physical and occupational rehabilitation, and diagnostic imaging.

[7] WCHSI has approximately 3,000 employees and serves a tri-state region, including western Maryland, southern Pennsylvania, and northern West Virginia. See Exhibit 3 for a full description of the programs and services provided through WCHSI and its subsidiaries.

B. Organizational Structure

TriState's Board of Directors is comprised of five representatives of the Class II member and eight Class I members (four PCPs, two surgeons, and two medical specialists, one of which must be a hospital-based practitioner).[8] On a daily basis, an administrative staff of eight oversees TriState's operations.[9]

To facilitate the implementation of its clinical integration program, the TriState Board left only its Nominating and Bylaws Committees unchanged and modified or approved the addition of the following committees:[10]

1. Finance-Contracting-Administration – monitors the financial performance of TriState and develops contracting strategies and proposals, including pay-for-performance models.

2. Communications – establishes communication and marketing strategies to effectively reach all present and potential clients and practitioner members with information and access to TriState, its products, services and staff.

3. Clinical Integration Oversight ("CIOC")- oversees all clinically-related corporate activities; will establish sub-committees as deemed necessary to conduct clinically-related activities.[11] The sub-committees currently include:[12]

    a. Credentialing - oversees the credentialing and recredentialing processes, including the development of participation criteria, and works closely with the Utilization Management/Quality Assurance ("UM/QA") Committee in evaluating the physicians' quality; solicits, evaluates and recommends candidates for Class I membership and non-Member provider participation status; and establishes and maintains participating provider files.

    b. UM/QA – develops implements, and oversees policies and procedures related to TriState's utilization management, case management, and disease

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[8] See Exhibit 4, TriState's Current Board of Directors.

[9] See Exhibit 5, TriState's Administrative Staff.

[10] See Exhibit 6, TriState's Committee Charges.

[11] A Class I Director chairs the CIOC. Its members are the sub-committee chairs plus one Class II Director.

[12] See Exhibit 7, TriState's Committee Membership.

management activities, including monitoring the metric and benchmark achievement; and makes recommendations for group improvement.

c. Service Improvement ("SIC") - reviews, monitors, and makes recommendations for improvement of clinical efficiency, utilizing available technology; annually reviews TriState's clinical policies and procedures and makes recommendations for changes; and develops new policies and procedures.

d. Quality Improvement ("QIC") - develops and monitors clinical practice guidelines, reviews and monitors the evidence-based medicine rules, ensures use of and adherence to the guidelines by the physicians, and ensures that processes are in place for migrating guidelines and rules to TriState's membership.

e. Pharmacy Benefits Management ("PBM") - reviews the prescription drug formulary, making recommendations for formulary changes and monitoring drug utilization.

f. Care Coordination ("CCC") – performs concurrent review of care, identifying issues for resolution through policy and/or procedure changes and transmits such recommendations to the SIC for action.

C. Background

Although TriState started as a risk-sharing joint venture, it contracted on a capitation basis only for a single year before ceasing to function as a financial risk-sharing PHO. In 1998, TriState entered into an arrangement with InforMed, L.L.C. ("InforMed"),[13] 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. TriState members who accepted InforMed's rates and agreed to participate in the InforMed provider network, Community Health Partners ("CHP"), signed new participation agreements with TriState.[14] In turn, TriState signed a contract with InforMed for its providers to participate in the CHP network; to provide some administrative services for InforMed, including credentialing, network management, clinical oversight, and utilization review; and to obtain health

[13] See http://www.informed-llc.com/ (providing more information on InforMed).

[14] The TriState physicians deal directly with InforMed on any issues related to fees or payment of 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.

information technology ("HIT") 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.

Through the years, InforMed has contracted with self-insured employers in Washington County to provide TPA services, hospital and physician services through its CHP network, and utilization and medical management to employers desiring these services. Starting in 2004, TriState began working with InforMed on a plan for TriState to assume more control, responsibility, and accountability over the medical management functions. TriState has since hired a data analyst, a care coordination manager, and two case managers, allowing it to subcontract with InforMed to provide all medical management services for InforMed's Washington County clients.

InforMed currently has contracts with three Washington County employers for which TriState provides medical management services and its providers, as part of CHP, render medical services. The largest employer is WCHSI, which contracts for its own health plan, the Washington County Health System Employee Health Benefits Plan (the "Plan"). Currently, the Plan covers 4,974 lives [redacted]. The other two Washington County InforMed customers are [redacted]

II. TriState's Market

A. Geography

TriState is based in Hagerstown, Maryland, the largest town in Washington County, but its primary service area ("PSA") extends slightly beyond the county. Washington County is located in a part of western Maryland that, at its narrowest point, is only eight miles wide. In addition, Interstates 70 and 81 intersect in Hagerstown, making interstate travel relatively easy. As such, TriState's secondary service area ("SSA") includes parts of Pennsylvania and West Virginia, as well as Frederick County, Maryland. To the east of Hagerstown, the next largest town is Frederick, approximately 25 miles away. To the west, the next town is Hancock, again about 25 miles away. To the north, about 15 miles away, is Waynesboro, Pennsylvania, and to the south, about 25 miles, is Martinsburg, West Virginia.

B. Alternative Providers

The 2007 population forecast for TriState's PSA is approximately 145,000, and its SSA is forecast to include more than 350,000 people. TriState's PSA accounts for 80.4% of WCH admissions, while 14.5% are from its SSA and 5.1% from other areas. Although

it has not studied how far patients travel for its physicians' services, TriState believes that the physicians' service area data would be similar to WCH's. There are no IPAs or PHOs other than TriState operating within Washington County.

The closest competing health system in TriState's service area is Summit Health, which includes Waynesboro Hospital, a 62-bed hospital, in Waynesboro, Pennsylvania (about 20 minutes north of Hagerstown) and the 232-bed Chambersburg Hospital (Chambersburg, Pennsylvania), located about 30 minutes from Hagerstown. Cumberland Valley Health Network ("CVHN"), the PHO aligned with Summit Health, is a payer-contracting organization.

Thirty minutes to the south, TriState's main competition comes from the providers associated with City Hospital, a 144-bed hospital in Martinsburg, West Virginia. City Hospital and many of its medical staff members contract with payers through Eastern Panhandle Integrated Delivery System ("EPIDS"). Based in Martinsburg, EPIDS is a provider-sponsored, vertical arrangement of physicians and hospitals serving nine counties in eastern West Virginia.

TriState's closest Maryland competitor is Frederick Memorial Hospital (Frederick, Maryland), a 253-bed hospital located about 30 minutes east of Hagerstown. Frederick County's only physician contracting organization ceased operations on December 31, 2006, and most of its former members now contract directly with payers.

C. The Payers

Approximately four percent of all patients in TriState's service area are self-pay patients. Medicare, Medicaid, and TriCare—the government payers—cover approximately 50 percent of patients, and workers compensation covers an additional two percent. Private health insurance or self-insured employers using the services of health plans or TPAs cover the remaining 44 percent of patients. The major commercial payers in TriState's market include CareFirst BlueCross BlueShield ("CareFirst"), United Health Care/MAMSI ("United"), Aetna, CIGNA, and InforMed. Together, CareFirst and United cover almost 66 percent of the private insurance subscribers. The dominant form of payer reimbursement for physician services in Washington County is discounted fee-for-service, although United still reimburses PCPs on a capitation basis for its MDIPA and Optimum Choice products.

III. TriState's Proposed Clinical Integration Strategy

TriState has three main objectives in developing and implementing its clinical integration strategy. First, the components and processes of the program—exchange of patient treatment information, clinical guideline development and adoption, performance

monitoring and reporting, and collective work towards improved quality—will facilitate and assure cooperative interaction and collaboration among TriState's member physicians. This cooperation and collaboration should 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. Second, the clinical integration strategy will engage every TriState stakeholder—physicians, case managers, administrators, payers, and patients—in a cohesive and comprehensive program of care management. Through the physicians' adherence to clinical practice guidelines, the physicians' and TriState's use of HIT to identify high-risk and high-cost patients, the interactive patient support of TriState's case managers and Medical Director, and involvement of payers in designing care management initiatives, TriState will more aggressively manage its patients' care than the stakeholders could achieve working independently. This aggressive care management should result in identifiable quality improvements for patients and significant financial benefits for payers. [15] Third, the clinical integration strategy will allow TriState to offer payers an integrated set of services—coordinated physician services focused on quality improvement and medical management—not previously available in the market. This integrated product will be desirable to self-insured employers looking to control the rising cost of providing health care coverage to employees. It 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.

Although ultimate responsibility for the clinical integration strategy rests with TriState's Board of Directors, TriState's members are, and will continue to be, actively and collectively engaged in the strategy. The Clinical Integration Oversight Committee ("CIOC") will oversee development and implementation of the program through its sub-committees—Credentialing, Utilization Management/Quality Assurance ("UM/QA"), Service Improvement ("SIC"), Quality Improvement ("QIC"), Pharmacy Benefits Management ("PBM") and Care Coordination ("CCC"). In addition to establishing the strategic goals for each subcommittee, the CIOC provides a formal communication forum for the subcommittee chairs, facilitating the exchange of information regarding the activities of the subcommittees.

The clinical integration strategy will embrace the following key elements, all of which will require the active and ongoing participation of TriState's member physicians:

1. TriState's program will be built around web-based HIT that will facilitate the exchange of patients' treatment and medical management information, resulting in coordinated care delivery, appropriate utilization of resources, controlled costs, and improved quality and efficiency.

[15] Data reflects that about five percent of beneficiaries in any health plan consume about 60 percent of claims expense, while 40 percent of beneficiaries submit no claims in a given year. Thus, aggressive management of the five percent can result in significant savings.

2. TriState's SIC will use InforMed's software to review episodes of care—all of the medical care and services a patient receives from the onset of an illness or disease through final treatment—encountered in their community and determine where performance improvement will have the greatest financial and quality impact. Using this information, the QIC and ad hoc committees of TriState member physicians will review the appropriateness of existing guidelines already incorporated in their HIT and develop additional, TriState-specific clinical guidelines, or Care Protocols. The CIOC and QIC will conduct periodic reviews of the clinical guidelines to ensure that the performance improvement sought has been met and, if not, to modify the protocols.

3. Through ad hoc peer education committees, the QIC will educate and train TriState's member physicians in the use and adoption of the Care Protocols. TriState will encourage use of HIT by the physicians to facilitate application of the Care Protocols to patient care and to create interdependence in their provision of medical care.

4. The CIOC and SIC will engage in ongoing monitoring to gauge the efficacy of the guidelines. Using HIT, the SIC will provide personalized feedback to TriState's members that compares each physician's actual performance against the performance goals for the TriState network. To assure progress in meeting its cost and quality efficiency goals, TriState has developed a performance improvement program, which includes peer education, behavior modification plans, and sanctions, if necessary.

5. TriState will involve its customers in the clinical integration program by sharing network performance reports, seeking customer input into modifications or additions to the quality improvement initiatives, and engaging the customers in the medical management program.

6. To complete its integrated product, TriState will integrate medical management with its physician services. The UM/QA will oversee the delivery of medical management services and the design of TriState's medical management program. The SIC will develop policies and programs to incorporate medical management into the physicians' practices. Using their HIT resources, TriState physicians and staff will identify patients who could benefit from disease and case management, and, with the support of the CCC, they will ensure that their patients receive cost-effective preventive care and avoid high-cost adverse incidents. Through the PBM, TriState physicians will work with local pharmacists to develop appropriate, cost-effective prescribing policies, medical necessity criteria for high-dollar drugs, recommended prescription drug

formularies, and initiatives for educating TriState's physicians and patients about generic drug alternatives. The PBM will also monitor patient medication compliance and will work with physicians and patients to improve compliance.

TriState fully intends to implement the program outlined herein. The CIOC and its subcommittees will closely monitor protocol compliance, benchmark achievement, patient outcomes, utilization data, and claims costs. If TriState does not achieve the anticipated quality and cost efficiencies within a reasonable time after implementation of the clinical integration strategy, the CIOC and its subcommittees will closely re-examine the strategy, determine whether changes need to be made and, if so, where, and implement those changes.

A. Integrative Health Information Technology

Internet-based HIT will serve as the foundation for TriState's clinical integration strategy. InforMed, TriState's historic partner in serving Washington County's self-insured employers, is tapping its extensive experience and expertise in HIT and supplying the technology for TriState's strategy. To provide the optimal HIT tools, InforMed is working with TriState's physicians on the UM/QA committee to redevelop its technology products to meet the needs of this program and facilitate an information exchange between the physicians' offices, WCH, and ancillary providers in the community.

The 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").[16] When delivered to the physician via the Internet, the Chart and its powerful analytical tools should facilitate a high degree of cooperation, collaboration, and mutual interdependence previously unattainable by these physicians working independently.

[16] Exhibit 8 provides a detailed description of the Symmetry components of the Chart. For more information on ETGs, see http://www.symmetry-health.com/ETGTut_Desc1.htm.

B. Development, Approval, and Implementation of the Care Protocols

1. Developing and Approving Guidelines to Improve Quality

EBM Connect's evidence-based guidelines for the treatment of 50 common, costly medical conditions and screening for eight preventive measures will serve as a starting point for TriState's guideline development efforts. Although panels of medical experts developed EBM Connect's guidelines, TriState's QIC is reviewing all of the EBM Connect guidelines for relevance to the population in the area served by TriState to ensure that the guidelines incorporate the best, most up-to-date practices. To ensure that the most qualified individuals review Symmetry's medical condition guidelines and preventive screenings, the QIC is convening multiple ad hoc committees of specialists in particular medical conditions (e.g., imaging, orthopedic and neurosurgical specialists to examine acute low back pain guidelines). The QIC is asking these ad hoc committees to carefully review each guideline and its care components to determine whether the guidelines follow current national standards and incorporate the best practices of TriState's members and, if not, what changes should be made.[20] By subjecting these guidelines to exhaustive physician reviews, the QIC anticipates the TriState members will see that the guidelines are tested and ready for implementation in the community, thus increasing the members' comfort level.

To truly affect all of its members' quality, TriState knows it will need guidelines in addition to those currently included in EBM Connect. The goal of the QIC is to have at least 80 percent of the medical conditions comprising at least 80 percent of the cost of care

[20] In a cardiology review already begun, the physicians discovered that a particular EBM Connect guideline is no longer considered a recommended best practice. A diabetes committee determined that a pharmaceutical drug used to treat diabetes mellitus also is used to treat infertility. Patients being treated for infertility with this drug were flagged as patients with diabetes. Through InforMed, the Symmetry licensee, TriState communicated both of these findings back to Symmetry so the software could be modified accordingly.

in the community, covered by at least one clinical guideline. The SIC, which will be monitoring the ETGs and the network medical costs, will determine where improvement in the treatment of specific ETGs encountered in the community would have the greatest impact on quality and cost. The SIC will then select specific diseases, diagnoses, and procedures from the identified ETGs and make recommendations to the QIC. Working from nationally available evidence-based guidelines, the QIC and its ad hoc committees will then develop TriState-specific clinical guidelines, or Care Protocols, covering those specific diseases, diagnoses, and procedures.

The QIC and its ad hoc committees will also develop the quality improvement benchmarks against which the TriState physicians' performance will be monitored. When setting the benchmarks for the guidelines and protocols, the QIC will look at the TriState physicians' current baseline, captured from the InforMed claims data, and then set the benchmarks at a level above the baseline that will be challenging, yet not unobtainable.

After an ad hoc committee reviews and, if necessary, revises a Care Protocol and its benchmarks, the QIC will review them and, if no additional modifications need to be made will present the guideline and benchmarks to the CIOC for its review and approval. The Board of Directors will conduct a final review and approve all Care Protocols and their benchmarks. After a Care Protocol receives final approval, the physicians to whom the guideline applies will be required to incorporate the Care Protocol into their practice and comply with the guideline when medically appropriate.

2. Implementing Quality Improvement

Once the TriState physicians sign on to the clinical integration concept, they will need to be educated about the program, the guidelines, the protocols, and the Chart.[21] Just as the QIC will appoint specialty-specific ad hoc committees to review the guidelines and develop the Care Protocols, it will also appoint specialty-specific ad hoc committees to educate their peers and implement the guidelines and protocols. TriState believes strongly that the best way to change its members' practices will be through peer education and training. By teaching each other and collectively working to improve their quality scores, TriState's physicians will become more interdependent.

TriState also believes that the Clinical Claims Chart will be instrumental in helping the physicians to adopt the guidelines and protocols into their clinical practices. By reviewing patients' records of treatment in the Chart, TriState physicians will be able to improve their compliance. Through peer teaching sessions, TriState physicians will work on peer engagement and improvement—first, by personal contact with colleagues when

[21] TriState requires in its participation agreement that the physicians will comply with all quality improvement policies, which would include the EBM Connect guidelines and TriState's Care Protocols. Exhibit 9 is a copy of TriState's provider participation agreement.

they are out of compliance for particular patients, and second, by monitoring network performance scores and encouraging each other to raise those scores.

C. Performance Monitoring and Feedback for Successful Improvement

To obtain the best result from its quality improvement and integration strategy, TriState, through the CIOC and its subcommittees, will monitor guideline compliance, benchmark achievement, hospital and emergency room admissions, service utilization, and network costs. Because TriState is most interested in improving the performance of non-compliant physicians ("moving the mean"), its focus will be on providing feedback to all its members and using competitiveness and education to improve outliers. When necessary, however, TriState will remove physicians from its network who refuse to improve ("culling the outliers").

The SIC will be the main CIOC subcommittee responsible for reviewing and monitoring practice efficiency, as well as moving the mean. Much of this will be done utilizing the ETG tool. By risk-adjusting each patient's data to account for their illness severity, the ETG report results are normalized, allowing direct comparisons across patients with similar diseases and physicians who treat those conditions. Where the ETG tool reveals TriState "best practices"—cost-effective methods of care with high quality results—the SIC will formally, positively recognize the TriState members who met or set the high standards. When the SIC identifies negative outliers or physicians who fail to meet TriState's benchmarks, it will use the ETG tool to show the lower-performing physicians their personal levels of utilization (both under and over) compared to the group, as well as particularly high-cost care, or unnecessary care, provided to individual patients. These physicians will be given an opportunity to discuss their quality and utilization data with the TriState Medical Director and the SIC members so that they can agree what the data indicates and discuss why, and how, practice modifications may need to be made. TriState's goal for the SIC is to create opportunities for peer discussions of the individual and network quality data, so that the physicians can exchange ideas about moving the mean and support each other as they all work to improve. It is expected that the SIC members will be aggressive instruments of change as they teach their peers about how to use the ETG tool information and work with their peers to improve their quality and cost performance.

When pay-for-performance ("P4P") incentives and peer education are insufficient to change providers' practice patterns, TriState will take more aggressive steps, which may include culling the outliers. Physicians who fail to improve after meeting with the SIC and Medical Director will be given a choice of resigning from the panel or working further on improvement. A physician who chooses to continue in the program will collaborate with the Medical Director and one or more physicians from his or her medical specialty in designing a behavior modification plan, which will set out improvement goals and a

timeline within which those goals will be met. The SIC will monitor the physician's progress in meeting the goals and will work with the physician, as necessary, to help him or her to achieve the goals. If, at the end of the period allotted in the behavior modification plan, the physician has not met the goals, the SIC will make a recommendation to the CIOC as to whether the physician should be given additional time or terminated from the panel. If the SIC recommends termination, the physician will be given an opportunity for a hearing before the CIOC. The CIOC will then make a recommendation to the Board, which will have the final say in a physician's termination from the TriState network.

The UM/QA will also perform a monitoring function, but it will do so as the payers' intermediaries. Thus, when it reviews the quality metrics and achievement of benchmarks, it will be looking at how the network performed with respect to the patients of specific payers. The UM/QA will identify quality deficiencies, or treatment regimens in need of improvement, and will make recommendations to the CIOC, such as educational meetings, specialty-specific meetings, out-reach to specific physicians or practices, or integration of medical management components into the delivery of the physicians' services. Once the CIOC decides upon a course of action, the UM/QA will oversee the new program and assure follow-through for improvement. Once TriState begins incorporating P4P into its contracts, the UM/QA committee will work with payers to determine which benchmarks will be used for the P4P initiatives, and it will work with TriState's physicians to ensure that they make changes in their practices necessary to achieve the P4P goals and obtain performance bonuses.

D. Incorporation of Medical Management for Higher Quality Care

Medical management is the final component of TriState's integrated product. Unlike medical management programs run by payers or offered by independent companies, TriState's medical management services will be integrated with its physician services, such that one set of services cannot be separated from the other. To do this, TriState is tapping its membership and its CIOC subcommittees to develop its medical management program. All medical management services will be overseen by the UM/QA, which will ensure that TriState's physicians are integral members of each managed patient's medical management team. In addition to working with TriState's case managers on specific patient cases and following guidelines and protocols that fit into TriState's disease management programs, the TriState physicians will monitor patient cost and claims data in the Clinical Claims Chart and engage medical management resources—disease and case management programs, assistance of case managers, or support of the CCC—when necessary to ensure patients receive cost-effective care and avoid high-cost adverse incidents. Through the PBM, the TriState physicians will be engaged in pharmacy benefit design, as well as review and development of prescribing policies.

The UM/QA will provide oversight and monitoring for all of TriState's medical management programs and functions. The Medical Director and the Manager of Care Coordination will report to the UM/QA committee regarding all active programs. The UM/QA will also develop, implement, and oversee policies and procedures related to TriState's utilization, case and disease management activities. To do this, it will actively engage the TriState physicians in developing the programs and policies, seeking feedback as the programs are implemented to ensure the physicians find value in participating in medical management efforts and make use of the available resources for their patients. The UM/QA will also utilize ad hoc physician committees to provide training to the TriState membership on medical management programs as they are rolled out, further reinforcing the concept of medical management integrated with physician services. Based on recommendations from the TriState physicians and administrators, the UM/QA will make policy and program change recommendations, as necessary, to improve quality and reduce costs for the patients and payers.

On the recommendations of the UM/QA committee, the CIOC will draft TriState's quality improvement policies and procedures relating to medical management. These policies and written procedures will be a means of memorializing the "lessons learned," as TriState's physicians become more involved in the medical management process, and should also facilitate quality improvement over time. The CIOC will annually review all medical management policies and procedures and recommend changes when necessary.

1. Disease Management/Case Management

One of the main roles of the UM/QA will be to recommend, based on data from the ETG and ERG tools, the development of disease management programs that will integrate case management services with the delivery of primary and specialty care physician services. In addition to working with TriState physicians and administrative staff to create these programs, the UM/QA committee will oversee and monitor the disease management programs, recommending changes to improve coordination and collaboration in the delivery of disease management services. Unlike many commercially-available or payer-run disease management programs, TriState's disease management programs will be developed and overseen by the physicians, who will be actively involved in working with their patients, their patients' other health care providers, and the TriState case managers in managing and improving their patients' health, as well as engaging patients to manage their own health. TriState believes its members, patients, and client-payers will see significant benefits from these disease management initiatives because of the success it has already had with the more limited diabetes management program that it currently operates.[22]

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[22] Two years ago, TriState launched a diabetes management program for WCHSI Plan members that involved aggressive case management work with diabetic patients and their PCPs. TriState identified participants by their ERG risk score, enrolling the highest risk patients first. Although costs for these patients went up in the

Supporting the medical management from the administrative side is TriState's Care Coordination Committee ("CCC"), which meets on a weekly basis to perform concurrent review of physician and hospital services. Although it performs a utilization review function, the purpose of the CCC is to identify operational and medical management issues in the delivery of physician and hospital services, reduce the expenses for high-cost patients, and ensure that patients receive the appropriate amount of service from TriState member physicians and care managers. The CCC involves the patients' PCPs in making decisions about care and, when necessary, also sees that patients are referred to SCPs who can recommend additional means of improving the patients' health.[23] TriState believes that its new approach to medical management will destroy the negative view of medical management as interfering and disruptive that many physicians have and already has seen that its members see the wisdom of working more closely with TriState's case managers to improve the health of their patients.

2. Pharmacy Management

Pharmaceuticals are among the largest contributors to payers' health care costs. Although payers often provide financial incentives to patients to use generics and less-costly alternatives, the payers' costs will not significantly change unless the physicians' prescribing patterns change. Payers attempt to do this through the creation of prescription drug formularies, which list the drugs the payers are willing to cover and the amount or portion of the drugs' cost the payers will cover. The problem with formularies is that they are often put together without physician input and differentiate coverage solely on the basis of cost for the individual medications. Thus, many physicians chafe at the restrictions of the formularies.

TriState believes that only through the collaborative efforts of physicians can pharmaceutical costs be reduced. To spearhead its pharmaceutical strategy, TriState established the PBM, which includes both local pharmacists and TriState physicians. One of the main functions of the PBM will be to monitor drug utilization, which will help TriState and its contracted payers to identify high-cost prescribing practices and low-cost alternatives. Through this committee, TriState's members will be able to debate the value

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first year due to the provision of preventive physician services and increase in case management, costs for the second year have decreased almost to the base year level. Given the progressive nature of the disease, it is not expected that costs will decrease over time below that of the base year. However, it is expected that the program will slow the rate of increase.

of certain therapies, as compared to their costs and risks, and identify "best prescribing practices." The physicians and pharmacists of the PBM will develop medical necessity criteria for high-dollar drugs and create generic drug initiatives to educate physicians and their patients about low-cost alternatives. The PBM will also make recommendations to the QIC regarding best prescribing practices that it believes should be translated into Care Protocols for TriState physicians. For self-insured employers and other payers seeking to get a better handle on their pharmaceutical costs, the PBM will review the payers' formularies and drug tiers[24] and, through the CIOC, recommend changes that will be both beneficial to the patients and approved by the physicians. Although payers will have the right to reject proposed formulary and tier changes, ideally TriState will have a single formulary with which its physicians comply, thus simplifying and standardizing the prescribing process. For self-insured employers, the PBM will also review and decide appeals for coverage of non-formulary drugs. TriState anticipates its physicians will be more responsive to determinations by this committee because they will know their peers reviewed their patients' appeals.

Because pharmaceutical costs consume a large portion of health care dollars, the PBM and UM/QA will work together in determining how to incorporate pharmaceutical management more intensely into TriState's medical management program. The physicians will benefit from pharmacists' expertise when trying to determine the best, most cost-effective course of treatment for their high-risk patients, and the patients will benefit from pharmacists reviewing their medications.

IV. TriState's Contracting with Payers

Payers who choose to purchase the integrated product will receive TriState's complete network of physicians, collaborative quality and cost improvement initiatives, and all of the medical management services integrated with the physicians' services. The TriState physicians will not be allowed to "opt out" of TriState's payer contracts; they will be contractually required to participate in any contracts TriState enters. When payers enter contracts with TriState, they will have the option of terminating any pre-existing direct contracts with TriState physicians or allowing the TriState contract to supercede the physician contracts. TriState will, however, be non-exclusive. If a payer doesn't want the complete physician network, or doesn't want to contract with TriState, then it will have the option of contracting directly with the physicians, and TriState's physician members will be free to do so. If a payer wants an employee wellness program—to address lifestyle changes necessary to prevent chronic disease—or medical management—case, disease, and/or pharmacy—services, TriState's administrative staff (rather than its physicians) will oversee and provide those services. But, the core parts of its product—protocol

[24] Many payers influence their members' choice of drugs by having tiered co-pays. Generally, generics have the lowest co-pay and lifestyle drugs, such as Viagra, have the highest co-pay.

development and implementation, quality monitoring, and cooperative management of patients' medical needs—cannot be sold separately because they will be integrated into, and inseparable from, the physicians' services. TriState believes that to fully achieve the anticipated cost and quality efficiencies of its clinical integration strategy, it must price and sell the full set of services as a single product. When selling its integrated product to payers, TriState will offer payers two different payment systems, P4P and fee-for-service.

A. Paying for Superior Outcomes and Quality Processes

While P4P is a relatively new payment methodology, the concept is rapidly gaining traction and many of the major payers–including Medicare and the managed Medicaid plans—are developing their own particular strategies for paying for documented quality.[25] While recognizing and paying for quality is generally a laudable goal, the issue at the individual physician level is that each payer's P4P strategy will be different and each will have attendant incremental costs for compliance.[26] In many cases, the costs to an individual physician to comply with a payer's program is greater than the available performance payment or recognition for the physician, making it unlikely many solo- or small-practice physicians will participate.

To bring about change through P4P, TriState plans to develop a single P4P program in which all commercial payers in the community will participate. TriState's model for its P4P program is the California P4P run by the Integrated Healthcare Association ("IHA").[27] The IHA's P4P program measures the performance of physician groups in treating their HMO patients on a common set of measures used statewide by seven participating payers who make incentive payments to the physician groups based on their performance on the standardized measures. Like the IHA collaborators, TriState

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[25] See, e.g., http://www.cms.hhs.gov/PhysicianFocusedQualInits/ (providing information on Medicare's P4P initiative); http://www.bridgestoexcellence.org/markets/states/maryland.mspx (describing programs operated by CareFirst and Aetna in Maryland); http://www.uhc.com/healthcaretrends/healthcarequality.htm (introducing United's concept of "premium" physicians who meet certain quality requirements).

[26] For example, one payer's P4P initiative may pay physicians higher if they receive "recognition status" through one of National Committee for Quality Assurance's ("NCQA") programs—diabetes, heart/stroke, back pain, and physician practice technology. To achieve the status and qualify for the payments, a physician must pay an application fee and incur a "data mining" cost for reviewing his or her medical records to determine compliance with the NCQA standard. A second payer's P4P program, though, may be based entirely on compliance with a set of guidelines that deal with performance of cancer screening tests. The physician then incurs incremental costs for complying with this requirement.

[27] See www.iha.org for details on the program. The IHA's program is a collaborative effort of payers, physician organizations, hospitals, pharmaceutical representatives, technology professionals, consumers and academic representatives. IHA's P4P program facilitates the financial reward of physicians, through their integrative groups, for improved performance in clinical care, HIT adoption, and patient satisfaction by providing a clear set of performance expectations.

physicians will work with the other stakeholders in the community—patient representatives, self-insured employers, and commercial payers—to develop a consensus-based P4P model that includes guidelines (Care Protocols), performance measures, and outcomes-based metrics. By having a program with uniform requirements and benchmarks, the TriState physicians will be able to focus all of their efforts and resources on working cooperatively to achieve quality improvements that will benefit all of the collaborating parties in the Washington County P4P. Unlike the IHA's program, TriState does not intend for its P4P to provide merely a bonus payment to its participating providers. Rather, TriState envisions a payment methodology under which all payments to its providers will take into account the quality of services its members provide.

TriState understands that its program must be sufficiently compelling to incentivize commercial payers like CareFirst and United to step outside of their own model and agree to work with a physician group that is focused on superior outcomes, achieving superior costs, and is data-driven. As a result, TriState believes that it will need to collect a year or more of performance data from its physicians, showing the success of its clinical integration strategy for self-insured employers and smaller payers. Thus, it will need to contract on a fee-for-service basis for some period before it is able to implement its P4P program.

B. Fee-for-Service Contracting

As part of its clinical integration strategy, TriState plans to negotiate both price and non-price terms with payers for the sale of its integrated package of services. TriState anticipates that its fee proposals will be based on a percentage of the Medicare Resource Based Relative Value Scale, which will cover its members' integrated physician services and the other components of the integrated product.

To develop competitive fee proposals, TriState's PHO External Relations Representative will survey the practices to determine what the physicians' price expectations may be and then will aggregate the data into a fee proposal. Only TriState's non-physician administrative staff will see the practice surveys, and, once the aggregation is complete, the survey responses will be destroyed.

Although TriState will show payers this aggregated fee proposal, it anticipates that some payers will make other proposals or counter proposals. TriState's Finance-Contracting-Administration committee ("FCA") will be responsible for reviewing the payers' offers and advising TriState's administrative staff. TriState's Board of Directors will review contract approval recommendations from the FCA. TriState's antitrust attorney will counsel the members of the FCA and Board of Directors regarding the need to keep all competitive terms confidential and not to allow negotiations of the joint venture

product to influence the terms and conditions upon which the physicians will agree to contract individually.

C. TriState's Need to Contract on its Members' Collective Behalf

TriState will negotiate the price and other terms for the sale of its integrated product. Although TriState acknowledges that contracting on its members' behalf will eliminate competition among its physicians as to the integrated product and, therefore, constitute "inherently suspect" conduct under Polygram, TriState's integration will generate significant cost and quality efficiencies, and its joint contracting is ancillary to achieving those efficiencies.[28]

Under the Polygram framework, TriState's joint negotiations are not summarily condemned if TriState can explain why the joint contracting is either not expected to have an adverse effect on competition, or is likely to provide benefits to consumers.[29] TriState must proffer justifications that are both cognizable—*i.e.*, they explain how the collective negotiation enables TriState and its physicians to "improve product quality, service, or innovation"—and plausible—*i.e.*, there is a "specific link" or "logical nexus" between the joint contracting and the articulated pro-competitive effects.[30] Specifically, TriState needs to show that its program "involves potentially efficiency-enhancing integration" among its members and that the collective negotiation is "reasonably necessary—*i.e.*, 'ancillary'—to the achievement of the proposed program's integrative efficiencies."[31] If, as TriState purports, its joint contracting is ancillary, the rule of reason applies to its joint negotiations,

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[28] See Polygram Holding, Inc., No. 9298, slip op. at 29-35 (FTC Jul. 21, 2003), reprinted in 5 Trade Reg. Rep. (CCH) ¶ 15,453, aff'd 416 F.3d 29 (D.C. Cir. 2005) ("Polygram"). The Commission has determined that physician collective negotiation through a provider-controlled contracting organization is "inherently suspect under Polygram. N. Tex. Specialty Physicians, No. 9312, slip op. at 26 (FTC Nov. 29, 2005), reprinted in 2005-2 Trade Cas. (CCH) ¶ 75,032, appeal argued, No. 06-60023 (5th Cir. Mar. 5, 2007) ("NTSP").

[29] At this point in the analysis, TriState "need only articulate a legitimate justification, and is not obliged to prove the competitive benefits." NTSP at 12.

[30] As the Commission explained in NTSP, the "concept of ancillary restraints, which allows an agreement that would otherwise be viewed as a naked restraint of trade to be evaluated in light of the procompetitive effects of an efficiency-enhancing integration of economic activity to which it is reasonably related, is subsumed in the Commission's Polygram analysis." Id. at 13 n. 20.

[31] Letter from David R. Pender, Acting Assistant Director, Bureau of Competition, to Clifton E. Johnson, Esq., Hall, Render, Killian, Heath & Lyman (March 28, 2006), available at http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf ("SHO"). See also, NTSP at 33 ("... if an IPA can establish that its joint negotiation of price is reasonably related to an efficiency-enhancing integration of the participants' economic activity and is reasonably related to achieve the procompetitive benefits of that integration, the price-related activities may be lawful.").

and the primary question becomes whether, through TriState, its physicians would be able to exercise market power.

1. Efficiency-enhancing Integration

TriState's integration strategy should create a degree of interdependence and facilitate collaboration among its members in their provision of care to their patients in ways that should generate significant cost and quality efficiencies. As explained above, TriState members are working together to develop and implement "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants."[32] The QIC is reviewing EBM Connect guidelines and developing Care Protocols, which the TriState physicians will incorporate into their practices. The physicians, individually and through TriState's committees, will track their quality and cost performance using the Clinical Claims Chart. The SIC will evaluate the physicians' progress, work to improve individual's and the network's quality, and recommend, if necessary, expulsion of persistently underachieving members. To further control costs and assure quality of care, the UM/QA committee will "establish[] mechanisms to monitor and control utilization of health care services" and develop policies and programs to integrate medical management services into the physicians' practices.[33] Thus, the quality of services the TriState physicians provide should improve, and health-care services and resources will be delivered and utilized more efficiently. Patients should also benefit from the time saved by the TriState physicians' use of the Clinical Claims Chart and electronic exchange of referral information.

The program's success will require a portion of the members' capital contributions to finance the infrastructure and HIT. The 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.

2. An Ancillary Agreement

TriState's contracting on behalf of its physician members will substantially enhance the success of its integrated product. TriState's contracting will be "part of a larger endeavor whose success they promote."[34] The following interrelated reasons provide "logical nexus[es]" between TriState's joint contracting and its achievement of

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[32] Statements, Statement 8.B.1.

[33] Id.

[34] Polk Bros., Inc. v. Forest City Enter., Inc., 776 F.2d 185, 189 (7th Cir. 1985).

cost and quality efficiencies.[35] 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. Unless it sells its members' services as part of a single package, TriState cannot discern how it will be able to ensure that all of its physicians are included in each contracted payer's network. In this respect, the collective contracting "serves to make the main transaction [the integration of medical services] more effective in accomplishing its purpose" of improving the quality of medical care and reducing health care costs.[36]

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.

First, having the same network for all integrated product contracts is important to integrating the quality improvement initiatives and medical management services into the physicians' practices. Maximizing the physicians' collective participation in payer contracts for the integrated product will, by extension, maximize the number of patients in each physician's practice covered by the integrated product. Each integrated-product 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 the TriState physicians engage in integrative activities, the more interdependent they become, increasing the likelihood they will achieve the anticipated cost and quality efficiencies.

Second, and related to the first, by having a single integrated network provide services under its integrated product contracts, TriState will be able to reinforce its in-network referral policy, ensuring that patients stay within the TriState network to the greatest extent possible. In-network referrals are important to TriState's integration strategy because each time a TriState patient goes out of network, TriState loses an opportunity to gather information for the Clinical Claims Chart, to ensure physicians have an accurate record of care, to improve the health of that patient, and to control the costs of the patient's care. If TriState's network changed from contract to contract, it would be difficult to ensure that referrals stay within the appropriate network because the TriState providers could not be certain that all TriState providers were part of a payer's network. Having a single, integrated network for every payer with which TriState contracts ensures that the TriState physicians will be able to keep referrals in the network for all services TriState physicians provide. In addition, TriState intends to seek contractual reinforcement

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[35] NTSP at 29.

[36] Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210, 224 (D.C. Cir. 1986).

from payers of its in-network referral policy. TriState's current self-insured-employer contracts through InforMed provide coverage through a tiered network—TriState is the first tier, contracted out-of-county and tertiary-care providers are the second tier, and a national rental PPO network is the third tier. Patients have a financial incentive, through lower co-payments and coinsurance, to stay within the TriState network, the first tier. InforMed data suggests that this tiered system has successfully limited out-of-TriState referrals, and TriState intends to negotiate for the inclusion of a similar tiered system in its payer contracts for its clinical integration product.

Third, joint contracting provides an important incentive for the TriState physicians to develop and implement the clinical integration program. "A restraint is ancillary when it may contribute to the success of a cooperative venture that promises greater productivity and output."[37] Absent assurance of participation in TriState's contracts, and thus a share of the revenue generated by those contracts, the physicians would have less incentive to devote substantial time to 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. Without the physicians' investment of time in developing and implementing the clinical integration strategy, there will be no integrated product for TriState to sell. Thus, collective negotiations are integral to the clinical-integration strategy's success.

Fourth, TriState's offering a single network for its integrated product, and requiring all members to participate in all network contracts, ensures that its network is readily identifiable by payers and their subscribers. When payers contract with a physician organization, it is often important to them that the organization provides an accurate list of its providers and guarantees those providers' participation. Only by contracting on behalf of all members, and requiring its members' participation in those contracts, can TriState ensure that payers will get the full network and thus that they need not negotiate contracts with numerous individual physicians as well.[38] Likewise, when patients sign up for benefits, they want to be able to quickly determine whether their physicians are in the payer's network. If it's clear that all TriState physicians must participate in a payer's TriState network, patients will not need to rely on the accuracy of provider directories.

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[37] Polk Bros., 776 F.2d at 189.

[38] Payers will also get the benefit of the transaction cost efficiencies from single-signature contracting. Although these efficiencies may be insufficient by themselves to justify TriState's collective contracting, their value to payers should be considered in light of the other proffered justifications. See generally, Broadcast Music, Inc. v. Columbia Broad. Sys., 441 U.S. 1 (1979).

Finally, having a single network will reduce TriState's administrative burdens and increase operational efficiencies. TriState won't have to deal with problems of monitoring and enforcing guidelines and protocols for different physicians for different contracts. It also will not need to create different lists of physicians for its online referral system.

D. No Adverse Effects on Competition

TriState's contracting on the collective behalf of its physicians is unlikely to have adverse consequences on competition in the markets for physician services.[39] First, TriState will take steps to prevent any anticompetitive spillover. Second, TriState will not have market power.

1. No anticompetitive Spillover

In the context of provider-controlled contracting networks, anticompetitive spillover effects can occur when pricing information, legitimately obtained and used by the network, is disseminated to, or otherwise obtained by, network physicians. The concern is that the physicians may use that information in establishing the prices for their services sold outside the network. To prevent this, TriState will take preventive steps. First, TriState will limit its members' access to competitively sensitive information. Second, it will provide antitrust counseling to members of the committees responsible for dealing with competitively sensitive information and antitrust guidelines to its members. Finally, it 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 TriState is developing its fee proposals, TriState's PHO External Relations Representative—a non-physician staff person—will conduct the surveys of member practices. Only non-physician staff, who will aggregate the information and destroy records from individual practices, will view physicians' prices.

Once a contract is in place and the physicians begin rendering services, the members of the UM/QA and SIC 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.

In addition, TriState's committee and board members will receive antitrust counseling to keep competitively sensitive information confidential, not to use TriState's

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[39] The Commission stated in NTSP, "A defendant can avoid summary condemnation, however, if it can advance a legitimate justification . . . '[s]uch justifications may consist of plausible reasons why practices that are competitively suspect as a general matter may not be expected to have adverse consequences in the context of the particular market in question'." NTSP at 12 (emphasis added) (citation omitted).

information for any business they conduct outside TriState, and not to discuss or exchange their own prices or competitive terms. All committee and board members will be required to sign confidentiality agreements, prohibiting them from disclosing competitively sensitive information to anyone outside their committee or board. If TriState learns of any such disclosure, it will enforce the confidentiality agreement and remove the individual(s) from the committee or board.

2. No Market Power

If TriState does not have "sufficient market power to restrain competition substantially...the inquiry is at an end; the practice is lawful."[40] TriState's participation percentage of physicians in Washington County will be high in some specialties, but TriState will be truly non-exclusive. Accordingly, TriState will not have market power.

a. Participating Physicians[41]

Short of litigation, defining the market and calculating market shares would be impossible. Although most of TriState's member physicians have offices in Hagerstown, the center of TriState's primary service area, they draw patients from a broad geographic area. TriState's secondary service area includes parts of Frederick County, Maryland, southern portions of Franklin and Fulton Counties in Pennsylvania, and Morgan, Berkeley and Jefferson Counties in West Virginia. Within the secondary service area, there are roughly 1,200 physicians, of which 16 percent are TriState's members.[42]

The vast majority of TriState members have admitting privileges at WCH.[43] As a group, TriState members comprise 64 percent of WCH's medical staff. In most specialties, they constitute half or more of the physicians with admitting privileges (anesthesiology, cardiology, family medicine, internal medicine, nuclear medicine, obstetrics/gynecology, oral & maxillofacial surgery, orthopedics, pediatrics, physical medicine, plastic surgery, podiatry, radiation oncology, and radiology). TriState's

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[40] General Leaseways, Inc. v. Nat'l Truck Leasing Ass'n, 744 F.2d 588, 596 (7th Cir. 1984).

[41] Because TriState does not know which, if any, of its contracted providers will participate in the clinical integration strategy, the TriState contracted providers are not included in the participation percentages. TriState does not believe this omission will greatly distort the numbers, as it is likely that a portion of its Class I Members will decide not to participate, as well.

[42] See Exhibit 10 (listing the providers by specialty). The source for the information was the American Medical Association broker listing.

[43] See Exhibit 2 (listing all TriState members, contracted providers and all physicians with admitting privileges at WCHA). Some TriState members do not have admitting privileges at WCH; they rely upon hospitalists to admit and care for patients who need inpatient care at WCH.

members comprise 100 percent of the physicians with privileges in 10 specialties (allergy, endocrinology, gastroenterology, infectious disease, neurosurgery, hematology/oncology, otolaryngology, pain management, and pathology). These percentages are somewhat deceptive, though, as there are small total numbers of physicians in many of these specialties. Although TriState does not expect all of its members to participate in the clinical integration strategy, it hopes that most will so that it can maintain adequate geographic and specialty coverage. TriState's clinical integration strategy will be most effective when it is able to provide all medical care with in-network providers.

Market shares, or participation percentages as proxies, are only one factor bearing on market power, as the Competitor Collaboration Guidelines recognize.[44] Even more important is "the extent to which the relevant agreement is non-exclusive in that participants are likely to continue to compete independently outside the collaboration in the market in which the collaboration operates."[45] If a network is truly non-exclusive, the physicians cannot obtain, or exercise, market power by contracting jointly through the network because all the alternatives that were available to payers remain available. All the network does is provide an additional competitive option.[46]

b. Non-exclusivity

TriState will be both *de jure* and *de facto* non-exclusive. If a payer does not want to contract with TriState, or cannot reach an agreement regarding contract terms, it will be free to contract directly with TriState's physicians. Because it is currently non-exclusive and its members contract directly with most payers, TriState has little concern about continuing to operate on a non-exclusive basis. It will, however, emphasize to its members that they may contract directly with any payer with which TriState does not have a contract. In addition, when payers notify TriState that they would prefer to contract with the physicians directly, TriState will send out notices to its providers to ensure they are aware of contracting opportunities and know that they are free to enter contracts with those payers. Thus, TriState's physicians will be available to, and in fact will, provide services to payers outside of TriState's programs.

TriState's administrative staff, who will be responsible for dealing with payer representatives, will receive antitrust counseling to ensure that they understand non-exclusivity, including the fact that payers must be free to decide whether to contract with

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[44] ABA Section of Antitrust Law, Joint Ventures: Antitrust Analysis of Collaborations Among Competitors § 3.34 (2006).

[45] Id.

[46] Cf. Wis. Music Network v. Muzak Ltd. Partnership, 5 F.3d 218, 222 (the "program enhances competition by increasing the available choices for . . . customers").

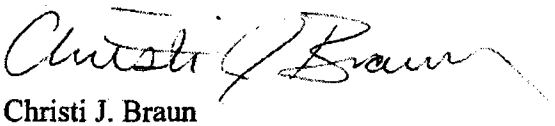
TriState. Although TriState will make every effort to market its integrated product on its merits, payers wishing to contract with TriState's physicians outside of the TriState's program will be able to do so. TriState will take no action to prevent the payer from contracting with its members directly.

V. Conclusion

TriState's goal, in implementing its clinical integration strategy, is to help provide a solution to the rising cost of health care for Washington County employers. Through the cooperation and collaboration of its physicians, TriState's integrated product should improve the quality and cost-effectiveness of the health care services its physicians deliver and should, therefore, provide important benefits to patients, employers, and payers. A secondary goal of the clinical integration strategy is to support the independently practicing physicians by giving them the tools to provide better care to their patients and helping them to produce a premium product for which purchasers are willing to pay a higher price. The program should benefit all three stakeholders—patients, payers, and physicians.

Pursuant to Federal Trade Commission Procedure Rule 1.4, 16 C.F.R. § 1.4 (2006), GRIPA requests that portions of this letter, as well as certain documents attached as exhibits hereto, be treated as confidential under Federal Trade Commission Procedure Rule 4.10, 16 C.F.R. § 4.10(a)(2) (2006), and § 6(f) of the Federal Trade Commission Act, 15 U.S.C. § 46(f) (2006). All information to be withheld is competitively sensitive information, including pricing, costs and information subject to confidentiality agreements, patents, or copyright protection.

Sincerely yours,



Christi J. Braun

Exhibit 1

BYLAWS OF

TRI-STATE HEALTH PARTNERS, INC.

Exhibit 2

Exhibit 2

TriState Physicians and Physicians with WCHA Privileges

Last	First	Middle	Title	Physicians Practice Group	Specialty Description	City	WCHA Hosp. Priv.	WCHSI employee	TriState Member	TriState Contracted	Other Hosp. Priv.
Mauriello	Paul		MD	Mauriello & Orfan, PA	Allergy/Immunology	Hagerstown	x		x		
Orfan	Nicholas		MD	Mauriello & Orfan, PA	Allergy/Immunology	Hagerstown	x		x		
Ajrawat	Satinder		MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Bradford	Norman	F.	MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Carpentieri	Richard	F.	MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Cifor	Sandra		DO	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Cios	Jerzy	H.	MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Cutler	Carlo		DO	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x				
D'Alauro	Frederic	S.	MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Horn	Michael		MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Kataria	Bideshwar		MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x				
Magnus	Adam	C	MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x				
Monteblanco	Sofia		DO	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x				
Shank	Luigina		MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Trevan (Bachenheimer)	Lisa	C.	MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x				
Wertheimer	Barry		MD	Blue Ridge Anesthesia Associates, LLC	Anesthesiology	Hagerstown	x		x		
Soodan	Ajay		MD	Baltimore Heart Associates, P.A.	Cardiac Electrophysiology	Randallstown	x				
Hornbaker	John	H.	MD	Cardiac Diagnostic Center	Cardiology	Hagerstown	x		x		
Amegashie	Ernest	Kojo	MD	Cardio-Vascular Center of Hagerstown	Cardiology	Hagerstown	x		x		
Faridi	Zubair	H	MD	Hagerstown Heart	Cardiology	Hagerstown	x		x		

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TriState Physicians and Physicians with WCHA Privileges

Last	First	Middle	Title	Physicians Practice Group	Specialty Description	City	WCHA Hosp. Priv.	WCHSI employee	TriState Member	TriState Contracted	Other Hosp. Priv.
Hamilton	Scott	Martin	MD	Hagerstown Heart	Cardiology	Hagerstown	x		x		
Hood	W.	Stephen	MD	Hagerstown Heart	Cardiology	Hagerstown	x		x		
Jones	Jeffrey	D	MD	Hagerstown Heart	Cardiology	Hagerstown	x		x		
Notabartolo	Dean		MD	Hagerstown Heart	Cardiology	Hagerstown	x		x		
Papuchis	Gary	C.	MD	Hagerstown Heart	Cardiology	Hagerstown	x		x		
Reilly	Joseph	M.	MD	Hagerstown Heart	Cardiology	Hagerstown	x		x		
Carlos	Michael	E	MD	Robinwood Heart Center	Cardiology	Hagerstown	x				
Haque	Reyaz	Ul	MD	Robinwood Heart Center	Cardiology	Hagerstown	x				
Padder	Feroz	Ahmad	MD	Robinwood Heart Center	Cardiology	Hagerstown	x		x		
Zirvi	Khalid	Mahmood	MD	Robinwood Heart Center	Cardiology	Hagerstown	x		x		
Donofrio	Mary	Teresa	MD	Children's National Medical Center	Cardiology, Pediatric	Washington, DC	x				
Doroshow	Robin	Winkler	MD	Children's National Medical Center	Cardiology, Pediatric	Washington, DC	x				
Nahar	Jai	K	MD	Children's National Medical Center	Cardiology, Pediatric	Washington, DC	x				
Spurney	Christopher	Fore	MD	Children's National Medical Center	Cardiology, Pediatric	Washington, DC	x				
Rumbarger	Tara	A	MD	Drs. Rumbarger & Schiro, PA	Dermatology	Hagerstown	x		x		
Schiro	James		MD	Drs. Rumbarger & Schiro, PA	Dermatology	Hagerstown	x		x		
Waldman	Paul		MD	Drs. Waldman & Money, PA	Dermatology	Hagerstown	x		x		
Barrueto	Fermin		MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Bernius	Morgen	Joliette	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Corwell	Brian	Aiall	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Darling	Robert	G.	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x			x	
Gaibi	Tanveer		MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Gilbert	Thomas	J.	DO	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x			x	
Helinski	Christine	LaRue	M.D.	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Kadiwar	Jayantilal		MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x			x	
Kotch	Stephen	J.	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				

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Liferidge	Aisha	Towana	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Malik	Mohammad	R.	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Mayo	Douglas	David	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
O'Mara	Sean	Joseph	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Prisk	David		DO	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Schruefer	John	Michael	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Stone	Roger	M.	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Twanmoh	Joseph	R	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Van Wie	Donald	Francis	DO	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Wegner	Scott	A	MD	Washington County Emergency Physicians, LLC	Emergency Medicine	Hagerstown	x				
Ellis	Vicki	Elaine	MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				
Folino	Lucille		DO	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				
Fowler	Sandra		MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				
Kugler	R.	Lawrence	MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x		x		
Pickard	Sybil	Dawn	MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				
Scherer	Patricia	DuPuis	MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				
Thompson	Edward	Monroe	MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				
Vandenbosche	Robert	C.	MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				

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Womeldorf	Susan		MD	Washington County Emergency Physicians, LLC	Emergency Medicine, Ex	Hagerstown	x				
El-Khodary	Ashraf		MD	Robinwood Endocrinology	Endocrinology	Hagerstown	x	x	x		
Maldonado-Brem	Adriana	Catalina	MD	Robinwood Endocrinology	Endocrinology	Hagerstown	x	x	x		
Lippman	Stephen		MD	Stephen S. Lippman, MD	Endocrinology	Hagerstown	x		x		
Krempel-Portier	Bonita		DO	Emmittsburg Osteopathic Primary Care Center, Inc.	Family Practice	Thurmont				x	x
Uzicanin	Ernest		MD	Ernest Uzicanin, M.D.	Family Practice	Hagerstown	x		x		
Guedenet	Robert	J.S.	MD	Family Medicine Center	Family Practice	Keedysville	x		x		
Blash	Steven	J.	MD	Hager Park Health Center	Family Practice	Hagerstown	x				
Shranatan	Larry	J.	DO	Hager Park Health Center	Family Practice	Hagerstown	x				
Shranatan	Sheila		DO	Hager Park Health Center	Family Practice	Hagerstown	x				
Xu	Guoping		MD	Hager Park Health Center	Family Practice	Hagerstown	x				
Bui	Tu		MD	Hagerstown Family Medicine, PC	Family Practice	Hagerstown	x		x		
Saxena	Preeti		MD	Hagerstown Family Medicine, PC	Family Practice	Hagerstown	x		x		
Saxena	Sanjay		MD	Hagerstown Family Medicine, PC	Family Practice	Hagerstown	x		x		
Mahmood	Shahid		MD	Howard N. Weeks, M.D., P.A.	Family Practice	Hagerstown	x				
Weeks	Howard		MD	Howard N. Weeks, M.D., P.A.	Family Practice	Hagerstown	x		x		
Qadir	Ghazala		MD	Malik & Qadir, PA	Family Practice	Boonsboro	x		x		
Ditto	Allen	W.	MD	Potomac Family Medicine	Family Practice	Hagerstown	x		x		
Kutzera	William	E.	MD	Potomac Family Medicine	Family Practice	Hagerstown	x		x		
Metzner	Stephen	E.	MD	Potomac Family Medicine	Family Practice	Hagerstown	x		x		
Strauss	Kelli	A.	MD	Potomac Family Medicine	Family Practice	Hagerstown	x		x		
Lynch	Robert		MD	Robert Lynch, MD	Family Practice	Martinsburg				x	x
Beckwith	Matthew		MD	Robinwood Family Practice	Family Practice	Hagerstown	x	x	x		
Brown	Stephanie	Denise	MD	Robinwood Family Practice	Family Practice	Hagerstown	x	x	x		
Joy	Teresa	M.	DO	Robinwood Family Practice	Family Practice	Hagerstown	x	x			
Patalinghug	Neal		MD	Robinwood Family Practice	Family Practice	Hagerstown	x	x	x		
Royster	William	E.	MD	Robinwood Family Practice	Family Practice	Hagerstown	x	x	x		
Bodenheimer	William	F.	MD	South Mountain Family Practice	Family Practice	Boonsboro	x		x		
Hahn	Matthew		MD	TriState Community Health Center	Family Practice	Hancock			x		
Datta	Vasant		MD	Vasant Datta, MD	Family Practice	Funkstown	x		x		
Haeckler	Barbara		MD	Walnut Street Community Health Center	Family Practice	Hagerstown			x		
Koilpillai	Gnanaraj		MD	Walnut Street Community Health Center	Family Practice	Hagerstown			x		

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Riggle	Martha		MD	Walnut Street Family Practice	Family Practice	Hagerstown			x		
Gallow	Gary		MD	Waynesboro Family Medical Associates	Family Practice	Waynesboro				x	x
Rettig	Stephen		MD	Waynesboro Family Medical Associates	Family Practice	Waynesboro				x	x
Stewart, III	Joseph		MD	Waynesboro Family Medical Associates	Family Practice	Waynesboro				x	x
Buchanan	Sarah		MD	Williamsport Family Practice	Family Practice	Williamsport		x	x		
Ciccarelli	K.	Jill	MD	Williamsport Family Practice	Family Practice	Williamsport	x	x	x		
Gibson	Matthew	Howard	MD	Williamsport Family Practice	Family Practice	Williamsport	x	x	x		
Rao	Samuel	Jayakara	MD	Williamsport Family Practice	Family Practice	Williamsport	x	x	x		
Bolarum	Praveen	K.	MD		Family Practice	Hagerstown	x				
Cremins	James		MD	Digestive Disorders Consultants	Gastroenterology	Hagerstown	x	x	x		
Ferreira	Nelson	L.	MD	Digestive Disorders Consultants	Gastroenterology	Hagerstown	x	x	x		
Lewis	Christine	P.	MD	Digestive Disorders Consultants	Gastroenterology	Hagerstown	x	x	x		
Tayler	Juan	A.	MD	Digestive Disorders Consultants	Gastroenterology	Hagerstown	x	x	x		
Enam	Pear	M	MD	Gastroenterology Associates	Gastroenterology	Hagerstown	x		x		
Trace	Robert	J	MD	Robert J. Trace, MD	Gastroenterology	Hagerstown	x		x		
Graves	William		MD	Graves Medical Practice	General Practice	Berkeley Springs				x	x
Milroth	William		MD	William Milroth, MD	General Practice	McConnellsburg				x	x
Uchino	Itsuro	John	MD	Center for Vein Medicine	General Surgery	Hagerstown	x				
Chaney	Charles	R.	MD	Charles R. Chaney, M.D.	General Surgery	Hagerstown	x			x	
Sachs	Stephen	M.	MD	Hagerstown Surgical Clinic	General Surgery	Hagerstown	x		x		
Collins	Frank	J	MD	Potomac Surgical Specialists, LLC	General Surgery	Hagerstown	x		x		
Hobart	Dona	C.	MD	Potomac Surgical Specialists, LLC	General Surgery	Hagerstown	x		x		
Nguyen	Anhtai	H.	MD	Potomac Surgical Specialists, LLC	General Surgery	Hagerstown	x		x		
Su	William	T.	MD	Potomac Surgical Specialists, LLC	General Surgery	Hagerstown	x		x		
Weinberg	Daniel	J.	MD	Potomac Surgical Specialists, LLC	General Surgery	Hagerstown	x		x		
Riggle	Karl	P.	MD	TriState Surgeons, LLC	General Surgery	Hagerstown	x		x		
Omeish	Esam	S.	MD	Esam S. Omeish, M.D.	General Surgery, Trauma	Hagerstown	x				
Kross	Marc	E.	MD	Marc E. Kross, MD	General Surgery, Trauma	Hagerstown	x	x	x		
Espinoza	Alida		MD	Antietam Oncology and Hematology Group, PC	Hematology/Oncology	Hagerstown	x		x		

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TriState Physicians and Physicians with WCHA Privileges

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Hamdan	Hind		MD	Antietam Oncology and Hematology Group, PC	Hematology/Oncology	Hagerstown	x		x		
Kass	Frederic	H	MD	Drs Newman, Wooster, Kass, Bradford & McCormack PA	Hematology/Oncology	Hagerstown	x		x		
McCormack	Michael	J.	MD	Drs Newman, Wooster, Kass, Bradford & McCormack PA	Hematology/Oncology	Hagerstown	x		x		
Agyako-Wiredu	David	A.	MD	Osler Inpatient Services	Hospitalist	Hagerstown	x			x	
Baran	Mark	S.	MD	Osler Inpatient Services	Hospitalist	Hagerstown	x			x	
Daniels	Francisco	A.	MD	Osler Inpatient Services	Hospitalist	Hagerstown	x			x	
Hubbly	Madhavi		MD	Osler Inpatient Services	Hospitalist	Hagerstown	x			x	
Kalka	Jaroslaw	R	MD	Osler Inpatient Services	Hospitalist	Hagerstown	x			x	
Kurapaty	Mercy	S	MD	Osler Inpatient Services	Hospitalist	Hagerstown	x				
Mbaoua	Judith		MD	Osler Inpatient Services	Hospitalist	Hagerstown	x			x	
Syed	Gaffar	A	MD	Osler Inpatient Services	Hospitalist	Hagerstown	x			x	
Delaportas	Dino	J.	MD	Dr. Dino J. Delaportas, PA	Infectious Disease	Hagerstown	x		x		
Asmar	Pierre		MD	Pierre Asmar, MD	Infertility/Reproductive Endocrinology	Annandale				x	x
Cohen	Barry	M.	MD	Barry M. Cohen, MD	Internal Medicine	Hagerstown	x			x	
Kuttner-Sands	Cynthia		MD	Cynthia Kuttner-Sands, MD	Internal Medicine	Hagerstown	x		x		
Higginbotham	Lisa	Kathleen	MD	Dr. Dino J. Delaportas, PA	Internal Medicine	Hagerstown	x		x		
Bradford	Pamela	F.	MD	Drs Newman, Wooster, Kass, Bradford & McCormack PA	Internal Medicine	Hagerstown	x		x		
Hurwitz	Jeffrey	D.	MD	Drs Newman, Wooster, Kass, Bradford & McCormack PA	Internal Medicine	Hagerstown	x		x		
Newman	George	C.	MD, PhD	Drs Newman, Wooster, Kass, Bradford & McCormack PA	Internal Medicine	Hagerstown	x		x		
Money	Mary	E.	MD	Drs. Waldman & Money, PA	Internal Medicine	Hagerstown	x		x		
Murshed	Farid		MD	Farid Murshed, M.D.	Internal Medicine	Hagerstown	x				
Andrade	Francisco	L.	MD	Francisco Andrade, MD	Internal Medicine	Hagerstown	x		x		
Hanif	Rashid		MD	Gastroenterology Associates	Internal Medicine	Hagerstown	x		x		
Theodoru	Radu	M	MD	Hager Park Health Center	Internal Medicine	Hagerstown	x				
Peprah	Koduah		MD	Internal Medicines Physicians, P.A.	Internal Medicine	Hagerstown	x				
Correces	Jerry	L	MD	Jerry L. Correces, MD, PC	Internal Medicine	Hagerstown	x		x		
Waseem	M.	Khalid	MD	Khalid M. Waseem, MD	Internal Medicine	Hagerstown	x		x		
Malik	Zafar	M	MD	Malik & Qadir, PA	Internal Medicine	Boonsboro	x		x		

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Bansal	Rina		MD	Manzar J. Shafi, M.D., P.A.	Internal Medicine	Hagerstown	x				
Shafi	Manzar	J.	MD	Manzar J. Shafi, M.D., P.A.	Internal Medicine	Hagerstown	x		x		
Brull	Robert		MD	Robert Brull, MD, PA	Internal Medicine	Hagerstown	x		x		
Hatleberg	Steven	L.	MD	Robinwood Internal Medicine	Internal Medicine	Hagerstown	x	x	x		
Krishnamoorthy	Mahesh		MD	Robinwood Internal Medicine	Internal Medicine	Hagerstown	x	x	x		
McDougal	Dan	H.	MD	Robinwood Internal Medicine	Internal Medicine	Hagerstown	x	x	x		
Sluder	Colleen		DO	Robinwood Internal Medicine	Internal Medicine	Hagerstown	x	x	x		
Chan	Samuel		MD	Samuel Chan, MD	Internal Medicine	Hagerstown	x		x		
Pasha	Tanvir		MD	Tanvir A. Pasha, MD	Internal Medicine	Hagerstown	x		x		
Brown-Tisdale	Chuckia	Nicole	MD	Women's Specialty Associates	Internal Medicine	Hagerstown	x	x	x		
Bonham	Brian	Kent	MD	Smithsburg Family Medical Center	Internal Medicine/ Pediatrics	Smithsburg	x	x	x		
Brown	Gail	M.	MD	Smithsburg Family Medical Center	Internal Medicine/ Pediatrics	Smithsburg	x	x	x		
Cantone	Vincent		MD	Smithsburg Family Medical Center	Internal Medicine/ Pediatrics	Smithsburg	x	x	x		
Henderson	Laura	E.	MD	Smithsburg Family Medical Center	Internal Medicine/ Pediatrics	Smithsburg	x	x	x		
Kerns	William	B.	MD	Smithsburg Family Medical Center	Internal Medicine/ Pediatrics	Smithsburg	x	x	x		
Reed	John	P	MD	Smithsburg Family Medical Center	Internal Medicine/ Pediatrics	Smithsburg	x	x	x		
Reeves	Inez	V	MD	Neonatology Associates, PC	Neonatal/Perinatal Medicine	Hagerstown	x				
Sukumar	Minakshi		MD	Neonatology Associates, PC	Neonatal/Perinatal Medicine	Hagerstown	x				
Anadu	Juliet	Ifeoma	MD	Neonatology Associates, PC	Neonatology	Hagerstown	x				
Gomez Prosper	Laura		MD	Neonatology Associates, PC	Neonatology	Hagerstown	x				
Koso-Thomas	Marion		MD	Neonatology Associates, PC	Neonatology	Hagerstown	x				
Ngwana-Mondoa	Theresa	E	MD	Neonatology Associates, PC	Neonatology	Hagerstown	x				
Nigam	Madhu		MD	Neonatology Associates, PC	Neonatology	Hagerstown	x				
Rost	James	Robert	MD	Neonatology Associates, PC	Neonatology	Hagerstown	x				
Uddin	Zia		MD	Neonatology Associates, PC	Neonatology	Hagerstown	x				
Johnson	William	H.	MD	Kidney Center of Hagerstown	Nephrology	Hagerstown	x				
Mishra	Tanuja		MD	Kidney Center of Hagerstown	Nephrology	Hagerstown	x				
Romanic	Branislav	S.	MD	Kidney Center of Hagerstown	Nephrology	Hagerstown	x				

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Adler	Oscar		MD, PhD	Meadow Kidney Care	Nephrology	Hagerstown	x				
Nahar	Anita		MD	Meadow Kidney Care	Nephrology	Hagerstown	x		x		
Roza	Eli		MD	Meadow Kidney Care	Nephrology	Hagerstown	x		x		
Welch	Paul	G.	MD	Meadow Kidney Care	Nephrology	Hagerstown	x		x		
Khan	Mehrullah		MD	Antietam Neurology Center, P.A.	Neurology	Hagerstown	x		x		
Anwar	Samina		MD	Neurology Consultants, PA	Neurology	Hagerstown	x		x		
Furlow	Thomas	W.	MD	Parkway Neuroscience and Spine Institute	Neurology	Hagerstown	x		x		
Dave	Prafull	K	MD	Prafull K. Dave, M.D.	Neurology		x				
Mir	Sarim		MD	Sarim R. Mir, MD, PA, Inc.	Neurology	Hagerstown			x		
Ali	Jamal		MD	Tristate Neurology Center	Neurology	Hagerstown	x		x		
Caruso	John	Robert	MD	Parkway Neuroscience and Spine Institute	Neurosurgery	Hagerstown	x		x		
Holmes	Brian		MD	Parkway Neuroscience and Spine Institute	Neurosurgery	Hagerstown	x		x		
O'Malley	Neil	P.	MD	Parkway Neuroscience and Spine Institute	Neurosurgery	Hagerstown	x		x		
Radley	Michael	G	MD	Parkway Neuroscience and Spine Institute	Neurosurgery	Hagerstown	x		x		
Sachariah	K.	George	MD	K. George Sachariah, M.D. & Associates, P.A.	Nuclear Medicine	Hagerstown	x		x		
Magram	Martin	Y.	MD	Martin Y. Magram, M.D.	Nuclear Medicine	Hagerstown	x		x		
Reba	Richard	C.	MD	Richard Reba, M.D.	Nuclear Medicine	Frederick	x				
Hudson	Chad		MD, PhD	Comprehensive Women's Care	OB/GYN	Hagerstown	x		x		
Kothari	Mitesh		MD	Comprehensive Women's Care	OB/GYN	Hagerstown	x		x		
Oh	Andrew	J.	MD	Comprehensive Women's Care	OB/GYN	Hagerstown	x		x		
Solberg	David	H.	MD	Comprehensive Women's Care	OB/GYN	Hagerstown	x		x		
Manger	George	E., Jr.	MD	George E. Manger, Jr., MD, PA	OB/GYN	Hagerstown	x		x		
Rider	Lynn	A.	MD	Lynn A. Rider, MD, PA	OB/GYN	Hagerstown	x		x		
Ginter	Hilary	W.	MD	Mid-Atlantic Women's Health Center	OB/GYN	Hagerstown	x		x		
Greenberg	Jay	B.	MD	Mid-Atlantic Women's Health Center	OB/GYN	Hagerstown	x		x		
Tramontana	Ann	M.	MD	Mid-Atlantic Women's Health Center	OB/GYN	Hagerstown	x		x		
Rosenshein	Neil	B.	MD	St. Paul Place Specialists	OB/GYN	Baltimore	x			x	

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Andele	Adjoavi (Bella)	Fakonam	MD	Women's Health Center at Robinwood	OB/GYN	Hagerstown	x	x	x		
Hamilton	William	C	MD	Women's Health Center at Robinwood	OB/GYN	Hagerstown	x	x	x		
Riddell	Scott	Robert	MD	Women's Health Center at Robinwood	OB/GYN	Hagerstown	x	x	x		
Smith	Gary	W.	MD	Women's Health Center at Robinwood	OB/GYN	Hagerstown	x	x	x		
Mullick	Jowheri		MD	Women's Specialty Associates	OB/GYN	Hagerstown	x	x	x		
Fanale	Jack	Michael	MD		OB/GYN		x				
Bergman	Erik	A.	MD	Bergman Eye Associates	Ophthalmology	Hagerstown	x			x	
Henry	John	Christopher	MD	Bergman Eye Associates	Ophthalmology	Hagerstown	x			x	
Patel	Chetankumar	Bhikhubhai	MD	Cumberland Valley Retina Consultants, PC	Ophthalmology	Hagerstown	x				
Wroblewski	John	J.	MD	Cumberland Valley Retina Consultants, PC	Ophthalmology	Hagerstown	x		x		
Edmonds	Craig		MD	Hagerstown Eye Specialists	Ophthalmology	Hagerstown	x			x	
Keener	Wilmer	J.	MD	Hagerstown Eye Specialists	Ophthalmology	Hagerstown	x			x	
Facchina	Stephen		MD	Ludwick Eye Center	Ophthalmology	Chambersburg, PA	x				
Danziger	Peter	F.	MD	Peter F. Danziger, MD, PA	Ophthalmology	Hagerstown	x				
Tash	Dara		MD	Retina Center of Western Maryland	Ophthalmology	Hagerstown	x				
Parnes	Robert	E.	MD	Robert E. Parnes, M.D., L.L.C.	Ophthalmology	Hagerstown	x		x		
Glaser	Stephen	R	MD		Ophthalmology		x				
Jensen	Allison		MD		Ophthalmology		x				
Nelson	Howard		DDS	Associated Oral & Maxillofacial Surgeons	Oral & Maxillofacial Surgery	Hagerstown			x		
Pike	Jon		DDS	Associated Oral & Maxillofacial Surgeons	Oral & Maxillofacial Surgery	Martinsburg				x	
Russell	W. Dean		DDS	Associated Oral & Maxillofacial Surgeons	Oral & Maxillofacial Surgery	Martinsburg				x	
Zwack	William		DDS	Associated Oral & Maxillofacial Surgeons	Oral & Maxillofacial Surgery	Hagerstown			x		
Pearlman	Jeffrey		DDS	Jeffrey Pearlman, D.D.S.	Oral Surgery	Hagerstown	x				
Behan	Richard	L.	DDS	Oral & Facial Surgery	Oral Surgery	Hagerstown	x		x		
Koterwas	Gary	E.	DDS	Oral & Facial Surgery	Oral Surgery	Hagerstown	x		x		

Exhibit 2

TriState Physicians and Physicians with WCHA Privileges

Last	First	Middle	Title	Physicians Practice Group	Specialty Description	City	WCHA Hosp. Priv.	WCHSI employee	TriState Member	TriState Contracted	Other Hosp. Priv.
Kramer	Richard	E.	DDS	Oral & Facial Surgery	Oral Surgery	Hagerstown	x		x		
Rothen	Roberta	L.	MD	Center for Joint Surgery & Sports Medicine	Orthopaedic Surgery	Hagerstown	x		x		
Salvagno	Ralph	T.	MD	Center for Joint Surgery & Sports Medicine	Orthopaedic Surgery	Hagerstown	x		x		
Amalfitano	Thomas	G	MD	Mid-Atlantic Orthopaedic Specialists, PC	Orthopaedic Surgery	Hagerstown	x		x		
Cirincione	Robert	J.	MD	Mid-Atlantic Orthopaedic Specialists, PC	Orthopaedic Surgery	Hagerstown	x		x		
Edwards	Bruce	N.	MD	Robinwood Orthopedic Specialists	Orthopaedic Surgery	Hagerstown	x		x		
Holobinko	Joseph	Newton	MD	Robinwood Orthopedic Specialists	Orthopaedic Surgery	Hagerstown	x		x		
Patterson	Donald	A.	MD	Robinwood Orthopedic Specialists	Orthopaedic Surgery	Hagerstown	x		x		
Winslow	Michael	A.	MD	Robinwood Orthopedic Specialists	Orthopaedic Surgery	Hagerstown	x		x		
Worrell	Scott	P.	MD	Robinwood Orthopedic Specialists	Orthopaedic Surgery	Hagerstown	x		x		
Brooks	Robert	L.	MD, PhD	Washington County Hospital	Orthopaedic Surgery	Hagerstown	x				
Milford	Richard	S.	MD	Mid-Atlantic Orthopaedic Specialists, PC	Orthopaedic Surgery, Hand	Hagerstown	x		x		
Stowell	Michael	T.	MD	Mid-Atlantic Orthopaedic Specialists, PC	Orthopaedic Surgery, Hand	Hagerstown	x		x		
Sherman	Gary	M.	MD	Robinwood Orthopedic Specialists	Orthopaedic Surgery, Hat	Hagerstown	x		x		
Supernavage	Charles	J.	MD	Charles J. Supernavage, MD, PC	Otolaryngology	Hagerstown	x		x		
Manilla	Anthony	Christopher	DO	Cumberland Valley ENT Consultants	Otolaryngology	Hagerstown	x		x		
McMahon	Steven	J.	MD	Cumberland Valley ENT Consultants	Otolaryngology	Hagerstown	x		x		
Saylor	Michael	J.	MD	Cumberland Valley ENT Consultants	Otolaryngology	Hagerstown	x		x		
Wathne	Jarl	T	MD	Cumberland Valley ENT Consultants	Otolaryngology	Hagerstown	x		x		
Bandy	Bibhas	C.	MD	Hagerstown Ear, Nose & Throat Associates	Otolaryngology	Hagerstown	x		x		
Olenczak	John	Edward	MD	Mid-Atlantic Orthopaedic Specialists, PC	Pain Management	Hagerstown	x		x		
El-Mohandes	Ali		MD	The Spine Center at the Center for Pain Management	Pain Management	Hagerstown	x		x		

Exhibit 2

TriState Physicians and Physicians with WCHA Privileges

Last	First	Middle	Title	Physicians Practice Group	Specialty Description	City	WCHA Hosp. Priv.	WCHSI employee	TriState Member	TriState Contracted	Other Hosp. Priv.
Loev	Marc	A	MD	The Spine Center at the Center for Pain Management	Pain Management	Hagerstown	x		x		
Dempsher	Chris	J.	MD	John G. Newby, MD, PC	Pathology	Hagerstown	x		x		
Mire	Gary	M.	MD	John G. Newby, MD, PC	Pathology	Hagerstown	x		x		
Newby	John	G	MD	John G. Newby, MD, PC	Pathology	Hagerstown	x		x		
O'Donoghue	Michael	J.	MD	John G. Newby, MD, PC	Pathology	Hagerstown	x		x		
Amponsem	Anthony	Amankwa	MD	Anthony Amponsem, M.D.	Pediatrics	Hagerstown	x				
Athey	Kristina	A.	MD	Antietam Pediatric & Adolescent Care	Pediatrics	Hagerstown	x		x		
Dwyer	Ruth	Choate	MD	Antietam Pediatric & Adolescent Care	Pediatrics	Hagerstown	x		x		
Oakley	Julia	D	MD	Antietam Pediatric & Adolescent Care	Pediatrics	Hagerstown	x		x		
Weaver	Leon	D.	MD	Antietam Pediatric & Adolescent Care	Pediatrics	Hagerstown	x		x		
Saif	Naheed	F.	MD	Clinic for Children, PA	Pediatrics	Hagerstown	x		x		
Khan	Shafaat	U.	MD	Hagerstown Pediatrics	Pediatrics	Hagerstown	x				
Iafolla	Ayne	Kimberly	MD	Neonatology Associates, PC	Pediatrics	Hagerstown	x				
Mustafa	Mahmoud	A.	MD	Partners in Pediatrics	Pediatrics	Hagerstown	x		x		
Obidi	Chukwuemeka		MD	Partners in Pediatrics	Pediatrics	Hagerstown	x		x		
Masood	Saqib		MD	The Children's Doctor	Pediatrics	Hagerstown	x			x	
Dawis	Maria	Agnes	MD	The Children's Doctor, LLC	Pediatrics	Hagerstown	x			x	
Shinaishin	Ahmed		MD	The Children's Doctor, LLC	Pediatrics	Hagerstown				x	
Strauss	Albert	J	MD	The Children's Doctor, LLC	Pediatrics	Hagerstown	x			x	
Becker	M.	Douglas	MD	Weiss, Becker & Shuster	Pediatrics	Hagerstown	x		x		
Budi	Atchuthanand		MD	Weiss, Becker & Shuster	Pediatrics	Hagerstown	x		x		
Shuster	Paul	E	MD	Weiss, Becker & Shuster	Pediatrics	Hagerstown	x		x		
Weiss	Robert	E.	MD	Weiss, Becker & Shuster	Pediatrics	Hagerstown	x		x		
Collins	Gary	Joseph	MD	Parkway Neuroscience and Spine Institute	Physical Med./ Rehabilitation	Hagerstown	x		x		
Sullivan	Daniel	J.	MD	Parkway Neuroscience and Spine Institute	Physical Med./ Rehabilitation	Hagerstown	x		x		
Efobi	Ngozi	Juliet	MD	Physical Medicine Specialists	Physical Med./ Rehabilitation	Hagerstown	x				
Yacyk	Mark	J	DO	Physical Medicine Specialists	Physical Med./ Rehabilitation	Hagerstown	x		x		

Exhibit 2

TriState Physicians and Physicians with WCHA Privileges

Last	First	Middle	Title	Physicians Practice Group	Specialty Description	City	WCHA Hosp. Priv.	WCHSI employee	TriState Member	TriState Contracted	Other Hosp. Priv.
Kosuri	Ramakrishna	R.	MD	Robinwood Orthopedic Specialists	Physical Med./ Rehabilitation	Hagerstown	x		x		
Albertoli	James	S.	MD	Allegheny Center Reconstructive Surgery	Plastic Surgery	Hagerstown	x				
Herrera	Aryeh	L.	MD	Allegheny Center Reconstructive Surgery	Plastic Surgery	Hagerstown	x				
Garazo	Henry		MD	Plastic Surgery Services	Plastic Surgery	Hagerstown	x			x	
Dimercurio	Salvatore		MD	Salvatore DiMercurio, MD, PA	Plastic Surgery	Hagerstown	x		x		
Michaels	Daniel	D.	DPM	Daniel D. Michaels, DPM, MS, LLC	Podiatry	Hagerstown	x		x		
Sanicola	Charles	P.	DPM	Drs. Charles P. & Karen F. Sanicola, DPM, PA	Podiatry	Hagerstown	x		x		
Sanicola	Karen	F.	DPM	Drs. Charles P. & Karen F. Sanicola, DPM, PA	Podiatry	Hagerstown	x		x		
Harrison	Todd	A.	DPM	Podiatry Associates of Hagerstown	Podiatry	Hagerstown	x		x		
Herman	Dale	S.	DPM	Podiatry Associates of Hagerstown	Podiatry	Hagerstown	x				
Roemer	Mark	A.	DPM	Podiatry Associates of Hagerstown	Podiatry	Hagerstown	x		x		
Rosenthal	Betsy	F	DPM	Podiatry Associates of Hagerstown	Podiatry	Hagerstown	x		x		
Smith	Gregory	A.	DPM	Podiatry Associates of Hagerstown	Podiatry	Hagerstown	x		x		
Holdaway	Peter	J	DPM	Scotland Podiatric	Podiatry	Hagerstown	x				
Seligman	Garry		MD	Behavioral Health Services	Psychiatry	Hagerstown	x	x	x		
Wagner	Matthew		MD	Behavioral Health Services	Psychiatry	Hagerstown	x	x	x		
Zerla	Aurelio	S.	MD	Behavioral Health Services	Psychiatry	Hagerstown	x	x	x		
Jurand	Joseph	A.	MD	Behavioral Health Services of Washington County	Psychiatry	Hagerstown	x				
Boyer-Patrick	Judith		MD	Brooklane Health Services	Psychiatry	Hagerstown				x	x
Carrill	John		MD	Brooklane Health Services	Psychiatry	Hagerstown				x	x
Relacion	Valerie		MD	Brooklane Health Services	Psychiatry	Hagerstown				x	x
Kurz	Corriene		MD	Corriene V. Kurz, MD	Psychiatry	Hagerstown				x	x
Gonzalez-Cawley	David		MD	David Gonzalez-Cawley, MD	Psychiatry	Hagerstown				x	x
Fawaz	Jamal		MD	Jamal Fawaz, MD	Psychiatry	Hagerstown				x	x

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TriState Physicians and Physicians with WCHA Privileges

Last	First	Middle	Title	Physicians Practice Group	Specialty Description	City	WCHA Hosp. Priv.	WCHSI employee	TriState Member	TriState Contracted	Other Hosp. Priv.
Latif	Mohammaed		MD	Mohammed Z. Latif, MD	Psychiatry	Hagerstown				x	x
Prescott	William		MD	William G. Prescott, MD	Psychiatry	Hagerstown				x	x
Egan	James		MD		Psychiatry					x	x
Patel	Daksha		MD		Psychiatry					x	x
Fox	Amy	Jo	PhD		Psychology		x				
Wooster	L.	Dwight	MD	Drs Newman, Wooster, Kass, Bradford & McCormack PA	Pulmonary Rehab	Hagerstown	x		x		
Ahmed	Kalim		MD	Pulmonary Consultants of Hagerstown	Pulmonary Rehab	Hagerstown	x		x		
Alencherry	Johny	P	MD	Pulmonary Consultants of Hagerstown	Pulmonary Rehab	Hagerstown	x		x		
Iqbal	Shaheen		MD	Pulmonary Consultants of Hagerstown	Pulmonary Rehab	Hagerstown	x		x		
Waheed	Abdul		MD	Pulmonary Consultants of Hagerstown	Pulmonary Rehab	Hagerstown	x		x		
Cornell	Dan	R	MD	John R. Marsh Cancer Center	Radiation Oncology	Hagerstown	x		x		
Norouzi	Ebrahim		MD	John R. Marsh Cancer Center	Radiation Oncology	Hagerstown	x				
Citro	Francis	J.	MD	Associated Radiologists, PA	Radiology	Hagerstown	x		x		
Hauser	Craig	Michael	M.D.	Associated Radiologists, PA	Radiology	Hagerstown	x				
Mazzei	Robert	E.	DO	Associated Radiologists, PA	Radiology	Hagerstown	x		x		
Zimmerman	Gregory	S	MD	Associated Radiologists, PA	Radiology	Hagerstown	x		x		
Bean	Marchelle	June	MD		Radiology		x				
Diehl	Steven	L.	MD	Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x		x		
Hesley	Kerri		MD	Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x		x		
Marinelli	Paul	C.	MD	Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x		x		
Murthy	Narasim		MD	Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x		x		
Muthiah	Annamalai (Annam)		MD	Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x		x		
Rossini	Michael	V	MD	Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x		x		
Saba, III	George	P		Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x				
Vu	Trung	Q.	MD	Associated Radiologists, PA	Radiology, Diagnostic	Hagerstown	x		x		
Agrawal	Gautam		MD		Radiology, Diagnostic		x				
Chow	Lawrence	Chang-Lun	MD		Radiology, Diagnostic		x				
Hsu	Raymond	M.	MD		Radiology, Diagnostic		x				
Johnson	Gregory	Lloyd	MD		Radiology, Diagnostic		x				
Leimkuhler	Melissa	May	MD		Radiology, Diagnostic		x				
Smith	Christopher	Leon	MD		Radiology, Diagnostic		x				

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TriState Physicians and Physicians with WCHA Privileges

Last	First	Middle	Title	Physicians Practice Group	Specialty Description	City	WCHA Hosp. Priv.	WCHSI employee	TriState Member	TriState Contracted	Other Hosp. Priv.
Klein	Steven	J	MD	Malamet & Klein, MD, PA	Rheumatology	Hagerstown	x			x	
Howell	Mary		MD		Rheumatology					x	
Chomiak	Paul	N.	MD	The Center for Chest Disease	Surgery, Thoracic	Hagerstown	x				
Radecki	Kevin	Michael	MD	The Center for Chest Disease	Surgery, Thoracic	Hagerstown	x				
Chaudhry	M.	Rafique	MD	The Urological Center	Urology	Hagerstown	x		x		
Dennis	Patrick	J.	MD	The Urological Center	Urology	Hagerstown	x			x	
Hackett	Kevin	C.	MD	The Urological Center	Urology	Hagerstown	x			x	
McWilliams	Wayne	A.	MD	The Urological Center	Urology	Hagerstown	x			x	
Talton	Hugh	J.	MD	The Urological Center	Urology	Hagerstown	x			x	
Hassoun	Heitham	Talal	MD	Heitham Hassoun, M.D.	Vascular Surgery	Baltimore	x				
Rogers	John	Paul	MD	Wound Center	Wound Care	Hagerstown	x			x	

Exhibit 3

Exhibit 3: Washington County Health System, Inc.

WCHSI is a private, non-profit corporation formed under the laws of the State of Maryland in 1989. WCHSI has over 3,000 employees and serves a tri-state region, including western Maryland, southern Pennsylvania, and northern West Virginia.

1. Washington County Hospital Association ("WCHA") - a private, non-profit, membership corporation formed under the laws of the State of Maryland operating an acute care hospital, WCH, and related facilities located in Washington County, Maryland. WCH opened in 1904 on Potomac Avenue in northern Hagerstown, with a complement of ten beds and a medical staff of six members.

WCHA provides hospital and healthcare services to the citizens of Washington and Frederick Counties in Maryland, Franklin and Fulton Counties in Pennsylvania, and Morgan, Jefferson and Berkeley Counties in West Virginia. WCHA is currently licensed to operate 292 beds to include 218 medical/surgical, 18 obstetric, 10 pediatric, 18 psychiatric, and 28 acute rehabilitation. WCH offers inpatient and outpatient services including adult medical/surgical care, obstetrics and newborn care (including a family birthing center), cardiac catheterization, comprehensive inpatient and outpatient rehabilitation, radiologic/diagnostic services, inpatient and outpatient mental health services, a regional Level III Trauma Center, an intensive care unit, a progressive care unit, a coronary care unit and a pediatric inpatient unit.

WCH is home to the Center for Joint Replacement, an innovative three-day program for hip and knee joint replacement which involves a team approach to education, care and recovery, and the John R. Marsh Cancer Center which provides ambulatory cancer therapy with 18,000 patients visits annually including chemotherapy, infusion therapy, blood transfusions and radiation seed treatments.

Other specialty services include: The Gynecologic Center of Western Maryland, providing evaluation and treatment services by a nationally recognized expert in gynecologic cancers and a pioneer in the field; comprehensive rehabilitation services, providing a full range of rehabilitation programs across service levels with locations at the Hospital, the Robinwood Medical Center campus, and its Health@Work facility on the west end of Hagerstown; behavioral health services including an Employee Assistance Program; and, mental health services for every age including adult inpatient programs at the Hospital and outpatient services. Specialty at-home services include "Care at Home", a fee-for-service personal care program, and "Home Health" for skilled nursing, rehabilitation services and oxygen therapy. All services are accredited by JCAHO.

2. Antietam Health Services ("AHS") – a wholly owned subsidiary of WCHSI. It was incorporated under the laws of the State of Maryland in 1985 as a for-profit corporation. Antietam has been involved in the development and operation of specific business enterprises related to the provision of outpatient healthcare that

complement the goals and objectives of WCHSI, including medical retail, home medical, corporate health and management services. Antietam's business units include joint ventures, contractual management arrangements and direct ownership of businesses plus development and management of the Robinwood Medical Center.

Robinwood is an approximately 373,000 square foot outpatient facility located 3.2 miles from WCH. Robinwood is designed to provide comprehensive, state-of-the-art health care in a comfortable, relaxed environment. The facility offers patients "one-stop shopping" where they can access many services all at the same location. The Robinwood facility is organized under a condominium regime. Unit owners include WCHA and various private providers of health care services, including physicians and dentists. The facility houses physician practices owned by WCHA and AHS. WCHSI owns approximately 44% of the Robinwood Medical Center square footage directly through its various subsidiaries or their business units.

As a fully-integrated health care delivery system, WCHSI has numerous business units and joint ventures affiliated with WCHA or AHS. A summary of these units follows:

ENTITY	AFFILIATION	DESCRIPTION
Behavioral Health Services	WCHA	Employee Assistance Program, Alcohol and Drug Program, employed physicians, psychologists and counselors, inpatient and outpatient services
Cardiac Diagnostic Center	WCHA	Located at Robinwood
Robinwood Endocrinology	WCHA	Robinwood tenant. Employed endocrinologist and comprehensive diabetes education center.
Home Health Care	WCHA	Private duty, nursing, and rehab care in home. Located off-site on Howell Road.
Maryland Neuro Rehab Foundation	WCHA	Inpatient and outpatient day program at Robinwood for brain and spine injury recovering patients.
Robinwood MRI	WCHA	Located at Robinwood; open MRI.
Total Rehab Care at Robinwood	WCHA	Physical/Occupational/Speech/Aqua therapy.
Urgent Care at Robinwood	WCHA	Located at Robinwood
Urgent Care at Pennsylvania Ave.	WCHA	Located on north end of Hagerstown.
Women's Health Center at Robinwood	WHCA	Located at Robinwood. Five employed OB/GYN physicians and five employed nurse midwives. Chiefly serve the underserved population.
WCH Trauma Physicians	WCHA	Nine contracted trauma surgeons to provide 24/7 trauma coverage.

ENTITY	AFFILIATION	DESCRIPTION
Hagerstown Medical Lab	AHS	Full service reference lab with ten draw stations in Washington County and one in Frederick County plus staff and serve the Hospital.
Medical Practices of Antietam	AHS	Employ primary care physicians in 6 offices (2 at Robinwood, 2 in Hagerstown, and 1 each in Williamsport and Smithsburg), plus a gastroenterology and a gynecology/women's primary care practice.
Home Care Pharmacies	AHS	Full service retail pharmacies with six locations in Washington County including at the Hospital.
Robinwood Infusion Pharmacy	AHC	Located at Robinwood.
Equipped for Life	AHS	Full service DME company with four locations in Washington County and one in Chambersburg, PA.
Health@Work, LLC	AHS	Located on Downsville Pike on the west end of Hagerstown, provides corporate clients with occupational medicine, industrial medicine rehab, EAP services, drug screenings, employee physicals, and on-site medical clinics.
Diagnostic Imaging Services, LLC	AHS – 50%	Joint venture with locations at Robinwood – including Women's Imaging Center – and at Eastern Boulevard in Hagerstown, site of numerous private physician offices.
Robinwood Surgery Center, LLC	AHS – 68%	Joint venture located at Robinwood with six OR's and four special procedure rooms. Employs anesthesiologists and CRNA's.
Endoscopy Center at Robinwood	AHS – owned 50% by Surgery Center	Joint venture located at Robinwood with four endoscopy suites.
Mid-Maryland Medical Transport, LLC	AHS – 33.3%	Joint venture ground ambulance company serving Washington and Frederick Counties. Other owners are Frederick Memorial Health System and Valley Regional Enterprises in Winchester, VA.
Western Maryland Medical Supply, LLC	AHS – 50%	Joint venture DME company. Equipped for Life is managing partner. Other owner is Western Maryland Health System in Cumberland, Maryland, about 75 miles west of Hagerstown.

3. Maryland Physicians Care - WCHA owns 25% of Maryland Physicians Care, a Maryland Medicaid HMO serving in excess of 90,000 members in Maryland and

about 9,000 in Washington County. Other partners include St. Agnes Hospital and Maryland General Hospital in Baltimore, and Western Maryland Health System in Cumberland, Maryland. Maryland Physicians Care also manages, on behalf of the state, a Primary Adult Care (PAC) Program and a Medicare Advantage plan for the special-needs, dual-eligible population in the western Maryland counties of Washington, Allegheny, and Garrett. Currently, there is no formal affiliation between TriState and MPC; however, there are discussions regarding the sharing of, and providing access to, claims data.

4. Walnut Street Community Health Center – WSCHC until 2004 was a group of family practice physicians employed by WCHA and located about 2 miles north of WCH in an underserved part of Hagerstown. In 2004, the Center was granted Federally Qualified Health Center status and became an independent business. WCHA and AHS provide services to the Center, and the Center physicians are members of TriState.

Exhibit 4

Exhibit 4: TriState's Current Board of Directors

NAME	CLASS	TITLE	SPECIALTY/TITLE
Datta, Vasant MD	I	President	Primary Care Family Practice
Hood, Stephen MD	I	Vice President	Specialist Medicine - Cardiology
Grahe, Raymond A.	II	Treasurer	VP Finance Hospital
McBurney, Brooks	II	Secretary	VP Human Resources Hospital
Hamill, James P.	II	Director	President and CEO Hospital
Brooks, Robert MD	II	Director	VP Medical Affairs Hospital
Uzicanin, Ernest MD	I	Director	Primary Care Family Practice – Private Practice
Mire, Gary MD	I	Director	Hospital Based – Pathology
Reed, John MD	I	Director	Primary Care IM/Peds – Antietam
Solberg, David MD	I	Director	Specialist Surgery – Obstetrics/Gynecology
Dwyer, Ruth MD	I	Director	Primary Care Pediatrics – Private Practice
Zampelli, Michael	II	Director	VP Antietam Health Services
Vacant (added 6/25/2007)	I	Director	Specialist

Exhibit 5

Exhibit 5: TriState's Administrative Staff

NAME	TITLE	YEARS IN POSITION
Field, Allan S.	Executive Director	3.25
Cirincione, Robert MD	Medical Director (contracted)	6.5
Atkinson, Wendy	Operations Manager	2.75
Grant, Shelley	Manager Care Coordination	1
Wieland, Charissa	External Relations Representative	1
Shaw, Amanda	PHO/Managed Care Specialist	9
Metzer, Guylene RN	Case Manager	< 1
Putnam, Marlen RN	Case Manager	< 1

Exhibit 6

Exhibit 7

Exhibit 7: Committee Membership

COMMITTEE	NAME	CLASS	SPECIALTY
Nominating	Newby, John MD – Chair	I	Pathology
	Reed, John MD	I	Internal Med/Peds
	Cirincione, Robert MD	I	Orthopaedics/Med Dir
	Grahe, Raymond	II	VP Finance Hospital
	Field, Allan S.	N/A	Executive Director
Contracting / Finance / Administration	Grahe, Raymond – Chair	II	VP Finance Hospital
	Hood, Stephen MD	I	Cardiology
	Mire, Gary MD	I	Pathology
	Reed, John MD	I	Internal Med/Peds
	Zampelli, Michael	II	VP Antietam
	Field, Allan S.	N/A	Executive Director
	Wieland, Charissa	N/A	Staff Support – *ex officio*
Bylaws	Datta, Vasant MD – Chair	I	Family Practice
	Malik, Zafar MD	I	Internal Medicine PCP
	Roza, Eli MD	I	Nephrology
	Edwards, Bruce MD	I	Orthopaedics
	Schaeffer, Michael Esq.	II	Hospital Attorney
	Brooks, Robert MD	II	VPMA Hospital
	Field, Allan S.	N/A	Executive Director
	Wieland, Charissa	N/A	Staff Support – *ex officio*
Communications	Mire, Gary MD – Chair	I	Pathology
	Su, William MD	I	General Surgery
	Hudson, Chad MD	I	Obstetrics/Gynecology
	Cantone, Vincent MD	I	Family Practice PCP
	Theriault, Maureen	II	Dir Public Relations Hosp
	Field, Allan S.	N/A	Executive Director
	Wieland, Charissa	N/A	Staff Support – *ex officio*
Clinical Integration Oversight	Reed, John MD – Chair	I	Internal Medicine/Peds
	Beckwith, Matthew MD	I	Family Practice
	Newby, John MD	I	Pathology
	Schiro, James MD	I	Dermatology
	Becker, M. Douglas MD	I	Pediatrics
	Cirincione, Robert MD	I	Orthopedics/Medical Dir
	Lowe, Robert PharmD	I	Home Care Pharmacy
	Field, Allan S.	N/A	Executive Director
	Grant, Shelley	N/A	Staff Support – *ex officio*
	Atkinson, Wendy	N/A	Staff Support – *ex officio*
Credentialing	Newby, John MD - Chair	I	Pathology
	Cirincione, Robert MD	I	Orthopaedics/Medical Dir
	Brooks, Robert MD		VPMA Hospital
	Cornell, Dan MD	II	Radiation Oncology
	Field, Allan S.	I	Executive Director
	Grant, Shelley	N/A	Staff Support – *ex officio*
	Shaw, Amanda	N/A	Staff Support – *ex officio*
		N/A	

COMMITTEE	NAME	CLASS	SPECIALTY
Utilization Management/Quality Assurance	Schiro, James MD - Chair	I	Dermatology
	Cirincione, Robert MD	I	Orthopaedics/Medical Dir
	Becker, M. Douglas MD	I	Pediatrics
	Baran, Mark MD	I	Hospitalist
	Ciccarelli, Jill MD	I	Family Practice
	Brooks, Robert MD	II	VPMA Hospital
	Jones, Jeff MD	I	Cardiology
	Pianta, Thomas	II	Dir Health Mgt Hospital
	Barnhart, Steve	II	Exec Ops Antietam
	Lowe, Robert PharmD	II	Home Care Pharmacy
	Shea, Michael Ed.D.	II	Behavioral Health – Hosp
	Field, Allan S.	N/A	Executive Director
	Gervais, Mary Ellen	N/A	MMARS
	Davis, Mitchell	N/A	InforMed
	Grant, Shelley	N/A	Staff Support – *ex officio*
	Atkinson, Wendy	N/A	Staff Support – *ex officio*
Service Improvement	Beckwith, Matthew MD – Chair	I	Family Practice
	Cirincione, Robert MD	I	Orthopaedics/Medical Dir
	Schiro, James MD	I	Dermatology
	Baran, Mark MD	I	Hospitalist
	Ditto, Allen MD	I	Family Practice
	Field, Allan S.	N/A	Executive Director
	Grant, Shelley	N/A	Staff Support – *ex officio*
	Atkinson, Wendy	N/A	Staff Support – *ex officio*
Quality Improvement	Becker, M. Douglas MD – Chair	I	Pediatrics PCP
	Cirincione, Robert MD	I	Orthopaedics/Medical Dir
	O'Donoghue, Michael MD	I	Pathology
	Hesley, Kerri MD	I	Radiology
	Krishnamoorthy, Mahesh MD	I	Internal Medicine PCP
	Qadir, Ghazala MD	I	Family Practice
	Budi, Anand MD	I	Pediatrics PCP
	Field, Allan S.	N/A	Executive Director
	Pianta, Thomas	II	Dir Health Mgt Hospital
	Grant, Shelley	N/A	Staff Support – *ex officio*
	Atkinson, Wendy	N/A	Staff Support – *ex officio*
Pharmacy Benefits Management	Lowe, Robert PharmD – Chair	II	Home Care Pharmacy
	Cirincione, Robert MD	I	Orthopaedics/Medical Dir
	Money, Mary MD	I	Internal Medicine PCP
	Delaportas, Dino MD	I	Infectious Disease
	McDougal, Daniel MD	I	Internal Medicine PCP
	Aziz, Gary PharmD	II	Home Care Pharmacy
	Berg, Mary	II	Exec Ops Antietam
	Ellis, Denise PharmD	II	Home Care Pharmacy
	Higgins, Sue PharmD	II	Home Care Pharmacy
	Hilker, Bobbi PharmD	II	Home Care Pharmacy
	Wills, Terry PharmD	II	Home Care Pharmacy
	Grant, Shelley	N/A	TriState Health Partners
	Atkinson, Wendy	N/A	TriState Health Partners
	Field, Allan S.	N/A	Executive Director

COMMITTEE	NAME	CLASS	SPECIALTY
Care Coordination	Cirincione, Robert MD – Chair	I	Orthopaedics/Medical Dir
	Grant, Shelley	II	Mgr Care Coor TriState
	Pianta, Thomas	II	Dir Health Mgt Hospital
	Wilkes, Kelsey	II	Dir Integ Pt Sup Svc Hosp
	Whyte, Roseann	N/A	InforMed
	Metzer, Guylene RN	N/A	Case Manager TriState
	Putnam, Marlen RN	N/A	Case Manager TriState
	Atkinson, Wendy	N/A	Ops Manager TriState
	Lowe, Robert PharmD	II	Home Care Pharmacy
	Moyer, Jeanni	II	Total Rehab Care – Hosp
	Lewis, Thorrenna	I	Mgr Integ Pt Sup Svc Hosp

During the first quarter of Fiscal Year 2008, recruitment will continue for: (1) at least three private practice physicians to serve on the Contracting / Finance / Administration Committee; (2) at least two primary care physicians for the Credentialing Committee; and (3) at least two primary care physicians for the Communications Committee.

Exhibit 8

Exhibit 9

TRISTATE MEMBER
PARTICIPATING PROVIDER CONTRACT – CLINICAL INTEGRATION

This participating provider contract ("Contract") is made as of this ____ day of _____, 200__ between Tri-State Health Partners, Inc. ("TriState"), a Maryland nonstock corporation, and the provider identified below ("Provider"), who is a member of TriState.

PROVIDER:

Name: _____

Address: _____

_____

Telephone Number: _____

Medical Specialty: _____

Exhibit 10

Exhibit 10: Secondary Service Area Physicians

PRIMARY SPECIALTY*	TriState Members	Non-TriState Members	Total Specialists	TriState Percentage
Addiction Medicine	0	1	1	0%
Aerospace Medicine	0	1	1	0%
Allergy, Allergy & Immunology	2	4	6	33%
Anesthesiology	9	41	50	18%
Cardiology, Pediatric	0	1	1	0%
Cardiovascular Disease	11	20	31	35%
Critical Care, Pediatric	0	1	1	0%
Dermatology	3	7	10	30%
Emergency Medicine, Urgent Care Medicine	1	53	54	2%
Endocrinology, Reproductive	0	1	1	0%
Endocrinology/Diabetes	3	2	5	60%
Family Practice/Geriatric Medicine	27	188	215	13%
Gastroenterology	6	11	17	35%
General Practice	0	38	38	0%
Immunology	0	1	1	0%
Infectious Diseases	1	16	17	6%
Internal Medicine	26	133	159	16%
Neonatal-Peri-natal Medicine	0	9	9	0%
Nephrology	3	10	13	23%
Neurology – child, adult	5	14	19	26%
Nuclear Medicine	2	3	5	40%
Obstetrics & Gynecology	14	47	61	23%
Occupational Medicine	0	5	5	0%
Oncology	4	15	19	21%
Ophthalmology	2	25	27	7%
Orthopedics/Hand Surgery/Sports Medicine	12	36	48	25%
Osteopathic Manipulative Medicine	0	1	1	0%
Other Specialty/Unspecified	0	24	24	0%
Pain Management	3	2	5	60%
Pathology	4	23	27	15%
Pediatrics	11	69	80	14%
Physical Medicine & Rehab	4	6	10	40%
Psychiatry – child, adult	3	48	51	6%
Pulmonary Disease, Pulmonary Critical Care	5	16	21	24%
Radiation Oncology	1	1	2	50%
Radiology	10	36	46	22%
Radiology, Vascular & Interventional	0	2	2	0%
Rheumatology	0	4	4	0%
Sleep Medicine	0	1	1	0%
Surgery, General	8	42	50	16%
Surgery, Neuro	4	6	10	40%
Surgery, Otolaryngology, Head & Neck	6	14	20	30%
Surgery, Plastic	1	7	8	13%
Surgery, Thoracic	0	4	4	0%
Surgery, Urological	1	19	20	5%
Surgery, Vascular	0	2	2	0%
TOTAL	**192** **16%**	**1010** **84%**	**1202** **100%**	

Not listed in AMA Database – Oral & Maxillofacial Surgery, Podiatry

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

Bureau of Competition
600 Pennsylvania Ave., N.W.
Washington, D.C. 20580

David M. Narrow
Attorney

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January 24, 2008

Christi J. Braun, Esquire
Ober, Kaler, Grimes & Shriver
1401 H Street, N.W., Suite 500
Washington, D.C. 20005-3324

RE: Advisory Opinion Request by TriState Health Partners, Inc.

Christi
Dear Ms. Braun:

This is a request for additional information concerning a proposed program by TriState Health Partners, Inc. ("TriState") for which you have requested an advisory opinion. According to your letter, TriState is a non-stock membership organization incorporated in 1995. You describe TriState as a "non-exclusive physician-hospital organization ("PHO")" consisting of approximately 200 medical practitioners and one hospital located in Washington County, Maryland. Class I members include Maryland-licensed physicians (both independently practicing, and employed, and including oral surgeons), and medical group practices whose physicians meet that requirement. Washington County Hospital is TriState's only Class II member. According to your letter, TriState's proposed program "will integrate its members clinically."

You ask for a staff advisory opinion as to what would be "the Commission's enforcement intentions and how would it analyze [TriState's] activities" under Section 5 of the FTC Act if, in conjunction with the physicians' clinical integration through the proposed program, TriState "develops contract proposals that include performance bonuses, negotiates contract terms (including price), and enters into contracts with third-party payers for the sale of the integrated product" as described in your letter. As you are aware, the staff cannot speak for the Commission regarding its law enforcement intentions, but can only address how the staff would analyze a particular arrangement or activity, and what recommendations, if any, staff would be likely to make to the Commission if the proposed conduct were undertaken. In order to respond to your request, it would be helpful if you could provide the following additional information concerning TriState's proposal:

I. Structure and Membership

You state that TriState currently has 64 primary care physicians ("PCPs")[1] and 140 specialty care physicians ("SCPs") practicing in 29 different medical specialties. Of these 204 total physicians, you note that 35, or about 17 percent of the total, are employed by subsidiaries of Washington County Health System, Inc. ("WCHSI"), which also is the parent organization of Washington County Hospital – TriState's hospital member. You note that TriState also has contracts to provide services to patients under contracts with TriState with an additional 69 physicians in 18 medical specialties who are not members of TriState. Your letter states that there is no limit on additional physicians joining TriState, and presumably participating in all of its programs, including the proposed clinical integration program. It is our understanding from your letter that all physicians currently involved with TriState (both members and contracting physicians) will be eligible to participate in the proposed program, although you anticipate that some contracted physicians may choose not to do so. What is your most recent information or expectation as to how many of TriState's members and its contracted physicians have elected, or will elect, to participate in the proposed program, and what is the basis for your estimate?

Other than having to execute the "TriState Member Participating Provider Contract – Clinical Integration" (Exhibit 9 of your initial submission), what, if any, selection or screening mechanisms or participation requirements will TriState apply initially regarding physicians who currently are members of, or who contract with, TriState and who seek to participate in the proposed program, in order to assure that they have the necessary commitment to work toward successful achievement of the program's clinical integration goals? What will be the bases or standards for accepting or excluding at the outset any physicians from participation? What is TriState's basis for believing that its physician participation screening standards will assure participation only by physicians who are committed to, and likely to help achieve, the clinical integration goals of TriState's proposed program?

Your letter states that "TriState has no restrictions on the addition of new Class I [i.e., physician] members." How, if at all, will physicians that subsequently seek to join TriState's proposed program be screened for suitability to participate in the program? Will any physicians be denied participation in the proposed program based on numbers of physicians (either total or specialty-based) already in the proposed program relative to the expected patient enrollment, or based on other factors, such as the ratio of specialists to PCPs? Will there be any restrictions on when additional physicians may joint TriState and participate in the proposed program? Has TriState considered whether and how allowing physicians to join TriState at any time may affect its ability to clinically integrate provision of care by TriState physicians, and the potential of the proposed program to achieve the anticipated resulting efficiencies in providing care to patients enrolled in the program?

What is the role of the Washington County Hospital, Washington County Hospital Association, and the Washington County Health System, Inc. (including any of its subsidiaries, "business units," or "joint venture affiliates," as identified in Exhibit 3 of your initial submission) in the proposed clinical integration program? What advantages (other than the hospital's $2500

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[1] Including general practitioners, family practitioners, pediatricians, and internists.

initial matching payment for each physician who becomes a TriState member) does the involvement of Washington County Hospital or Washington County Health System, Inc. (including any of its subsidiaries) hold for the proposed program? Likewise, what potential disadvantages (e.g., possible pressure to fill hospital beds, or adopt policies that otherwise potentially involve efficiency/utilization conflicts of interest) does the involvement of the hospital and its subsidiaries pose for the proposed program's success, and how will TriState address any such potential disadvantages?

II. Integration and Achievement of Efficiencies

In your letter, you state that Tristate contracted on a capitation basis for only one year, and that as of 1998 its operations have been on other than that basis – i.e., not involving financial risk sharing among its physicians. What in TriState's experience supports the expectation that, absent such financial risk-sharing among its physicians, TriState is likely to be able to achieve the necessary high degree of interdependence and cooperation to control costs and ensure quality among its independently practicing physicians in their provision of medical care to patients covered under the proposed program? Does TriState have any experience under its capitation program or otherwise in dealing with physicians who are either non-compliant or performing at sub-optimal levels regarding programs or standards under which TriState has operated?

Your letter states that member physicians (but not contracting physicians) each pay a "joining fee" of $2,500 for participation in TriState, which payment to TriState is matched by Washington County Hospital. Is this a new fee for existing TriState physician members to participate in the proposed program, or is it a pre-existing requirement for membership in TriState generally, that already has been paid by those physicians who currently are members, and therefore will only apply to new TriState members? If the latter, will there be any additional fees charged to current TriState member physicians who already have paid the $2,500 joining fee in order for them to participate in the proposed program? What other financial "investment," if any, will TriState member physicians be required to make in the proposed program (e.g., computer hardware/software, etc.)? Will member physicians participating in the proposed program be required to make any non-financial investments in the proposed program (e.g., personal participation in program activities or committees, training of themselves and/or their office staffs, etc.)?

Will contracting physicians (i.e., those who do not become TriState members, but who contract directly with a payer through TriState's messenger arrangement to provide services under future TriState clinical integration program contracts) be required to make investments of any kind in TriState in order to participate in the proposed program? What requirements, if any, regarding HIT capability and participation will apply to contracting physicians? What will evidence or assure contracting physicians' commitment to successful implementation of the proposed program? Describe how contracting physicians will participate in all aspects of the proposed program, including how, operationally, TriState will assure that the services of contracted physicians are provided in an integrated fashion with those of TriState's member physicians.

What will be the nature and extent of participation by TriState member and contracting physicians in the Clinical Integration Oversight Committee and its six sub-committees? Exhibit 7

of your initial submission lists members of various committees and subcommittees. However, terms of service and future membership rotation do not appear to be addressed. Will TriState require participation by all or certain TriState member physicians on any committees, subcommittees, or in other organization activities regarding the performance of physicians other than themselves (i.e., relating to their interdependent, as opposed to individual, performance)? Please explain how Sections [redacted] and [redacted] of Exhibit 9 of your original submission ("TriState Member Participating Provider Contract – Clinical Integration") are consistent with TriState's purportedly operating as a clinically integrated joint venture of its physician members.

Given the current extensive relationship between TriState and InforMed, and the information and support systems, technology, and other capabilities already available and in use through that arrangement, what will the proposed program be able to do or achieve that the current arrangement involving TriState and InforMed cannot, and why? What, exactly, will occur operationally under the proposed program that is different from, and not currently occurring under, TriState's current operations?

III. Need for Joint Contracting with Payers, and Collective Determination and Negotiation of Fees, in Order to Offer the Proposed Program

What aspects of, or programs or activities that will be part of, the proposed clinical integration program are currently in place or operating with regard to TriState's provision of services under its existing contracts? Please explain exactly how the proposed program will differ from existing practices and programs of TriState. How will the proposed program differ from the utilization and medical management services currently provided by TriState through its arrangement with InforMed and its CHP network?

You state in your letter that "having the same network for all integrated product contracts is important to integrating the quality improvement initiatives and medical management services into the physicians' practices." How does TriState's proposed program assure that it will have "the same network for all integrated product contracts?" Specifically, why isn't TriState's policy of allowing additional physicians to join TriState at any time and participate in the clinical integration program – which necessarily will change the composition of the network – inconsistent with this rationale? Similarly, how is allowing contracted physicians (who represent about 25 percent (69 of 273) of physicians currently participating in TriState's network programs) to decide whether to participate in the proposed program on a contract-by-contract basis consistent with the stated necessity of having the same physician network for all contracts in order to achieve the network's integration and efficiencies?

TriState's proposed program anticipates that non-member (i.e., contracted) physicians will provide services to patients covered under the program, presumably without substantial loss in the program's clinical integration and efficiencies. Such contracted physicians, however, will not participate in TriState's joint negotiation of contracts with purchasers and payers, but rather will contract individually with those purchasers and payers through a messenger arrangement. If the contracted physicians can be an integral part of the clinical integration program without joint contracting, why can't the TriState member physicians do so as well? Similarly, you state that having the "single integrated network" that will result from joint contracting will enable Tristate to "reinforce its in-network referral policy, ensuring that patients stay within the TriState network to the greatest extent possible." How is this justification consistent with using contracted physicians to whom referrals will be made as part of the program, when those physicians

participate on a contract-by-contract basis, and different contracted physicians may be participating in each contract? If patients referred to contracted physicians are part of the integrated provision of care, and this is done without their participating in the joint contracting process, why is it necessary for TriState to jointly contract regarding member physicians? Conversely, if contracted physicians will not be part of the integrated provision of care under the program, why isn't this a significant deficiency in the program's potential for achieving efficiencies, given that contracted physicians represent a significant portion of physicians currently participating in TriState's network programs?

In your discussion of the need for joint contracting through TriState, you state (page 29 of your initial submission) that "[a]bsent assurance of participation in TriState's contracts, and thus a share of the revenue generated by those contracts, the physicians would have less incentive to devote substantial time" to the various activities necessary to successfully implement the proposed program. While we understand that physicians may need to recover the opportunity costs of their participation in a program that requires additional time and effort on their part, or desire to make a profit from development of such a program, it is not apparent why that payment or profit needs to come from presumably higher, jointly agreed upon, fee-for-service charge levels by the physicians for their underlying medical services provided under the program.

Regarding the discussion in your initial submission of a future "pay-for-performance" component of TriState's operations, it is our understanding that your current request for an advisory opinion is not premised on an assertion of financial integration among TriState's physicians based on this possible future activity. However, you state that, in order to implement that program, "TriState believes that it will need to collect a year or more of performance data from its physicians, showing the success of its clinical integration strategy for self-insured employers and smaller payers. Thus, it will need to contract on a fee-for-service basis for some period before it is able to implement its P4P program." It is not clear whether you therefore are separately asserting that such fee-for-service contracting is justified at this time as reasonably necessary (i.e., "ancillary") to implementing a financially integrated, efficiency enhancing, joint venture among TriState physicians in the future.

IV. Market Factors

What basis does TriState have for believing that payers or other potential customers will be interested in contracting with TriState for the proposed program? Have any payers or other potential customers (e.g., employers) expressed any views regarding the proposed program or TriState's current programs and operation?

Regarding the "non-exclusive" participation of TriState physicians in the proposed program, you discuss their freedom to contract individually and directly with payers. Is there any restriction or limitation on the ability of TriState physicians to also become members of other physician or provider networks, including other clinically integrated arrangements?

Thank you for your consideration of this request for additional information. While we have tried to be complete in our request, it nevertheless is possible that we subsequently may

require some further information or clarification regarding the proposed program. If you have any questions, please call me at (202) 326-2744.

Very truly,

David M. Narrow

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July 18, 2008

VIA COURIER

David M. Narrow, Esq.
Federal Trade Commission
601 New Jersey Avenue, NW
Washington, DC 20001
Phone: (202) 326-2744

Dear David,

This letter responds to your January 24, 2008 letter regarding the advisory opinion request by TriState Health Partners, Inc. ("THP"). THP's management, committees, and Board have spent considerable time working through, and addressing, your questions and concerns, and, as a result, they have made some changes to their proposed program. In addition to addressing your questions, this letter will explain the changes that have been made. Many of the answers to your questions come directly from THP and are written from their perspective. This reply contains 11 sections, but focuses on the following nine major areas:

- THP contractors and how THP will address their status going forward.
- THP members and how THP will address current and future membership requirements including securing commitment to clinical integration.
- The role of the Washington County Health System, Inc., and its subsidiaries in clinical integration.
- The relationship between InforMed and THP going forward.
- THP's experience in diabetes management and how this supports the expectation that THP will be able to achieve the interdependence and cooperation necessary to obtain the program's intended efficiencies.
- How THP's clinical integration program will be similar to and different from current THP programs and operations.
- Payer interest in the clinical integration program.
- THP's pay-for-performance plan and it's affect on the FTC's legal analysis.
- The reasonable necessity of THP's joint contracting on behalf of its physician members.

I. Contractors

The following is expected to address questions raised on pages 3 and 4 of your letter regarding THP contractors.

Background – When THP was formed in 1994, certain physicians in the community elected not to join the PHO (physician-hospital organization) with reasons including:

- Lack of desire to pay the membership fee ($2,000 during the 90-day open enrollment period and $2,500 thereafter, unchanged since inception).
- Desire to remain independent practitioners and a fear of joining any organization that could restrict their autonomy.
- General reluctance to join any organization that smacked of insurance or managed care.
- Recognition by a few that the PHO needed their services more than they needed to join the PHO.
- Service areas predominantly outside of Washington County.
- The PHO's inability to assure a return on investment because the PHO was formed as a membership, as opposed to stock, corporation.

From about 1997 to date, THP's major client for network and medical management services has been the Washington County Health System Employee Health Benefit Plan ("WCHSI Plan" or the "Plan"). The Plan insisted that several of these non-member physicians or physician groups needed to be included in the THP network in order for the Plan to have a viable network to care for its enrollees in a cost-effective manner.

To provide an adequate network for the Plan, THP's response was to create a "contractor" status within the PHO. These practitioners would have no governance rights, nor would they share in distributions, if any. But these practitioners did agree to accept the Plan (InforMed) fee schedule and not balance bill Plan enrollees. This arrangement has worked very well for the past ten years for the Plan and other self-insured employer groups who have accessed the THP network. The contractor status also has been used as a convenient designation for non-physician practitioners (e.g., nurse midwives) who provide care to Plan enrollees but do not qualify for actual THP membership.

Discussion – THP has come to realize that to develop a clinically integrated network, continuation of the contractor status within THP is not viable. THP lacks the ability to secure unfettered commitment to its clinical integration strategy, including the efficiency-producing initiatives, from these contracted practitioners. Even with a

requirement that these practitioners sign the "Participating Provider Contract – Clinical Integration," THP could not guarantee to payers that these practitioners will be committed to the success and guiding principles of clinical integration. Nor could THP guarantee that each contracted provider would commit to participation in each payer's contract; thus, it could not have a single network of committed practitioners, which it believes is integral to the success of its integrative efforts.

THP also recognizes that its network of member physicians is small when compared to that of CareFirst BlueCross BlueShield or United Healthcare, but beneficiaries of these plans will have access to the entire plan network, which far exceed the THP network by sheer numbers and geography. Critical to the success of THP's strategy, however, is access to all payer claims data for these enrollees. As the Electronic Health Record ("EHR") is populated with claims data from practitioners outside of the THP membership, THP will be able to examine the care of these enrollees and determine whether the care is being managed in accord with the principles of THP's clinical integration strategy. THP, then, will be able to provide plans with the data necessary to review the patient care being provided by the plan's entire network. Over time, it is expected that THP will be able to demonstrate to employers, plans, and enrollees the value of the quality its committed CI network provides over the benefit of the larger size of the commercial plan networks.

In our letter of July 9, 2007, we reported a total of 69 contractors; as of this date, the number is 70. THP is in the process of eliminating the contractor status by offering options to these practitioners.

1. With a few exceptions (see 2. following), the contractors have all been offered a one-time opportunity to join THP as a Class I member. Those who have either joined, or are in the process of joining as of the date of this letter, already have met the credentialing standards of THP. As a condition of their invitation to join, they must agree to meet the standards for commitment to clinical integration, as outlined later in this letter.

2. The exceptions from an offer to join THP either are not eligible for membership in THP (15 Licensed Clinical Social Workers) or are currently employed by the Class II member and not eligible for membership (the 4 nurse midwives). The Licensed Clinical Social Workers will be given the opportunity to direct-contract with Community Health Partners ("CHP"), the regional network owned by InforMed.

3. The practitioners offered membership in THP who elect not to join THP and participate in its clinical integration program, will be able to direct-contract with CHP. As part of the CHP network, they will be part of a

second tier network (higher copay and lower benefits, unless waived due to medical necessity) available to the WCHSI Plan enrollees and the claims data will be added to the enrollees' EHRs. In the event that Plan enrollees see CHP physicians, the THP physicians, through monitoring of their patients' EHRs, 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, THP 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 THP's network.

II. THP Membership

The following should address your questions on pages 2 and 4 of your letter regarding THP's membership, in particular how THP will address access to membership and commitment to the program by its members.

THP has been an "open-PHO" since inception. Generally speaking, any physician who met THP's credentialing standards, which are similar to NCQA's, was able to join the PHO. To date, no physician's membership has been involuntarily terminated. Moving forward, however, it is THP's intent to be much more selective in allowing new physicians to join. THP is developing a policy intended to ensure that physicians who join THP at the inception of its clinical integration program, and in limited numbers later, are committed to the program objectives of controlling costs and assuring quality care.

Many of THP's members are practice groups, as opposed to individual practitioners. THP recognizes that, generally, the entire practice is involved in the care of a particular patient.[1] THP's program will be focused not only at the individual physician level, but also at the practice level. Therefore, the entire practice needs to commit to the clinical integration principles of collaboration, cooperation, and mutual interdependence. In order for a practice's participation agreement to be ratified, each member of the practice must sign an attestation agreeing to committed participation in THP's clinical integration program. The failure of one physician in a practice to either commit to, or adhere to, THP's programs of continuous process improvement will place the entire practice's continued participation in the program at risk.

[1] Group members generally provide call coverage for one another and may see each other's patients when scheduling problems arise. In addition, practice group members often discuss patients' treatment option with each other, particularly in complex cases, and surgeons may even assist one another.

In order to assure purchasers of the clinical integration product that THP can deliver an entire network of providers absolutely committed to the guiding principles of improving quality and controlling costs through collective behaviors, THP has determined that once THP's current membership has had an opportunity to determine whether or not they wish to participate in THP's clinical integration program, the PHO will be closed to new members with the following exceptions:

1. Current members who decline to participate in THP after the 60-day open enrollment period for the CI program will have limited opportunities to participate later. An exception may be made for those physicians who are in limited-access specialties or serve a geographic region currently not served. In addition, THP will conduct an annual, 30-day open-enrollment period for those physician members who declined initial participation in the program but are reconsidering their original non-participation decision. All requests for reconsideration will be reviewed by the THP Board of Directors on a situational dependent, case-by-case basis following an independent, third-party analysis of need. These physicians would need to present clear and compelling commitment to THP's guiding principles of clinical integration before they can be reinstated as members.

2. Physicians new to the community joining existing member practices, such as taking the place of retiring or relocating physicians, will be expected to join THP[2] and agree to participate actively in the group's commitment to clinical integration. Failure to do so may place an entire practice group's continued participation at risk.

3. As determined by the Board of Directors, physicians who wish to join THP in the future and who either are in a must-have specialty or provide services in a geographically under-served area may be eligible to join THP, as determined by an independent, third-party needs analysis. Again, the Board of Directors will make these determinations on a situational dependent, case-by-case basis only after the physician has been able to demonstrate clear and compelling commitment to the program.

THP has not yet distributed the "Participating Provider Contract – Clinical Integration" ("new contract") to the membership. We await any concerns or changes that may need to be made to the new contract following review by the FTC. We acknowledge that once the new contract goes out to the membership, any changes requested by one physician must be made for all, if approved by the leadership. In an attempt to mitigate the possibility that the membership may have numerous lawyers reviewing individual

[2] New physicians will be expected to meet the THP credentialing requirements.

contracts, THP paid for the services of an independent lawyer to represent the interests of the physicians in the preparation of this contract. The President of the Medical Staff of WCHA (an independent, private-practicing THP-member physician) selected a lawyer known to most of the membership and who has represented their interests for many years.

THP acknowledges that when the contract is released for review and ratification by the membership, individual members will have concerns, especially with the no opt-out provisions. The THP Communications Committee has developed a plan for disseminating the new contract to the membership. The Committee formed a "Messenger Training School" whereby six physician volunteers have agreed to serve as messengers to communicate the clinical integration strategy, in detail, to their peers in what the Committee has referred to as a "retail sales" strategy. These physician messengers also are prepared to discuss with their peers the elements of the new participation contract and the eventual closing of the PHO to new members.

These physician leaders collectively recognize that society's focus is changing from, "how much is paid and who pays" to "what is society getting for our healthcare dollars." They recognize that the traditional independent practice of medicine, in the absence of a platform for putting individual best interests aside for the collective good of the whole, is a failed business model for making significant gains in improving quality and controlling costs.

Most importantly, the physician messengers have volunteered to serve in this capacity because of the value they see for the community of physicians coming together under a clinically-integrated model represented by a high degree of cooperation, collaboration and mutual interdependence. These six physicians, plus the more than 40 physicians currently serving on various THP committees, are the early adopters of clinical integration.

Although THP has not as yet introduced the new participation contract, it has no reason to believe that more than a few current member practices will decline initial participation. Rather, the general tone among the membership is cautious optimism that the program will be viewed by the FTC as one that, once fully implemented, will achieve demonstrated superior outcomes at demonstrated superior cost savings to their patients and the purchasers of health care. With over 20 percent of the membership already represented on different clinical integration and governance committees and additional physicians serving in an ad hoc capacity as consultants to the development of clinical practice guidelines, THP believes a significant portion of its members will join the clinical integration program.

THP has a vested interest in providing a comprehensive network to payers. Network access is a very important component of any managed care strategy. However,

THP is not willing to sacrifice quality for quantity--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, and showing progress towards continual process improvement ("moving the mean").

The Quality Improvement Committee ("QIC") is focusing on continuous improvement and ongoing initiatives that will sustain the long-term commitment to THP's clinical integration objectives.[3] THP, through the active collaboration of its QIC and Credentialing Committee, and oversight by the Clinical Integration Oversight Committee, will use data from the ETG and EBM Connect data sets during the biannual recredentialing process and at periodic intervals through the year to identify best practices and monitor movement of the mean for the individual physician, the individual group practices, and the entire PHO, and report progress or lack thereof. Continual process improvement by individual member physicians will result in successful recredentialing and signify one's continuing commitment to the success of the program. Continued failure to show improvement will result in peer intervention and could result in eventual termination from the PHO, if improvement is not seen.

When the leadership decided to embark on a clinical integration initiative, they made it clear that it was not their desire to cull the outliers. Rather, a guiding principal has been THP's goal to "move the mean" for the entire network, fully recognizing that the day may come when it may be necessary to cull the outliers from the network. THP has the will to cull, but prefers, initially, to work with the entire community of physicians to give them the tools to move their individual mean. The Symmetry suite of software, integrated by InforMed and customized by THP, gives THP the ability to turn data into information; the "heavy lifting" will be the community of physicians coming together under a clinically integrated program to turn that information into action.

By example, utilizing actual data from the fourth quarter of 2007 for its current diabetes management project (discussed in more detail in Section VI below), THP knows

[redacted]

[3] NOTE: Since the July 9, 2007 THP request for an advisory opinion letter, the Service Improvement Committee, charged with monitoring the compliance to clinical practice guidelines, has been collapsed into the QIC. The physicians, after meeting several times, believe that the clinical integration objectives are better served by having the same committee that develops the guidelines also monitor those guidelines.

[redacted] The QIC will use data like the above as action items for the membership at large, and the findings will be incorporated into the evaluation process. Specifically:

1. What can the selected PCP learn from the rest of the membership in order to favorably decrease his/her patient hemoglobin A1C scores?
2. What can the membership learn from the selected PCP to increase their annual screening rate for diabetic retinopathy?
3. Using the fourth quarter 2007 as a baseline, how will the membership show improvement over time by moving the mean from [redacted] overall compliance to incrementally increasing goals and established "stretch targets"?

III. Other Specific Responses Relating to Members and Membership

Following are other specific questions regarding membership concerns that the FTC raised and our responses.

1. Membership Update

Attached as Exhibit A is an updated membership chart, which shows the current number of THP member physicians and practice groups in each medical specialty. At this time, THP has a total of 212 physician members, 41 of which are employees of WCHSI or one of its subsidiaries.

2. Does TriState have any experience under its capitation program or otherwise in dealing with physicians who are either non-compliant or performing at sub-optimal levels regarding programs or standards under which TriState has operated?

TriState is in the very early stages of development of clinical practice guidelines. To date, 18 have been approved by the Board of Directors although 30 are in various stages of development and review. None of the guidelines have been disseminated to the membership as of yet, as THP also 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.

THP does have several examples of successfully dealing with physician groups who initially were non-compliant with program standards. [redacted]

[redacted]

The second example applies to THP's diabetes disease management program for the WCHSI Plan (described in more detail in Section VI below). [redacted]

3. Is this ($2,500 "joining fee") a new fee for existing TriState physician members to participate in the proposed program, or is it a pre-existing requirement for membership in TriState generally, that already has been paid by those physicians who currently are members, and therefore will only apply to new TriState members?

The "joining," or membership, fee as established in 1994 was, and continues to be, a one-time fee of $2,500. THP gave a $500 discount to those physicians who joined in the first 90 days. The membership fee has remained $2,500 since the close of the first 90-day open membership period and has been paid by all new members since then. Changes to the membership fee are at Board discretion, but no changes are anticipated. All future, new members will be required to pay the membership fee.

4. If the latter, will there be any additional fees charged to current TriState member physicians who already have paid the $2,500 joining fee in order for them to participate in the proposed program?

At this time, no additional fees are expected to be required of the membership. Capital contributions and retained earnings from network access, medical management, and health risk assessment fees charged to self-insured employer groups have been adequate to fund THP operations to this point. THP plans to continue funding its operation from payer network access and medical management fees. In the event that

THP's operation costs and the costs of the EHR exceed THP's income, the THP Board does have the ability to assess THP's members.

5. What other financial "investment," if any, will TriState member physicians be required to make in the proposed program (e.g., computer hardware/software, etc.)?

One hundred percent of THP member offices currently have computers and internet access, which are requirements of all members for participation in the clinical integration program. The estimated annual cost to a physician office for high speed internet access is $600, with an annual modem fee of $60. Because 69.8 percent of THP practices are already using the THP/InforMed online system for administrative functions (e.g., referrals and claims submissions) related to Plan enrollees, many offices may not require additional hardware. Physician offices generally embrace this technology and have made the necessary purchases that help to increase office efficiency. The remaining offices that are not currently accessing the online system will likely need to add additional computers and printers. THP estimates that cost to be approximately $2600.

THP anticipates that each physician will be required to attend four hours of training. After checking with several offices (both primary care and specialists), THP estimates the potential lost income of this attendance is approximately [redacted] per physician. Office staff will receive the same four-hour training as physicians, with the addition of customization of the EHR for the practice. The cost to the practice for training of the office manager would be approximately [redacted] for wages, and the cost to the practice for each nurse's training would be approximately [redacted]. For the average two-physician practice, a four-hour training session will cost the practice approximately $2500.

The rate limiting factor for the success of the EHR is having enough covered lives in the data warehouse to make the office effort worthwhile. THP is unsure what the critical mass requirement is, but does realize that the current number of covered lives (less than 6,000) is not sufficient. Anecdotally, THP has heard that physicians will use the EHR in one or more of the following four ways:

a. Several physicians have reported that they want the capability to have the applications available to them when the patient is sitting in front of them, and they wish to be able to log-in and pull up the chart. Those physicians may need to purchase additional hardware and internet access capability (hardwire, wireless, etc.) in order to use the EHR in this fashion.

b. For most practices, it is expected that the receptionist will print the EHR for each scheduled patient and place it on top of the patient chart for the physician to review during the patient visit. This also may require additional hardware, such as a dedicated computer and printer.

c. In order to move the mean, physicians have identified opportunities to use the EHR to reach out to non-compliant patients and schedule them for appointments. Again, this may require additional time investment by the physician and office staff to identify non-compliant patients and contact those patients.

d. At the request of the physician, THP's nurse case managers will review the EHR and forward to the physician areas of non-compliance or concern. Physicians will then have an additional time investment in determining how to become compliant, or, if the non-compliance is due to patient non-compliance, how to assist the patient.

It is noteworthy to mention that three physician directors attended the full-day seminar at the Federal Trade Commission on May 29, 2008 and that four physician directors and one physician committee member attended a full-day seminar in Chicago on June 25, 2008. A full-day out of the office for these eight physicians, plus a half-day out for travel to Chicago for the five, represent a considerable loss of income for these practitioners, but speaks volumes about their commitment to the success of the program and their willingness to convey lessons learned to their peers.

6. Will member physicians participating in the proposed program be required to make any non-financial investments in the proposed program (e.g., personal participation in program activities or committees, training of themselves and/or their office staffs, etc.)?

As stated earlier, over 40 physicians currently are participating in formal committees and governance. Many 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 THP,[4] but also an affirmation of commitment to clinical integration.

[4] See [redacted] of the newly revised Participating Provider Contract, which is Exhibit B to this letter.

Every physician and their immediate support staff will be required to attend training sessions on the use of the EHR, as noted above. Office staffs generally are very familiar and comfortable already with the basics of the software, as they use the software for InforMed referral management, claims submission, and enrollment verification. We anticipate that the office staff will adopt the EHR quickly, due to their current familiarity with the basic system, and can be expected to be an excellent front-line resource for keeping the physicians informed.

7. What will be the nature and extent of participation by TriState member and contracting physicians in the Clinical Integration Oversight Committee and its six sub-committees?

The Clinical Integration Oversight Committee ("CIOC") is composed of the chairs of the five sub-committees–Quality Assurance/Utilization Management ("QA/UM"), Credentialing, QIC, Pharmacy Benefits Management, and Care Coordination. The CIOC Chair is a physician Board member.

As of this writing, 35 physician members fill 51 physician governance positions. This excludes the medical director, who serves on 7 governance committees, attends the Board of Directors meetings, and also is a Class I member of THP. The physicians who serve in multiple roles, for the most part, are Board members who serve on committees, and committee chairs, who also serve on the CIOC.

The current Class I physician participation in each committee, including the medical director, is as follows:

Board of Directors – 9
Clinical Integration Oversight – 6
Quality Assurance/Utilization Management –5
Credentialing – 5
Quality Improvement – 11
Pharmacy Benefits Management – 4
Care Coordination – 1
Communications – 4
Bylaws – 4
Nominating – 5
Contracting Finance Administration – 6

To date, very few physicians have said "no" to a request to join a THP CIOC sub-committee or any of the other standing committees (Communications, Bylaws, Nominating, and Contracting Finance Administration) and those that have had very good reasons. All committees currently have a sufficient number of volunteers serving.

It is anticipated that the QA/UM Committee will add 4 additional physicians in 2009, while the QIC will add an additional 5 physicians as the committee begins to focus on quality metrics.

THP anticipates no problems in filling vacancies as physicians determine that it is time for them to rotate off of a committee. THP currently has no plans to impose term limits. As long as the leadership determines that a volunteer committee member continues to contribute in a positive manner and attend meetings, there would be no compelling reason to arbitrarily tell that physician that his/her services are no longer needed. While all of the standing committees have many new members, the two oldest committees– Quality Assurance / Utilization Management and Credentialing–have members who have served since inception (1995). These physicians have been critical to the development of the clinical integration program, have a vast amount of institutional history and perspective, and are looked at as leaders of the program. Again, THP has no plans or desire to arbitrarily rotate them off of these key leadership positions. THP has, however, included a requirement in its participation contract that each member physician commit to serving on a CIOC sub-committee if and when called upon.[5]

8. Will TriState require participation by all or certain TriState member physicians on any committees, subcommittees, or in other organization activities regarding the performance of physicians other than themselves (i.e., relating to their interdependent, as opposed to individual, performance)?

The QIC is committed to the process of utilizing data to review the activities of their peers in order to achieve continual process improvement and "move the mean." This includes the development of reporting mechanisms and actual presentations to the physicians, which will show where each physician meets standards or needs improvement. The committee is prepared to reach out to other physicians for assistance in this process, and the membership will know that their participation is a requirement of the program.

Physicians, perhaps more than most other professionals, are hesitant to sit in judgment of their peers lest those same physicians sit in judgment of them. In addition, physicians rely upon other physicians for referrals; any actions taken by one physician, such as advising another that his/her practice patterns are not up to the community standard, needs to be done very carefully. The leadership fully recognizes, though, that the way things have been done in the past is not sustainable for the future.

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[5] See [redacted] of the Participating Provider Contract, attached as Exhibit B.

Continual process improvement and resultant population health improvement will not occur without the courage to confront performance issues. The entire membership will be required to participate in these activities when called upon. This is an expectation of continued membership in THP and participation in the program and is embedded in the new contract. The QIC will be developing improvement goals, issuing "report cards" to the member physicians with recommendations for improvement, and working with those physician groups needing improvement.

Specifically, all physician members of THP will be expected to participate when called upon, and when appropriate, in quality improvement activities to include, but not be limited to:

a. Challenging peers to improve.

b. Sharing "best practice" ideas and methods with competitors in a manner that will help all learn and improve.

c. Mentoring practices that demonstrate difficulty in achieving quality improvement.

d. Reviewing patient files of lower performing physicians and making recommendations for improvement.

e. Leading training sessions in specialty-specific clinical practice guidelines and assisting colleagues in implementing those guidelines.

9. Please explain how Sections [redacted] of Exhibit 9 of your original submission ("TriState Member Participating Provider Contract - Clinical Integration") are consistent with TriState's purportedly operating as a clinically integrated joint venture of its physician members.

Section [redacted] of the original contract states, "Provider agrees and acknowledges that he or she remains solely responsible for all clinical judgments he or she makes with respect to his or her patients." Section [redacted] states, "For the purpose of this Contract and all services to be provided hereunder, each party is, and will be deemed to be, an independent contractor, and, except as provided in [redacted] of this Contract, not an agent or employee of the other party and neither may hold itself out as an agent or employee of the other party." The FTC staff should note that these provisions are standard contract provisions. There are two main reasons that these provisions are included in the contract, neither of which affects THP's integration.

First, these provisions are intended to preclude THP from liability in a provider's medical malpractice case. Even though THP's physicians will be guided in their practice by THP's guidelines, only the physicians will know whether following a guideline is the appropriate treatment for their patients. For example, a THP guideline may call for the prescription of aspirin to heart patients. Only the physician will know, though, whether a patient has an aspirin allergy that would contraindicate prescribing aspirin. Thus, the physicians must be responsible for assessing the patients and, ultimately, making treatment decisions.

Second, the Maryland Board of Physicians, the Maryland physician licensing body, has taken the position that a corporation may not employ a physician unless it is: 1) a professional service corporation; 2) a hospital; or 3) a health maintenance organization. Therefore, THP cannot legally control its members' clinical decision-making, nor can the physician members be anything other than independent contractors of THP.

Even if these legal justifications were not present, the contract provisions would still not be inconsistent with THP's operation as a clinically integrated joint venture. Clinical integration is a partial integration of providers who combine some, but not all, of their business activities through the joint venture. If the physicians were employees of THP or THP otherwise controlled their practices, THP would be a fully integrated entity and there would be no question as to whether there was sufficient integration for THP to contract with payers on their collective behalf.

10. Regarding the "non-exclusive" participation of TriState physicians in the proposed program, you discuss their freedom to contract individually and directly with payers. Is there any restriction or limitation on the ability of TriState physicians to also become members of other physician or provider networks, including other clinically integrated arrangements?

THP does not restrict its members' ability to join another physician or provider network. The only restriction regarding other networks is that a Class I THP Board member may not serve on the Board of Directors of another provider arrangement. As for joining a clinically integrated network, THP is not aware of any other initiatives in this area to form a clinically integrated network. THP is following the activities of other provider organizations in our market area, however. Should such an initiative arise, THP will evaluate, at that time, whether or not imposing such restrictions are both viable and legal. Our concern is that if the quality improvement initiatives of another such arrangement are significantly different than those of THP, THP's program could be jeopardized. Again, counsel will be consulted before decisions are made regarding permitting participation in such arrangements.

IV. Role of Washington County Hospital Association and the Health System

This section will discuss the advantages and disadvantages to THP of having the Washington County Hospital Association ("WCHA") and its ancillary business entities as partners in the clinical integration strategy. It also will discuss the advantages and disadvantages to the Hospital and its ancillaries of participating in the program. Suffice to say however, the hospital leadership is 100 percent committed to the success of the partnership and, to date, has taken absolutely no actions that could be interpreted as anything less than full support. As will be evident from the discussion, WCHSI is more than a contracting payer for the program, and WCHA is more than a member of THP, an investor, a partnering provider, and a competitor.

Advantages to THP

1. The Washington County Health System, with about 2,970 employees in total, is the largest employer in Washington County (according to the 2008 Business & Industry Directory of Washington County). As such, the health system has [redacted] total covered lives in its employee health benefit plan. There are two major advantages to THP with these numbers:

   a. The EHR development, monitoring of baseline compliance to evidence-based medicine and clinical-practice guidelines, and the evaluation of preliminary practice efficiency indexes would not have been possible without an initial large volume of covered lives populating the data warehouse. The WCHSI Plan has provided sufficient covered lives to get the clinical integration program started. With these [redacted] covered lives, we are able to demonstrate to payers, purchasers, and the physician membership the "art of the possible." For many, seeing the technology fulfill its potential has truly been an enlightening moment.

   b. The access, medical management, and disease-risk assessment fees paid for care rendered to THP's current self-insured enrollees, including the WCHSI Plan, have allowed THP to fund its day-to-day operations to a level sufficient to build the internal infrastructure to support the program. Future initiatives, such as a community-wide electronic medical record or development of a local health information exchange organization, may require capital beyond the capabilities of either partner. There are significant advantages to having the hospital as a partner when THP will face increased capital requirements to fund the next generation of quality improvement initiatives. Funds will also come from payers supporting THP programs that produce better outcomes for their members, a direct result of physicians

providing clinically integrated services to those payers. While THP non-clinically integrated programs currently are focused on the self-insured market, it is anticipated that the long-term value to the community will be with the fully-insured market where aggressive care management and clinically-integrated programs are essential to population health improvement, increased quality, lower costs, and decreased financial exposure to the health plans.

2. The 50 percent capital contribution by the hospital is not insignificant. Again, when matched to that of the physician contribution, these funds have provided sufficient funding to date for infrastructure development to support the program.

3. The power of the EHR over other such advancements in technology is the marriage of medical claims data with lab values and pharmacy data. This marriage would not have been so easily, or possibly, achievable if outside reference labs or non-aligned retail pharmacies were used. As an owner of the major reference lab in the county, Hagerstown Medical Lab ("HML") and with about [redacted] pharmacy market share through its owned pharmacies (Home Care Pharmacy), synergies have been created that significantly enhance the value of the program technology to the end user. For example, WCHA bills generic revenue codes for lab testing performed for emergency room and inpatient patients, so plain claims data would not supply useful data for the EHR on the tests performed. Because HML is integrated with WCHA, HML is able to transmit to THP for inclusion in the EHR lab values for WCHA patients. Inclusion of the lab values in the EHR should prevent duplication of tests and allow for better tracking of health changes post-discharge, reducing readmissions.

4. Several of the hospital-employed, hospital-based and joint-venture-aligned physicians serve in prominent leadership and support roles in the development of the program. The expertise, counsel, and advice these consultants bring to THP may not have been present were they not aligned with the PHO through the health system's involvement and commitment to the program.

5. Several key hospital and Antietam Health Services directors and managers serve on THP committees. From the hospital, this includes the vice president of medical affairs, the vice president of finance, director of public relations, director of health management, director of behavioral health, both the director and manager of integrated patient support services, and the manager of total rehab care. From Antietam, this includes the vice president of operations, executive of operations, pharmacy benefits coordinator, and four of the clinical pharmacists. Without the "H" partner in the PHO, the expertise of these personnel would not be realized.

6. As a major employer, the hospital, its executive leadership, and its board of directors have a significant presence in the business community. These hospital representatives are key to assisting THP in communicating its message to other purchasers of health care in the community. An example is coordination of introductions to community groups where THP can present its strategy for population health improvement.

7. The hospital provides formal forums for presentation of the program to key constituents. This includes the quarterly meeting of the medical staff, medical staff departmental meetings, and various boards.

8. The THP member physicians, as partners with the hospital in the clinical integration program, will have better alignment with the hospital, as both parties focus on outcomes and the care of the patient through the treatment continuum. Payers will place high value on the presence of a vertically integrated program in the market place because of the potential cost savings through the management of patients' care.

9. According to speaker Toby G. Singer, Esq., at the FTC Clinical Integration Workshop of May 29, 2008, clinically-integrated provider programs aligned with a hospital partner, such as PHO's, generally are more successful due to the hospital's access to capital, information technology expertise, funding capabilities, and awareness of Stark and regulatory restrictions.

Disadvantages to THP

1. A major disadvantage of having the hospital as a partner is the issue of patient steerage to the hospital and its rate regulated environment, as both inpatient and outpatient rates are non-negotiable in Maryland when provided in the hospital setting. Payer fiscal interests are best met when as much care as possible can be delivered outside of the hospital because those rates of reimbursement are negotiable. As such, payer and THP incentives are potentially opposed to those of the hospital.

   THP has long recognized that when services are provided within the hospital's own walls for services the hospital also pays for as a self-insured employer, it is in the hospital's best interests to steer that business within. These transactions impact the hospital income and expense statements, but not the balance sheet. However, physicians are making care decisions based on what is most appropriate and cost effective for an individual patient's circumstance.

   To date, however, the issue of steerage to the rate-regulated environment has not been an issue when it is not in the best fiscal interests of the non-

WCHSI, self-insured health plans managed by THP. For these plans, THP steers to the unregulated environment, unless there is a compelling clinical reason for utilizing the regulated environment. The hospital fully supports these THP steerage decisions, which are made in the best fiscal and clinical interests of the clients.

2. Angst has been expressed periodically that the hospital could exert influence in ways that are detrimental either to THP or to the independent physicians. While this has not occurred to date, it almost is a natural tension point that always will exist between independent physicians and any hospital. At the Board of Directors level, the Class I members (physicians) have one vote and the Class II (hospital) has one. There must be unanimity for a resolution to pass. To date, this has been an effective mechanism for dealing with fears of an imbalance of power at the highest level of PHO leadership.

3. The hospital is viewed by many private physicians as a competitor. As in other areas throughout the country, physicians in Washington County have been expanding their outpatient services and seeking new business and investment opportunities. While the hospital has successfully joint ventured with many of these physicians and clearly wishes to continue these business arrangements, not all physicians want the hospital as a joint-venture partner. This tension is most clearly obvious when the hospital insists that the care for which it pays for WCHSI Plan enrollees is delivered within the WCHSI system. Several physicians have used WCHSI's steerage of Plan enrollees as a reason for not wishing to further partner with the hospital. Generally speaking, however, once physicians understand the economics from the hospital's perspective, tension dissolves.

Advantages to Hospital

1. Population health improvement, continuous quality improvement, and controlling the escalating costs of healthcare support the mission of the hospital and health system. Through its alignment with THP, the health system has been able to keep its increase in medical and pharmacy claims to [redacted] for the past fiscal year over the previous fiscal year. For the current fiscal year-to-date, the trend is [redacted]. Anecdotally, we hear of increases year-over-year of 15 percent to 35 percent for local fully-insured employer groups. One of the hospital's agenda items is to ensure that local employer groups--whether fully- or self-insured--have access to the successes the hospital has enjoyed as a result of its relationship with THP.

2. As mentioned previously, there exists at all times a state of tension between a hospital and its medical staff. Unless the two parties are joint-

venture partners, it is very difficult to align incentives. The PHO, however, is a powerful joint venture and medical staff integration strategy. As both sides continue to work to develop the program, and recognize the value the other brings to the process, relationships can only be strengthened. This serves as a compelling incentive for the hospital to participate in the program.

3. THP, through its active governance and committee structure, is serving as an excellent vehicle for developing physician leaders for the future. As these physician leaders learn to work more closely with the hospital leadership on THP's clinical integration program, they will gain the skills to work more closely with the hospital in medical staff leadership positions. From the hospital's perspective, THP membership is a good investment in its own future physician leadership development and integration strategies.

4. Under the Maryland's hospital rate-regulated-reimbursement system, hospitals have an incentive to receive the incremental admission. The hospital fully recognizes that between managed care payers and THP, forces external to them will work to keep patients out of the hospital. But when that patient does require acute hospital care, WCHA wants to ensure that the incremental admission is coming to it. If WCHA is closely aligned with THP and its clinical integration program, the sense is that the physicians will want to admit to a hospital that adheres to its program protocols.

5. Hospitals in Maryland, under the regulated reimbursement system, have a financial incentive to reduce length of stay. The more that care is managed by THP and its physician partners, the more the hospital can trust that its joint-venture partners are protecting its interests in controlling length of stay.

Disadvantages to Hospital

There are few disadvantages of THP membership to the hospital that have not been addressed in one way or another previously. The hospital can be expected to see its admissions decrease, but this is happening regardless. The hospital will continue to lose outpatient business to the physicians, but this is happening regardless. And the hospital will need to continue to match the physicians with capital infusion but again, this is an investment that the hospital believes to be worthwhile. A venue for the hospital to create business partnerships with key physicians and to focus physicians on hospital goals (such as reduced length of stay) is an advantage that outweighs any significant disadvantages of the partnership. The hospital recognizes that physicians drive clinical outcomes and desires to support the physicians in the process.

V. InforMed Relationship

The InforMed suite of technology tools serves as the platform that supports the entire clinical integration program. Specifically, the EHR is the vehicle which facilitates the interaction among disparate groups of physicians that will occur when all can view, at their individual desktops, the entire continuum of care including office, hospital inpatient and outpatient, tertiary facility, in-network, out-of-network, and ancillary services including pharmacy and lab values, home care, and durable medical equipment. The suite of software also provides the evidence-based medicine guidelines, reporting of compliance to those guidelines, predictive modeling, and efficiency index comparisons for the individual physicians to local, regional, and national databases.

As critical as the EHR is to THP's clinical integration program, its effectiveness is severely limited by a lack of critical mass of data flowing through the data warehouse. Currently, the EHR is populated only by those claims for which InforMed is the TPA.

In an absolutely ideal world, every citizen in our community would have an individual EHR available at the desktop of every physician and caregiver in the community. Because populating the EHR requires claims flowing through the InforMed data warehouse, this would require that every claim produced by every provider find its way to InforMed, which is unlikely to happen in the near future. Although the EHR will be of optimal value if it contains all information for all patients, it is not valueless if it only contains information for all patients covered by clinical integration contracts. THP's physicians will need some means of seeing for those patients whether the guideline-directed care has been delivered.

THP intends to populate the InforMed data warehouse with claims data from the plans with which it contracts. THP will negotiate with payers interested in purchasing THP's program to ensure the payers furnish the data that populates the InforMed data warehouse. THP is aware that CareFirst BlueCross BlueShield currently makes claims data available to InforMed for other client arrangements. If payers are unable to furnish the data, THP's fall-back position is to obtain the claims data from its members. THP's member participation contract requires all THP members to submit duplicate claims to InforMed upon request. Because of the challenges of collecting claims data from hundreds of physicians, as opposed to the handful of payers, data collection from the members is likely to be a short-term requirement of program participation.

THP's current clients, including the WCHSI Plan, chiefly relate to InforMed for TPA services–claims adjudication and payment, membership enrollment, stop loss insurance placement, etc. THP's relationship with InforMed, however, is more as the technology support company. The obvious strength of this relationship is the availability of the EHR, in addition to the medical management suite of software

(MMOTS - Medical Management Outcomes Tracking Software).[6] The real value InforMed provides THP is its data warehouse capabilities.

Once THP begins to sell its program, it anticipates that InforMed will continue to serve existing self-insured clients in our market as the TPA. InforMed may even develop additional TPA business as a result of its relationship with THP. In fact, THP would prefer that future self-insured clients choose InforMed as their TPA because of the excellent working relationship developed over the years between the two parties.

THP, however, does not need InforMed as the TPA for any of its future clients who purchase its programs, including self-insured clients. When THP's plan to sell its programs to the major payers comes to fruition, it is not expected that InforMed will be involved in any role other than THP's data warehouse, software development, and technology vendor. What InforMed cannot bring to THP are fully-insured, major purchasers. In addition, due to its lack of physical presence in the community, InforMed has been relatively unsuccessful at bringing self-insured clients to THP.

Since our letter of July 9, 2007 to the FTC, THP has created a position of manager of business development. [redacted] Again, unless InforMed also serves as the TPA to these potential new lines of business, the only expectation of InforMed is that it will continue to serve as THP's data warehouse, software development, and technology vendor.

VI. Diabetes Management Program

On February 1, 2005, THP implemented a three-year diabetes management program (the "Program") on behalf of the WCHSI Plan. The Program was intended to demonstrate that intensive care management of a population, combined with a network of cooperating and collaborating physicians, could have a positive impact on the health of these Plan members. THP's Quality Assurance/Utilization Management Committee developed, and had continual oversight over, the program. THP was confident of its ability to manage this program and put $81,577 at risk. If there were Plan savings, THP would receive 50 percent of those savings up to $81,577 (the "stop loss" point), but if there were no savings, THP would reimburse the Plan 50 percent of the downside up to the stop loss point. Due to the successful results of the program, the THP's share of the savings was $79,949.

[6] Of note is InforMed developed the EHR with the active support and involvement of the THP QA/UM Committee and management.

A. Program Design

The Plan agreed to the following THP recommendations for the Program:

1. [redacted]
2.
3.
4.
5.
6.

The period 2/1/2004 to 1/31/2005 served as the baseline year. The costs of managing this population were calculated along with baseline clinical and utilization metrics. The Plan agreed that the annual costs during the Program would be adjusted each year for comparison to the base year to account for:

1. Cost increases due to inpatient care rate increases granted by the Maryland Health Service Cost Review Commission ("HSCRC").

2. Expected increased costs due to the natural progression of the disease, determined by the ADA to be five percent per year.

3. Cost increases due to the addition of a bariatric surgery benefit, a benefit not available to Plan members during the base year.

B. Physician Involvement

THP's physicians' engagement and cooperation were critical to the success of the program. Specific physician engagement in the program included:

1. The QA/UM Committee developed the program and monitored the program to ensure success.

2. THP's Medical Director held meetings at which the member physicians engaged in a dialogue with THP's staff about the best means by which the staff could support the physicians in implementation of the program.

3. THP physician members worked closely with THP's Disease Managers to ensure patients received proper medications, appropriate testing was ordered in accordance with the time guidelines, patient were properly encouraged to comply with treatment regimens.

4. Disease Managers encouraged patients to discuss and address health issues with their primary care physicians and would let physicians know about patient issues, facilitating timelier and better focused treatment.

C. Population Clinical Results

1.
2.
3.
4.

[redacted]

D. Population Utilization Results

1.
2.
3.
4.
5.

[redacted] These trends indicate:

a. THP and its physicians successfully directed the right care to the right setting at the right time.

b. THP and its physicians decreased the Program population's use of high-cost acute-care settings, including the emergency room.

c. Patients who were admitted to the hospital required more intensive resources, as evidenced by a [redacted] percent increase in the per diem costs over the Program (an amount not entirely attributable to HSCRC rate increases).

d. Patients who were admitted to the hospital, despite being more complex than admittees in the baseline year (as evidenced by the per diem increases), had shorter lengths of stay.

e. Physician-patient bonding was enhanced for both established and new patients; patients not being seen enough were being seen more often, and diabetic patients previously not obtaining preventive care were successfully directed to physicians' offices.

E. Population Financial Results

1. Overall, the Plan experienced a $159,898 reduction in total costs for this population during the 3-year period. Thus, THP physician performance was rewarded with 50 percent of these savings, or $79,949.

2. The Plan experienced a [redacted] percent increase in medical management costs, paid to THP for managing this population. The medical management return on investment (ROI) was conservatively calculated at [redacted], somewhat better than commercially available disease management programs.

F. Conclusions

THP and its member physicians are extraordinarily proud and pleased with the results of the Program. Physician participation in this demonstration project was voluntary. All physicians and practice groups with diabetic Plan enrollees cooperated in the program, with the exception of one primary care practice that did not initially commit to the Program but later agreed to participate.

Clearly, physician engagement and cooperation, with excellent support from THP staff, resulted in a successful program. Highly personalized disease case management, coupled with a motivated community of physicians, resulted in a positive impact on a small (190) patient population with a disease particularly challenging to manage.

Utilizing lessons learned from the Program and the technology tools provided by InforMed, THP and its member physicians are optimistic that the lessons from this experience can be extrapolated to the clinical integration program—a larger-scale quality- and cost-improvement effort that will cover multiple diseases for a significantly larger patient population and require active cooperation and engagement by all members of THP. A positive advisory opinion from the FTC will permit THP and its physicians to begin discussions with the other health plans in the THP market area, allowing THP to reach other community members who can benefit from THP's emerging clinical integration strategy and its medical management programs.

VII. Differences and Similarities Between Current and Future Operations

The following answers respond to questions raised on page 4 of your letter.

What aspects of, or programs or activities that will be part of, the proposed clinical integration program are currently in place or operating with regard to TriState's provision of services under its existing contracts?

With regard to services provided currently to payers under THP's existing contracts, THP will continue to offer:

1. Delegated credentialing. THP's credentialing program exceeds the standards set by NCQA.

2. Utilization, disease, case, and pharmacy management. The full medical management services that THP currently sells health benefit plans will still be available for purchase. THP will, however, incorporate certain aspects of these services into its clinical integration program, as explained more fully below.

3. Online referral management. The referral management program on the THP/InforMed web site is currently only used for InforMed-contracted plans. Following implementation of the clinical integration program, THP providers will use the software to initiate all referrals for THP-contracted plan enrollees.

4. Utilization of the Symmetry software suite on the InforMed site. The ETG, ERG, and EBM Connect software are currently used by THP staff to provide information to contracted payers. This will continue. Currently, THP committees make limited use of the software, but that will change under clinical integration. Few THP member physicians even know about

this software right now, but that will soon change as is explained more fully below.

5. Health Risk Assessments ("HRA") – THP utilizes a commercially available disease risk assessment tool from BioSignia (Know Your Number) that serves as not only a robust predictor of risk for ten major diseases but also as a powerful tool to reflect the percentage of that risk that is patient-modifiable through targeted lifestyle changes.

Current interactions between THP and its member physician offices are currently confined to limited activities, all of which will continue under the proposed clinical integration program. These activities include:

1. Credentialing and recredentialing, including site surveys. This comprises close to 80% of the current interaction between THP and its member offices.
2. Administrative assistance solving providers' problems with InforMed and THP clients.
3. Training assistance to the office staff on the referral management and eligibility verification components of the InforMed software.
4. Issuing passwords to the InforMed site for new employees and "resetting" passwords when required.
5. Nurse case managers interact with office staff and member physicians on a situational dependent, case-by-case basis, including support to the WCHSI Plan diabetes disease management program described above.
6. Provision of "value add" services to the membership, such as group purchasing of supplies and group discounts from a collection agency.

Please explain exactly how the proposed program will differ from existing practices and programs of TriState.

The proposed clinical integration program will see significantly increased interaction between THP member physicians and between THP and its member physician offices. These activities will include:

1. Utilization of the EHR – All physicians will be expected to access and utilize the EHR as the main tool for ensuring a high degree of cooperation, collaboration, and mutual interdependence, which are lacking under the current model. THP will be monitoring closely the "hits" to the EHR from its members to ensure the expected utilization and will work with those

that may be less than compliant in utilization. THP's physician leadership expects that significant utilization of the tool will result in such improvements as virtual elimination of duplicate and/or unnecessary diagnostic tests, increased compliance with prescription drug utilization, increased communication between physicians on coordinated-care plans, increased evidence-based-medicine compliance, and improved patient education. All plans with which THP contracts will be expected to furnish data to the THP/InforMed data warehouse to populate the EHR.

2. Clinical Guidelines – The QIC, with the assistance of many THP members, continues to develop clinical practice guidelines in anticipation of a favorable advisory opinion and the subsequent implementation of the clinical integration program. It is the objective of the QIC to create at least one guideline for each medical specialty THP's members represent. Every physician will be required to comply with the guidelines applicable to their patients.

3. Performance Improvement - Utilizing both the ETG and EBM Connect components of the software, THP's QIC and staff will identify both over- and under-utilization by THP physicians and use that information to work with THP's members on performance improvement activities, with the combined objectives of identifying and promoting "best practices" and moving the mean on key quality indicators (e.g., increasing colorectal cancer screening compliance, lowering HbA1C percentage scores, and monitoring and improving lipid profile scores). As explained more fully in Section III above, THP also intends to make use of peer education opportunities.

4. Cost Containment Measures – THP's QA/UM committee, with the support of THP's staff, will monitor the cost of care for, and use of resources by, each physician. Using report cards, THP will provide feedback to the physicians with comparisons to not only their THP peers but also to regional and national benchmarks. Physicians identified as high cost providers, and/or over/under consumers of resources, will receive assistance from THP staff and case managers and, if necessary, counseling from peer physicians.

5. Patient Compliance Assistance – The nurse case managers, when requested by a physician, will monitor compliance metrics and work with the physician and patient to increase compliance. Physicians who do not avail themselves of this support will be monitored to ensure that they are practicing to program standards and, if they are not, the QIC may recommend intervention by the nurse case managers where appropriate.

6. Wellness Programs – THP will be developing additional wellness programs with the expectation that its member physicians participate not only in program development but also in supporting and promoting these programs.

7. HRA – Currently, THP highly encourages HRA participants to share the results of their profile with their physicians, but THP does no follow up. After implementation of the clinical integration program, THP and the physicians will work together with the participants to assist them in modifying and lowering their risk.

8. Pharmacy Assistance – THP currently conducts focused pharmacy reviews only on patients with chronic diseases. Under the clinical integration program, THP will add to this service assistance with pharmacy pre-authorizations and methodologies for increasing generic utilization. A long-term THP objective is for the Pharmacy Benefits Management Committee to develop a single formulary that will apply to all payers contracting with THP.

9. Coding Assistance – As the EHR is populated with claims data, it is imperative that procedure and diagnosis coding is accurate and thorough. While the THP leadership fully recognizes that the data "is what it is," it also recognizes that there always will be room for improvement to make the EHR more relevant and actionable for the end-users. For example, [redacted] THP will be working closely with its member physicians and their office staffs to ensure appropriate coding.

How will the proposed program differ from the utilization and medical management services currently provided by TriState through its arrangement with InforMed and its CHP network?

The utilization and medical management services provided by THP currently benefit only those clients who specifically contract for those services, such as the WCHSI Plan, [redacted]. Payers with which THP contracts under the clinical integration program will be encouraged, and possibly receive special financial incentives, to utilize THP's utilization, case, medical and disease management programs in order to ensure a more seamless provision of care. THP recognizes, however, that the major plans in the THP market have invested significant

resources in providing these services and may not wish to outsource them. Regardless, they will be required to furnish enrollment and claims data to THP in order to populate the EHR.

It is important to note that THP's current utilization and medical management services are primarily provided by THP staff, not its member physicians. Thus, they are supplemental services that can greatly benefit, but are not central to, THP's clinical integration program, under which physicians will be the key service providers. The utilization management under clinical integration will be done by the QA/UM and QIC committees and will focus more on the use of resources by THP's physicians, as explained above. For plans that do not purchase medical and disease management, THP physicians will have the assistance of THP's nurse case managers for working with high-cost and non-compliant patients, so that the physicians will still be able to attain quality and cost benchmarks.

VIII. THP Staffing Update

THP continues to develop infrastructure to support the PHO and its clinical integration programs. Since our letter of July 9, 2007, two additional positions have been added and there has been turnover in one manager position.

IX. Payer Interest

THP has presented its clinical integration strategy and use of technology tools to the administrative and clinical leadership of United Healthcare, Coventry and Maryland Physicians Care, and to the local medical director of Aetna. The concept has been presented to the administrative leadership of CareFirst BlueCross BlueShield and to Today's Options, a Medicare private-fee-for-service program that also will be offering PPO and HMO products in the THP market in 2009. No negotiations have ensued with any of these plans.

1. United Healthcare, through its subsidiary Ingenix, owns the Symmetry suite of software that InforMed has implemented to support THP's program. In the summer of 2006, several senior level executives – including a medical director and an information technology senior vice president – visited THP for a 4-hour presentation on the EHR. Due to our ability to capture lab values plus mental health and pharmacy data, United was intrigued by our progress with the technology, admitting that they were not able to use the technology in such a way so as to deliver actionable information directly to a physician desktop. A United senior vice president has indicated that United is keenly interested in working with THP once THP has a favorable advisory opinion. United understands and supports the decision not to move forward with any negotiations until the advisory opinion is received. It is noteworthy to mention that the United executive contacts THP on a quarterly basis to inquire about THP's progress.

   United purchased MAMSI Health Plans about three years ago. MAMSI's entire senior management team, including the local president,

have also visited THP and participated in a demonstration. It was their keen interest conveyed to corporate United that lead to the 2006 visit by United. [redacted]. During this visit, the MAMSI medical director expressed significant surprise that any provider would be thinking the way THP was thinking; this was a first for him. THP is optimistic that United, once it is able to resolve the hurdle of furnishing claims data to THP's data warehouse, will be an important future partner.

United/MAMSI is the second largest commercial payer in the Washington County market.

2. Coventry of Delaware is a plan new to the Washington County market. [redacted] Coventry is seeking any and all strategies that will enhance its value to employers in our market. Senior executives and the plan medical director have visited, reviewed the technology, and, like United, await the opportunity potentially to partner with us.

3. Maryland Physicians Care is the Medicaid managed care organization 25 percent owned by the Washington County Hospital Association and managed by Schaller Anderson, Inc. (SAI) of Phoenix, Arizona. [redacted]

4. The local Aetna medical director has visited and reviewed the technology. This physician was clearly impressed by the program and wants to be kept abreast of developments. [redacted]

5. Senior leadership of THP, Washington County Hospital, and CareFirst BlueCross BlueShield have discussed the clinical integration program in concept. [redacted]

6. Today's Options is a Medicare Advantage plan currently offering only a private-fee-for-service (PFFS) product in our market. However, Today's Options anticipates a migration of the PFFS population to HMO and PPO products. This will result if Congress takes much-anticipated action on reducing outlays to the PFFS product, a product that has cost the federal government, on average, 19 percent more than traditional Medicare.

Once a favorable advisory opinion is received, THP intends to begin active discussions with the self-insured plans currently under management–WCHSI Plan, [redacted]–plus United, Today's Options, and CareFirst. We are confident that these payers will give us the platform from which to introduce the program to virtually all payers, including other governmental programs.

X. Pay-for-performance

As noted in the advisory opinion request, THP intends to work with payers to develop a pay-for-performance ("P4P") model under which THP physicians will have one set of guidelines and will be held to one set of performance measures, across all payers, for those guidelines. The following are your questions and our responses regarding P4P:

Regarding the discussion in your initial submission of a future "pay-for-performance" component of TriState's operations, it is our understanding- that your current request for an advisory opinion is not premised on an assertion of financial integration among TriState's physicians based on this possible future

activity. However, you state that, in order to implement that program, "TriState believes that it will need to collect a year or more of performance data from its physicians, showing the success of its clinical integration strategy for self-insured employers and smaller payers. Thus, it will need to contract on a fee-for-service basis for some period before it is able to implement its P4P program." It is not clear whether you therefore are separately asserting that such fee-for-service contracting is justified at this time as reasonably necessary (i.e., "ancillary") to implementing a financially integrated, efficiency enhancing, joint venture among TriState physicians in the future.

THP is not requesting an advisory opinion as to whether its proposed P4P program will result in sufficient financial integration to justify joint contracting. Because THP has not been able to engage in contract-term discussions with payers, THP is unsure whether payers will initially include P4P in their contracts with THP and, if they do, what amount of money the payers may place "at risk" for THP meeting specified benchmarks on a set of performance measures. Without knowing the amount at risk, there is no way for THP, or the FTC staff, to assess whether the amount at risk would provide sufficient incentive to THP's members to work cooperatively to control costs and improve quality.

Although it is possible that THP's P4P program could result in financial integration of its members at some point in the future, THP intends for the P4P program to supplement its clinical integration program and provide a means of partnering with the payers to achieve quality and cost efficiencies. As such, THP is not claiming that its fee-for-service contracting with payers for its clinically integrated product is ancillary to implementing the P4P program.

THP's statement in its July 9, 2007 letter regarding the need to collect a year or more of data and provide payers evidence of the clinical integration program's success prior to implementing its P4P program was not intended to raise questions as to the legality of the P4P contracting methodology, or joint contracting for the clinical integration product. Rather, the statement was directly related to the preceding supposition regarding payers' potential reticence to set aside their own P4P models. Several of the large payers who have expressed interest in THP's program (as explained above in Section IX) currently have their own P4P programs. If these payers contract with THP on a P4P basis in the first year, they will likely insist that THP participate in the payers' own P4P programs. Hence, THP's argument that payers will most likely need evidence of the clinical integration program's success—achievement of the payers' P4P goals—before those payers will be willing to work cooperatively with THP.

XI. Questions Regarding the Justification for Joint Contracting

In your letter, you raised a number of questions regarding THP's need to contract on the collective behalf of member physicians and its asserted justifications. A number of questions raised on pages 4 and 5 relating to the contract physicians are no longer relevant, due to THP's elimination of contract physicians. The following should address the remaining issues.

How does TriState's proposed program assure that it will have "the same network for all integrated product contracts?" Specifically, why isn't TriState's policy of allowing additional physicians to join TriState at any time and participate in the clinical integration program—which necessarily will change the composition of the network—inconsistent with this rationale?

As explained in Section II above, THP has made the decision to close the PHO after an initial period and to only allow new members to join in limited circumstances. With this new policy in place, THP anticipates that additions and deletions will be minimal, and THP's clinical integration network should remain fairly uniform after program implementation. There is no expectation that limited additions will have any affect on THP's ability to achieve its efficiency goals, and it is likely that payers and patients will welcome additions, particularly where they fill gaps in THP's network. The minimal additions also should not adversely affect THP's joint contracting rationale of ensuring the same network for all integrated product contracts.

In your discussion of the need for joint contracting through TriState, you state (page 29 of your initial submission) that "[a]bsent assurance of participation in TriState's contracts, and thus a share of the revenue generated by those contracts, the physicians would have less incentive to devote substantial time" to the various activities necessary to successfully implement the proposed program. While we understand that physicians may need to recover the opportunity costs of their participation in a program that requires additional time and effort on their part, or desire to make a profit from development of such a program, it is not apparent why that payment or profit needs to come from presumably higher, jointly agreed upon, fee-for-service charge levels by the physicians for their underlying medical services provided under the program.

Although THP does hope to sell a premium product for a premium price, THP did not intend to suggest that THP physicians will not participate in the clinical integration program unless they get paid more than they do currently. Rather, THP physicians will not have a reason to invest their time and effort into the program if they are not guaranteed participation in the THP payer contracts (regardless of the level of reimbursement they receive). Without such investments, the program will not be successful.

XII. Market Power Questions

In a recent conversation, you asked whether THP, or THP in combination with WCHSI or its subsidiaries, would have market power in medical services markets or insurance markets. The answer is no.

A. THP Will not Have Market Power in the Physician Services Market

As we explained in our July 9, 2007 letter, THP will be a non-exclusive network, and, therefore, payers will remain completely free to contract with its participating providers directly or through other organizations. Accordingly, were THP to attempt to exercise market power by raising prices for physician services above competitive, quality-adjusted levels, payers could simply refuse to contract with THP and purchase physician services through other venues. As a result of THP's non-exclusivity, payers will be able to defeat any attempt by THP to exercise market power. To obtain payer contracts, THP will have to price its clinical integration product competitively.

B. THP and WCHA Will not Engage in an Illegal Tying Arrangement

We understand that concern exists that THP may condition the sale of hospital services on payers' purchasing physician services from it. THP has not tied, and will not tie, hospital services and physician services in contracting with its customers.

WCHA also will not tie the sale of its hospital services to payers' purchasing THP's physician services. WCHSI and WCHA are supportive of THP's clinical integration program and have much to gain, as discussed above, from THP's success.[7] THP will actively market its clinical integration product to payers and, if asked regarding THP's performance, WCHSI representatives will share their Plan's positive experiences indicating that THP can deliver a superior product. But WCHA will not force any payer to buy THP's clinically integrated product by conditioning the sale of WCHA's hospital services on the payer contracting with THP.[8]

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[7] See the discussion in Section IV regarding the advantages and disadvantages to WCHA for its participation in THP.

[8] THP and WCHA understand that the advisory opinion will be based on their representations. Assuming that the opinion is positive (i.e., Commission staff will not recommend an enforcement action if THP proceeds with implementation), both parties know that engaging in activities counter to their representations could result in rescission of the opinion and an enforcement action by the Commission.

C. THP and WCHSI Cannot Monopolize the Private Insurance Market

THP and WCHSI, through its subsidiaries, sell products and services to self-insured employers and health insurance plans. Neither THP nor WCHSI sell private health insurance.[9] A company cannot monopolize or attempt to monopolize a market in which it does not compete. Therefore, THP, by itself or through some arrangement with WCHSI, cannot monopolize, attempt to monopolize, or obtain any market power at all in the market for private health insurance.

****

THP appreciates the opportunity to respond to your questions and concerns. They have attempted to respond to your questions in as complete a manner as possible. If you have any questions regarding any of the above responses or any additional questions or concerns with their proposed program, please let me know.

Best regards,

Christi J. Braun

Enclosures

[9] WCHSI and three other health systems own Maryland Physicians Care, a Maryland Managed Care Organization that is licensed to provide health care services to Medicaid enrollees in Maryland's HealthChoice program.

Exhibit A

SPECIALTY	WCHSI EMPLOYED[5]	TRISTATE MEMBERS[5]	TOTAL[5]
Allergy, Asthma/Immunology	0	2 (1)	2 (1)
Anesthesiology	0	9 (1)	9 (1)
Cardiology	0	14 (4)	14 (4)
Dermatology	0	3 (2)	3 (2)
Endocrinology	1 (1)	1 (1)	2 (2)
Family Practice	12 (4)	14 (9)	26 (13)
Gastroenterology	4 (1)	4 (2)	8 (3)
General Surgery	1 (1)	7 (6)	8 (7)
Gynecology	0	1 (1)	1 (1)
Internal Medicine Primary Care	12 (4)	18 (13)	30 (17)
Medical Oncology	0	1 (1)	1 (1)
Nephrology	0	2 (1)	2 (1)
Neurology	0	7 (5)	7 (5)
Neurosurgery	0	4 (1)	4 (1)
Nuclear Medicine/Nuclear Cardiology	1 (1)	0	1 (1)
Obstetrics/Gynecology	6 (2)	8 (3)	14 (5)
Ophthalmology	0	2 (2)	2 (2)
Oral & Maxillofacial Surgery	0	5 (2)	5 (2)
Orthopedics	1 (1)	12 (3)	13 (4)
Otolaryngology	0	7 (3)	7 (3)
Pain Management	0	4 (3)	4 (3)
Pathology	0	4 (1)	4 (1)
Pediatrics Primary Care	0	12 (4)	12 (4)
Physical Medicine/Rehabilitation	0	4 (2)	4 (2)
Plastic Surgery	0	1 (1)	1 (1)
Podiatry	0	8 (3)	8 (3)
Psychiatry	3 (1)	0	3 (1)
Pulmonary Disease	0	5 (1)	5 (1)
Radiation Oncology	0	1 (1)	1 (1)
Radiology	0	10 (1)	10 (1)
Urology	0	1 (1)	1 (1)
TOTALS	41 19%	171 81%	212 100%

[5] The first numbers in the column represent the total number of TriState physicians in each specialty, and the number in parentheses represent the number of medical groups within which those physicians practice.

Exhibit B

TRISTATE MEMBER
PARTICIPATING PROVIDER CONTRACT – CLINICAL INTEGRATION

This participating provider contract ("Contract") is made as of this ____ day of _____, 200__ between Tri-State Health Partners, Inc. ("THP"), a Maryland nonstock corporation, and the provider identified below ("Provider"), who is a member of THP.

PROVIDER:

Name: _____

Address: _____

_____

Telephone Number: _____

Medical Specialty: _____

Braun, Christi J.

From: Braun, Christi J.
Sent: Thursday, February 26, 2009 1:50 PM
To: 'dnarrow@ftc.gov'
Subject: THP TriState Health Partners

David,

The following responds to your e-mailed questions of February 18, 2009.

Q1: The statistics you provided regarding payer penetration/percentage of covered lives in the "market" did not specify whether they referred to TriState/WCHA's primary service area (essentially Washington County, MD), to the larger secondary service area, or equally to both.

A1: We assume your question relates to the information in the paragraph under Section II.C. of the request letter. The statistics represent the payer mix of the majority of WCHSI business units (i.e., WCHA, Medical Practices of Antietam, Hagerstown Medical Laboratory, and the joint ventures including Robinwood Diagnostic Imaging Services, Endoscopy Center at Robinwood, and Robinwood Surgery Center). That is, the statements in the section explain who pays for the services WCHSI provides to patients. Thus, in answer to your question, the service area referred to is WCHSI's service area, which is the area from which more than 90% of WCHSI's patients come. THP has no reason to believe, though, that the statistics would be different if it looked only at patients residing in Washington County, Maryland, which is roughly its primary service area.

Recently, WCHSI completed a review of its payer mix for fiscal year 2008. The numbers that would replace those in Section II.C for 2008 are: self-pay 4.4%; Medicare, Medicaid and TriCare 48.3%; workers comp 1.2%; and all other (includes private health insurance and self-insured employers) 46.1%. CareFirst BCBS and United/MAMSI were 70.9% of all other.

THP does not have access to the payers' actual market share numbers for either the primary service area or secondary service area. It believes, though, that WCHSI's payer mix provides a fairly accurate approximation of payer market shares for two reasons. First, WCHSI is an in-network participant for all third-party payers, so there is no financial incentive for patients to avoid seeking care from WCHSI providers. Second, WCHSI's payer mix is calculated across a broad range of health care provider types (in-patient and out-patient hospital, physician, urgent care, lab, diagnostic imaging, and ASC services) and is, therefore, likely to have provided services to a broad section of the populations of both the primary and secondary service markets.

Q2: Re the Board. It consists of eight Class I representatives and five Class II representatives, appointed by WCHA. One of the Class I Board members must be a "hospital-based" physician. Can he/she be a hospital-employed physician? Are physicians employed by WCHA/WCHSI Class I members? If so, can WCHA effectively have a majority of the TriState Board, through its five Class II member representatives plus some Class I members who are its or its affiliates' (e.g., Antietem's) employees?

A2a: The individual currently filling the THP Board position of "hospital-based" physician is not employed by WCHA or Antietam. In fact, all hospital-based Class I members currently are employed by their own PA or PC. Thus, at this time, no hospital-based physician Board member could be a hospital-employed physician.

A2b: Physicians employed by WCHA/WCHSI can serve as Class I directors. To do so, they must be elected by the affirmative vote of a majority of Class I Members at a meeting at which at least 25 percent of all Class I Members are present.

A2c: You ask whether WCHA (or WCHSI) could employ a majority of the Board. We think what you actually want to know is whether WCHA (or WCHSI) could ever employ enough of the THP Board members to control the Board. Employing a majority would not give THP control of the Board. To actually control the decisions of the Board, WCHSI would need to employ at least five of the Class I Directors, or 10 out of the 13 Board positions. The reason is that, under Section [redacted] of

the Bylaws, an act of the Board requires an affirmative vote of a majority of Class I Directors present **and** an affirmative vote of a majority of Class II Directors present.

In the highly unlikely event that THP's physician members were inclined to approve five WCHSI-employed physicians for Class I Board positions, they could not do so. [redacted] Although it may not be evident from a plain reading of Section [redacted], the intent of the section is that only one physician employed by WCHSI (inclusive of its subsidiaries) can serve on the THP Board as a Class I Director. Therefore, neither WCHA nor WCHSI will ever employ five Class I Directors.

In addition, one should not assume that a hospital-employed physician would automatically vote in the same manner as the hospital, particularly if the decision would go against the wishes of the peers who elected him or her.

Please let me know if you need additional clarification of any of the above answers.

-Christi

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May 8, 2009

Mr. Donald S. Clark
Secretary
Federal Trade Commission
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

Dear Mr. Clark:

On April 13, 2009, Commission staff in the Health Care Products & Services Division issued an advisory opinion to TriState Health Partners, Inc. ("TriState"). I have been informed that the Commission would like to post TriState's submissions to the Commission and Commission staff on the FTC's web site with the advisory opinion. In its advisory opinion request and follow-up submissions, TriState complied with FTC Procedure Rule 4.9(c), 16 C.F.R. § 4.9(c), designating certain information and documents as "confidential" and requesting that it be withheld from the public record under FTC Procedure Rule 4.10, 16 C.F.R. § 4.10(a)(2), and § 6(f) of the Federal Trade Commission Act, 15 U.S.C. § 46(f).

To allow the Commission to post TriState's documents on the Commission's web site, I have redacted all confidential information and mentions of confidentiality from the "public version" documents, which are attached to this letter. Where documents were withheld in their entirety, there are place-holder pages. All information withheld is competitively sensitive information, including prices, costs, and information subject to confidentiality agreements, patents, or copyright protection.

If you have any questions regarding the attached package, please call me at (202) 326-5046.

Sincerely,

Christi J. Braun

cc: David M. Narrow, Esquire

Attachment

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