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

Bureau of Competition
Health Care Division

April 13, 2009

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

Re: TriState Health Partners, Inc. Advisory Opinion

Dear Ms. Braun:

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

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

> TriState's proposed program, while still in the early stages of development in some respects, appears to have the potential to create substantial integration a ve Cra f TriSta ifEd qualitTD

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

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

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

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

[5] TriState's member physicians include primary care physicians (identified as including pediatricians, family practitioners, general practitioners, and internists, excluding those practicing in internal medicine sub-specialties), specialty care physicians, hospital-based physicians, and oral surgeons, as specified in the hospital-b

[5](...continued)
Approximatelyl

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

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

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

You state that TriState's primary service area, which includes and extends slig

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

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

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

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

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

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

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

---

[12](...continued)
Pennsylvania and West Virginia, as well as Frederick County, Maryland, has a population approaching 350,000.

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

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

service area, which accounts for an additional 14.5 percent of hospital admissions.[15] Within this broade

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

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

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

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

III. TriState's Proposed Program

A. Purpose and Description of the Proposed Program

TriState now proposes to develop and implement a program through a "multi-provider network joint venture that will integrate its members clinically as described in Statements 8 and 9 [of the joint FTC and Department of Justice *Health Care Statements*]." Under the proposed program, TriState and its members would provide medical and other health services, including hospital services, to persons covered under health benefits programs offered by self-insured employers and other payers in TriState's service area. TriState identifies three main objectives for its proposed program: (1) to "facilitate and assure cooperative interaction and collaboration among TriState's me

[19] In contrast to TriState's current contracts with self-insured employers through InforMed, under TriState's proposed program, InforMed will no longer serve as the third-party administrator for self-insured employers. TriState.

More specifically, you identify a variety of activities that TriState plans to undertake or expand from its current activities, as part of its proposed program.[20] Central to the proposed program is TriState's plan to implement a web-based health information technology system that will help identify "high-risk and high-cost patients from the [y]ear 0.s 0.0000 0000 TD(st sa)Tj17.7600 0.0004.440

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

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

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

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

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

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

B. Participants' Obligations and Commitments Under the Proposed Program

1. Membership and Financial Investment in TriState

While most of the physicians who provide their professional services under TriState's current contracts and other health care providers to TriState, will be the

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

(continued...)

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

[25] Apparently physicians and other health care providers who are not TriState members nevertheless may be allowed to provide services to patients covered under TriState's program contracts with self-insured employers or other payers if the employer or payer chooses to allow access to this supplemental provider panel, and separately contracts with Informed's Community Health Partners network or other providers or networks for such services. You anticipate that this type of arrangement may occur regarding the Washington County Health System, Inc., employee benefit plan that currently is TriState's largest contract. You go on to say that, in order to provide incentives for enrollees to stay within the program for their care, TriState will attempt to have payers designate these additional providers as part of a "second tier network," with higher co-payments and lower benefits (unless waived due to medical necessity) for enrollees using their services. You should be aware that the conclusions regarding TriState's and its members' joint negotiation and contracting with payers regarding the proposed program does no600 0.0000 TD(n)Tj

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

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

The participation agreement also generally obligates each physician member to comply with all of TriState's "policies, procedures, rules and regulations," and specifically identifies a number of areas where physicians must cooperate with the proposed program. For example, physicians must cooperate with the proposed program's requirements regarding utilization management, patient referrals, pre-authorization of services, use of clinical practice guidelines, provision of information to TriState for it to effectively monitor physician performance and pa

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

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

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

Under the participating provider contract, physician members agree to "cooperate with [TriState] in the development and implementation of [TriState's] clinical integration program." They also agree to "give due consideration to a request . . . to participate in" such activities as sharing clinical best-practice ideas and methods; developing, reviewing, or commenting upon clinical

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

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

See, e.g., Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982); *United States v.*

[31] *See Health Care Statements* at Statement 8, § A.4. (Sharing of substantial financial risk "normally is a clear and reliable indicator that a physician network involves sufficient i

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

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

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

roviders.

inc[35] It is not clear whether other physicians practicing in TriState's service area, but who currently are neither TriState members nor contracting physicians, are also ing ien p o

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

2. Physician Invest00 TD(tur)Tj16 0.00TD(p.0000 TD(tio)Tj12.7200 0 nd)(is)Tjfary ol

---

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

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

While no such additional fees currently are contemplated, TriState's board is empo

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

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

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

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

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

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

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

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

S

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

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

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

1. TriState's Proffered Justifications for Joint Contracting

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

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

You go on to identify several reasons why you believe that full participation of all TriState physicians in all payer contracts is reasonably (d p)Tj15e9[illegible]

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

In this regard, as noted previously, you have stated that TriState intends to seek to have included in all payer

Letter to Christi J. Braun

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

Guaranteed uniform participation by all physicians under all contracts, through joint contracting, also is likely to contribute to the physicians' commitment to the success of the program. The greater the number of patients that a physician has who are under the proposed program, the more he or she is likely to care about its operation and success, and the greater is likely to be the physician's willingness to invest the necessary time and effort in the various aspects of its operaoperaste000 TD(i)Tj3.3600 0.0000 TD(o)Tj6.0000 0.0000le

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

Tri

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

TriState physicians represent half or more of the physicians w

This contras

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

[59] Because of the ownership of numerous other related medical and health care providers and services by Washing

The Supreme Court

While higher prices certainly are a concern, physicians generally know the payment levels they receive from various payers for their individual services, and presumably price their services as the market permits (or demands, in the case of certain government programs). Having information on their individual payment levels from payers under the proposed program would be no different from the type of information that they currently have from all other payers under all programs in which they participate. Payers would remain free26.0 TD(y)Tj5.6400 0.00000 1.cdj9vr a

indicate a concern that Washington County Hospital Association will use its market power to essentially require use by all area physicians of Washington County Hospital Association's health care facilities and capabilities, thereby making it impossi

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

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

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

re