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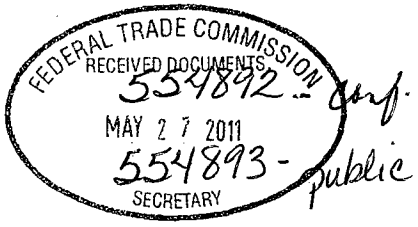
May 26, 2011

ORIGINAL



FEDERAL EXPRESS

Donald S. Clark
Secretary
Federal Trade Commission
600 Pennsylvania Avenue, N.W.
Room 135-H
Washington, D.C. 20580

Re: Norman Physician Hospital Organization

Dear Mr. Clark:

Enclosed is a request for an advisory opinion that we are submitting on behalf of Norman Physician Hospital Organization and its members. The enclosures include:

- One manually executed letter requesting an advisory opinion;
- Two paper copies of the letter;
- One electronic copy on compact disc; and
- One copy of the letter with confidential information redacted.

We appreciate your prompt attention to this request.

Very truly yours,

Michael E. Joseph

Michael E. Joseph

Enclosures

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PUBLIC

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Mr. Donald S. Clark
Secretary
Federal Trade Commission
600 Pennsylvania Avenue, N.W.
Room 135-H
Washington, D.C. 20580

Re: Norman Physician Hospital Organization

Dear Mr. Clark:

Pursuant to FTC Procedure Rules 1.1 through 1.4, 16 C.F.R. §§ 1.1-1.4 (2010), we request an advisory opinion regarding proposed, prospective activities of Norman Physician Hospital Organization ("**NPHO**") and its members. Specifically, NPHO proposes to restructure operations and further develop a clinically integrated, centrally managed organization that offers market efficiencies and facilitates innovation in the efficient delivery of high-quality health care services to patients. As described below, NPHO will operate in a manner that creates a high degree of interdependence, interaction, and cooperation among the participating physicians and healthcare providers in order to improve quality of care and control costs. We ask the FTC to advise how the FTC staff would analyze this arrangement and the recommendations, if any, that the FTC staff would be likely to make if NPHO develops contract proposals, negotiates contract terms, and enters into contracts with third-party payers for the provision of the clinically integrated services described in this letter.

Part I of this letter provides background information about NPHO and its two founding members, Norman Physicians Association ("**NPA**") and Norman Regional Health System ("**NRHS**"). **Part II** provides information about market characteristics and demographic information, including an overview of location and service area characteristics, NPHO service area hospitals, and physicians in the NPHO service area. **Part III** addresses NPHO's clinical integration plan, including purposes and background of clinical integration; future plans for enhanced clinical integration, including participation requirements and costs; organizational arrangements necessary for clinical integration; and community benefits of clinical integration. **Part IV** describes the contracting issues, including the historical approach to contracting, the proposed approach, and an explanation of why joint contracting is essential for meaningful clinical integration. **Part V** provides a brief legal analysis and commentary.

I. BACKGROUND AND OVERVIEW

A. Norman Physician Hospital Organization

NPHO is based in Norman, Oklahoma, which is part of the greater Oklahoma City metropolitan area. It was founded in 1994 by NPA and NRHS as a physician-hospital organization. NPHO's purpose is to provide, arrange for, and coordinate the delivery of high quality, readily accessible, cost-effective health care services to residents of the communities served by the physicians, hospitals, and other healthcare providers that comprise NPHO. Since its inception, NPHO has helped to link health insurers, health plans, third-party administrators, and employers to an established network of healthcare providers and professionals who share a common interest in providing optimal healthcare. NPHO is organized as an Oklahoma limited liability company and is owned equally by its two founding members, NPA and NRHS. Additional information regarding NPHO can be found on its website: www.normanpho.com.

NPA is an Oklahoma limited liability company whose members are physicians that are members of the medical staff of affiliated NRHS hospitals. NRHS is operated by Norman Regional Hospital Authority, a public trust, and includes the following hospitals: Norman Regional Hospital in Norman, Oklahoma; Moore Medical Center in Moore, Oklahoma; the HealthPlex campus in Norman, Oklahoma; and Family Medicine Centers in Norman, Moore, Newcastle, and Blanchard, Oklahoma. NRHS has obtained a single hospital license from the Oklahoma State Department of Health covering Norman Regional Hospital, Moore Medical Center, and facilities at the HealthPlex campus, each of which is otherwise a separate facility. Purcell Municipal Hospital, which is a separately licensed hospital located in Purcell, Oklahoma, is a participating hospital in NPHO. For convenience in this letter, we have referred to Norman Regional Hospital, Moore Medical Center, the HealthPlex facilities, and Purcell Municipal Hospital as the "Hospitals."

NRHS and NPA shared equally in the initial funding of NPHO, and they continue to share equally in the cost of operations and ongoing capital needs. The cost of operations [redacted] is covered principally through withholds of fees paid to NPHO for services provided in accordance with contracts entered into directly between NPHO and several employers. In addition, individual physicians and medical group practices are required to pay NPHO significant fees for the implementation and maintenance of electronic medical records and an electronic interface software system. Each participating physician also pays membership dues to NPA in the amount of $150 per year. While NPHO maintains a lean operation and expects to continue to do so in the future, the operating costs of NPHO – which can be expected to increase as the clinical integration plan is implemented – reflect a meaningful investment by NPHO's members in the organization. NPHO believes that additional investment, along with a substantial investment of time by participants in order to accomplish NPHO's objectives, will result in significant clinical benefits and efficiencies in the organization's goal to provide cost effective, quality health care services to patients.

A chart showing the organizational structure and relationships among NPHO members is attached as **Exhibit I** to this letter. A copy of the NPHO Operating Agreement is provided as **Exhibit II** to this letter.

1. NPHO Historical Operations

NPHO was organized as a non-exclusive association of physicians in partnership with Norman Regional Hospital for the purpose of collectively providing cost-effective, quality health care services to the residents of the region. Initial physician membership of NPHO was comprised of approximately 125 physicians. This included multiple groups of Pediatricians, Family Practitioners, Internal Medicine physicians, and Obstetricians-Gynecologists. Membership also included physicians specializing in Anesthesiology, Cardiology, Dermatology, General Surgery, Gastroenterology, Neurosurgery, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Otorhinolaryngology, Pathology, Podiatry, Psychiatry, Radiology, and Urology.

Since its inception, NPHO has offered specialized benefit plans developed for use by employers, third-party administrators, commercial health care payers and other purchasers of care ("Payers"). These special benefit plans have created savings for those Payers, which should in turn be passed along to the ultimate health care consumer, the patient. NPHO growth was accomplished through the addition of more direct employer accounts and by entering into contracts with PPOs, HMOs, and other commercial insurance Payers.

2. NPHO Membership Today

As of August 1, 2010, 237 physicians who practice in 38 specialties participate in NPHO. All of these physicians are members of NPA. Participation in NPHO is open to licensed physicians who are willing to commit to the goals, objectives, and plans of the organization. NPHO plans to continue to add physicians who practice throughout the service area.

Each physician member of NPHO joins through an application process that requires submission of a letter requesting membership in NPA and, as a result, membership in NPHO. An interested physician submits a completed application to the NPA Board of Directors, which reviews the application and votes on acceptance of the applicant as a member. If an applicant is accepted, NPA bills the new member a $350 membership fee and $150 annually for dues. After the physician pays dues and enters into a contract with NPA, the physician signs all other necessary documentation relating to NPHO membership. Membership fees and dues represent the primary source of working capital for NPA. NPHO generates revenue for its day-to-day activities through [redacted] NPHO expects withholds to increase slightly in order to provide sufficient working capital to accomplish the clinical integration plan and objectives described in **Part III**.

Most of the physicians in and around Norman have chosen to participate in NPHO. However, NPHO members represent less than 10% of all physicians in the NPHO service area (which, as described in **Part II**, is roughly coextensive with the greater Oklahoma City metropolitan area), and less than 10% of the total number of physicians in any one specialty in the NPHO service area are members of NPHO. In addition, a number of physicians who maintain medical practices in Norman, Moore, Purcell, and other parts of NPHO's primary service area do not participate in NPHO. For example, one neurosurgeon who chose not participate believed he would not make enough money. Another pediatric specialist chose not to

participate because he was the only pediatrician in the area offering a particular subspecialty and, therefore, could charge higher rates for his services.

3. NPHO Governance and Management

NPHO is managed by a Board of Managers comprised of eleven representatives, one of whom is the president of NRHS, two of whom are appointed by NRHS (with one vacancy at present), and eight physicians elected annually by the members of the NPA. Physician managers are elected annually by the members of NPA. The physician representatives include four primary care physicians representing general internal medicine, family practice, pediatrics, and obstetrics-gynecology, and four physicians practicing unduplicated specialties. The chairperson of the NPHO board is always a physician who typically also serves as chairperson of NPA, which assists in assuring organizational alignment. Each physician manager serves for a period of three years and may be re-elected for additional terms. A table listing the members of the NPHO Board of Managers is attached as **Exhibit III** to this letter.

NPHO currently maintains a staff of eight, including a full-time Executive Director, part-time Medical Director, full-time Quality Assurance Director, a contracts supervisor, a Director of Physician Informatics, and three full-time technical personnel who provide information systems training and support to participating health care providers and professionals. Additionally, NPHO contracts with a physician who serves as the Medical Informatics Officer. A brief overview of the background of each NPHO staff member is set forth in **Exhibit IV** to this letter.

4. NPHO Contractual Arrangements

NPHO is a non-exclusive network. Physicians who are members of NPHO may enter into contracts directly with Payers and are not required to limit their contracting arrangements through NPHO. NPHO does not impose any restrictions or limitations on the ability of NPHO physicians to become members of other physician networks or other provider networks. Some NPHO physicians are members of other physician networks.

NPHO maintains a comprehensive credentialing oversight process for all participating health care professionals to ensure quality medical care and services are provided within its network. NPHO's credentialing requirements satisfy the standards of The Joint Commission and guidelines of the National Council of Quality Assurance.

To the extent the services of specialists or other health care professionals are not available through NPHO physicians, patients and Payers may obtain those services directly from other physicians and health care professionals. In those situations, NPHO physicians will typically refer patients to other specialists in the greater Oklahoma City area for care. NPHO does not enter into contracts for those services. For example, if patients require care or treatment by pediatric gastroenterologists, pediatric oncologists, pediatric cardiologists, pediatric pulmonologists, or other pediatric subspecialists who are not members of NPHO, then NPHO pediatricians and other NPHO physicians will refer patients to those subspecialists for care.

B. Norman Physicians Association

NPA was formed as an Oklahoma nonprofit corporation 1987, seven years before the creation of NPHO. The focus of NPA was to offer and promote high quality, reputable medical and dental care to employers and other consumer groups at the lowest rate commensurate with the provision of high quality care. NPA also coordinated and administered contracts between its members and various Payers, and developed and operated a utilization review program for its members.

NPA members are licensed physicians, dentists, and podiatrists who:

- satisfy the current admission criteria for the medical staff of affiliated Hospitals;
- comply with the credentialing plan of NPA;
- pay required fees, dues, and assessments;
- want to supply cost-effective, high quality medical care to qualified individuals;
- agree to be bound by and maintain the standards of medical care developed by NPA;
- execute a Participation Agreement with NPA; and
- are approved by the Board of Directors of NPA.

NPA is governed by an eight-member Board of Directors elected by the membership. The Board of Directors is responsible for managing and conducting the business of NPA. It has the authority to select and remove officers, agents, and employees; to conduct, manage, and control the affairs and business of NPA; to incur indebtedness on behalf of NPA; to assess and collect membership fees and dues; and other powers necessary to manage the business affairs of NPA. The election of directors and the approval of any action by the members require the affirmative vote of a majority of the members present in person or by proxy at a meeting. A copy of the Bylaws of NPA is included as **Exhibit V** to this letter.

As noted above, NPA members are assessed an initial membership fee and annual dues. The Board of Directors may assess additional dues from each member through the application of a percentage withhold from fees paid by Payers during the prior year. Currently, [redacted] Membership may be terminated, without reimbursement of membership fees, when a physician no longer satisfies any of the membership eligibility requirements.

C. Norman Regional Hospital Authority and Norman Regional Health System

NRHS traces its origin to Norman Municipal Hospital, a 61-bed hospital that opened in 1946. In 1984, Norman Municipal Hospital changed its name to Norman Regional Hospital to better reflect the expanding geographic boundaries of the communities it serves. The stated objective of NRHS is to offer easily accessible, cost-efficient health care services that prevent diseases or lessen their severity, while promoting health and wellness in the communities served.

Currently, NRHS is comprised of:

- Norman Regional Hospital, a 337-bed acute care hospital located in Norman, Oklahoma, that offers a wide range of inpatient, outpatient, and emergency services;
- Moore Medical Center, a 46-bed community hospital located in Moore, Oklahoma; and
- HealthPlex, a new acute care hospital and medical campus in Norman specializing in cardiology and cardiovascular care, orthopedics and spine care, services for women and children, and emergency care.

Before 1969, Norman Regional Hospital was owned and operated by the city of Norman. In 1969 Norman Regional Hospital Authority was created to operate Norman Regional Hospital. The hospital is now owned in part by Norman Regional Hospital Authority and in part by the city of Norman. Under a Lease Agreement dated April 1, 1970, the city leased the hospital campus to Norman Regional Hospital Authority. In March 2007, Norman Regional Hospital Authority acquired Moore Medical Center through a bankruptcy auction bid. In 2008 NRHS initiated construction of the new HealthPlex facility. Norman Regional Hospital, Moore Medical Center, and HealthPlex operate under a single hospital license issued by the Oklahoma State Department of Health.

NRHS is governed by the Board of Trustees. Trustees are appointed for terms of three years by the Mayor of Norman and confirmed by the Norman City Council.

The Norman Regional Hospital campus is situated on approximately 30 acres. Nursing beds are located in four towers: a five-story tower constructed in 1968 and expanded in 1972; a five-story tower constructed in 1981; a three-story tower constructed in 1992; and a three-story tower constructed in 1995. In addition to the inpatient care towers, the main campus also includes a Cancer Management Center, an Education Center, three support buildings, an ambulance facility, and a hospitality house.

Moore Medical Center includes the hospital and two medical office buildings. It is located approximately 8.6 miles from the principal campus of Norman Regional Hospital.

Norman Regional Hospital Authority developed a third inpatient hospital and related campus – the HealthPlex – on a 95-acre site located four miles west of the original Norman Regional Hospital campus and five miles south of the Moore Medical Center campus. Among other facilities and services, the HealthPlex includes a 36-bed heart hospital, a 36-bed women's and children's hospital, and a 28-bed orthopedic and neurosurgical hospital.

Purcell Municipal Hospital is a 39-bed community hospital located in Purcell, Oklahoma. Purcell Municipal Hospital is not owned or operated by Norman Regional Hospital Authority, but is a participating hospital in NPHO.

A table highlighting services provided by the Hospitals is provided in **Exhibit VI** to this letter.

The medical staff of the Hospitals is comprised of physicians, oral surgeons, and podiatrists who represent a broad range of medical and surgical specialties. Nearly all members of the medical staff of the Hospitals are NPHO participating physicians.

NPHO participating physicians are not required to refer or admit patients to NHRS facilities, Purcell Municipal Hospital, or other health care providers that participate in NPHO. Referral and admission decisions are based on the medical needs of the patient and patient preference. While these guidelines will continue to drive future referral and admission decisions, it is anticipated that enhanced clinical integration of NPHO will increase utilization of NPHO participating providers and help to assure that patients, insurers, health plans, employers, and health care providers benefit from NPHO's Clinical Integration Plan, as described in **Part III**.

If participating hospitals do not offer the programs, facilities, or capacity to provide medically necessary care for patients of NPHO physicians, then NPHO physicians will typically refer the patients to other hospitals in the Oklahoma City metropolitan area that can provide the needed services. NPHO does not maintain contractual relationships with other hospitals relating to the provision of care to patients.

II. MARKET AND DEMOGRAPHIC INFORMATION

This section and **Exhibit VI** to this letter contain market and demographic information. As this information shows, the NPHO service area overlaps almost entirely with the boundaries of the Oklahoma City metropolitan area and the Oklahoma City Combined Statistical Area ("**CSA**"). The NRHS Hospitals make up less than 10% of the hospitals in the CSA, and NPHO discharges are similarly small percentages of the discharges of the Oklahoma City area hospitals as a whole. Likewise, NPHO physicians make up a small fraction of the physicians in the CSA. As a practical matter, patients across the NPHO service area and the Payers that NPHO physicians contract with enjoy numerous adequate substitutes for NPHO services.

The remainder of this section reviews and summarizes certain pertinent information regarding location and service area characteristics; NPHO service area hospitals; and physicians in the service area. **Exhibit VI** includes additional information about:

- Service area demographic information (Exhibit VI.A)
- Population and density data, and narrative profile, of NPHO Service Area (Exhibit VI.B)
- Patient Populations and Insurance Coverage Estimates (Exhibit VI.C)
- Employers and employees in the service area (Exhibit VI.D)
- Available data regarding Health Insurance Plans, HMOs, Discount Medical Plans, and Third-Party Administrators (Exhibit VI.E)
- Medical, surgical, diagnostic, and ancillary services provided by participating hospitals (Exhibit VI.F)
- Other ancillary service providers (Exhibit VI.G)
- Physician Shortages in Selected Specialties (Exhibit VI.H)

A. Location and Service Area Population and Characteristics

NPHO Hospitals are located in central Oklahoma, in Cleveland and McClain counties. The medical clinics and offices of the NPHO physicians and the facilities of other participating health care providers are located in Norman, Moore, Blanchard, Newcastle, Purcell and Noble. Based on hospital patient origin data, NPHO serves a six-county area, including patients from Cleveland, Garvin, Grady, McClain, Oklahoma, and Pottawatomie counties. As seen in **Exhibit VI.A** and **Exhibit VI.B**, according the U.S. Census Bureau, an estimated 1.13 million persons resided in the six-county NPHO service area as of 2008. Almost 85% of these residents reside in Oklahoma and Cleveland counties.

The contiguous six-county NPHO service area encompasses a land area of 4,511.8 square miles with 759.5 residents per square mile. These counties are interconnected through a system of interstate highways, state highways, and major roads, all of which share comparatively low traffic density and provide easy and unusually efficient access from one area to another. Indeed, Oklahoma City (which is in Oklahoma County) is an integral point in the U.S. Interstate Highway system; the area is bisected north and south by I-35 and west to east by I-40 and I-44.

The NPHO service area overlaps significantly (if not entirely) with the boundaries of the Oklahoma City metropolitan area and the Oklahoma City CSA. With an estimated 2008 population of 1.206 million, the metropolitan area is comprised of seven counties: Canadian, Cleveland, Grady, Lincoln, Logan, McClain, and Oklahoma. The CSA also includes the micro-urban area of Shawnee (Pottawatomie County), which brings the region's population to 1.275 million. Patients can cross the Oklahoma City CSA in nearly any direction in a drive of no longer than 45 minutes to an hour.

Demographic data for NPHO's six-county service area is available in **Exhibit VI.A.** Population data, land area information, and a narrative profile, by county, is available in **Exhibit VI.B.** Median household income and poverty statistics and insurance coverage estimates for the NPHO service area, also broken down by county, is available at **Exhibit VI.C**. A summary of NPHO service area employers and employees, and health insurance plans, are available at **Exhibit VI.D** and **VI.E**, respectively.

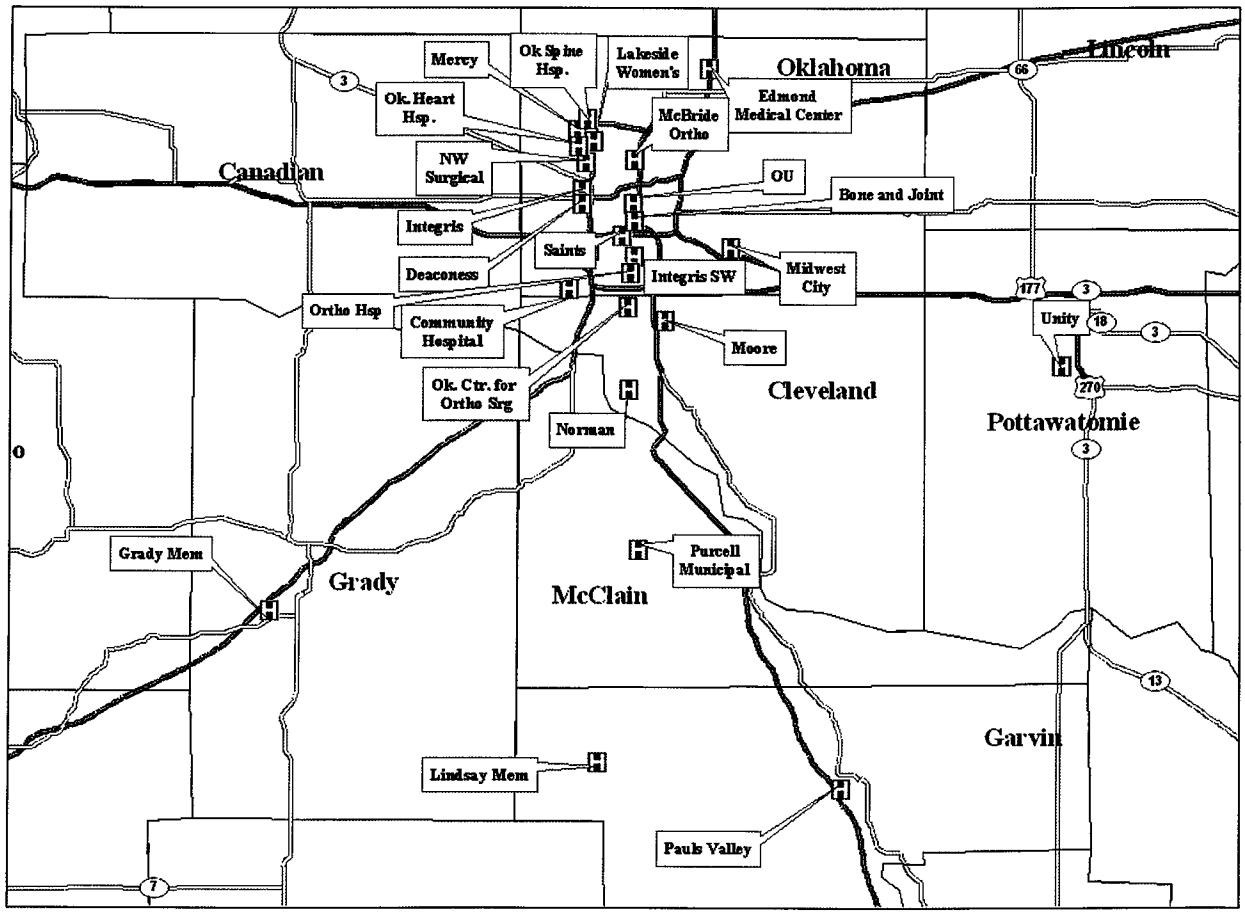
B. NPHO Service Area Hospitals

According to the Oklahoma State Department of Health, 35 licensed hospitals are located in the six-county NPHO service area. Hospitals are licensed by the Department of Health as acute care/long term care hospitals, psychiatric hospitals, and rehabilitation hospitals. Of the total licensed hospitals in the six-county area, 24 are acute care hospitals, four are long term care facilities, two are psychiatric hospitals, and four are rehabilitation hospitals. There are no critical access hospitals in the NPHO service area.

Of the 24 acute care hospitals, 16 are considered to be general acute care hospitals and eight are specialty hospitals that limit services primarily to surgery, orthopedic, cardiology, or women's services. Nineteen of the acute care hospitals are located in Oklahoma and Canadian counties, the two service area counties with the greatest concentration of service area residents. Bisected by I-35 and I-40, and encompassing a 1,246 square mile area with 697 persons per square mile, these two counties account for 84% of the estimated 2009 NPHO service area

population and 95% of NPHO service area physicians. Residents of the four surrounding NPHO service area counties may reach nearly any metropolitan area hospital or physician in less than an hour of travel time.

Norman Physician Hospital Association
Location of Acute Care Hospitals



Acute care hospitals in the NPHO service area include a total of 4,429 staffed beds. Collectively, these hospitals admitted about 213,000 patients in 2006. As seen in Tables 1 and 2 below, as of 2006, Hospitals affiliated with the NPHO represent approximately **9.96%** of total beds operated by acute care hospitals in the NPHO service area and **9.44%** of reported hospital admissions. As shown in Table 3, below, Norman Regional Hospital, Moore Medical Center, and Purcell Municipal Hospital captured a combined market share of **13%** of NPHO service area acute care hospital discharges. Table 3 also provides a breakdown of patients discharged from the six-county area by county and hospital, which reveals that combined hospital market share ranged from a low of 2% of Oklahoma County discharges to a high of 60% of McClain County discharges.

Table 1
Service Area Acute Inpatient (Non-Federal) Facilities, 2006

Acute Care Facility	County	Beds	Admission
Service Area Market			
Grady Memorial Hospital	Grady	55	2,767
Purcell Municipal Hospital	McClain	30	1,436
Bone and Joint Hospital	Oklahoma	11	786
Community Hospital	Oklahoma	49	1,412
Deaconess Hospital	Oklahoma	273	12,686
Edmond Medical Center	Oklahoma	92	3,903
INTEGRIS Baptist Medical Center	Oklahoma	570	24,230
INTEGRIS Southwest Medical Center	Oklahoma	358	16,128
Lakeside Women's Hospital	Oklahoma	23	2,677
McBride Clinic Orthopedic Hospital, LLC	Oklahoma	78	2,820
Mercy Health Center	Oklahoma	338	17,910
Midwest Regional Medical Center	Oklahoma	255	16,919
Moore Medical Center	Oklahoma	46	3,533
Northwest Surgical Hospital	Oklahoma	9	594
Ok. Center for Orthopedic & Multi-Splty	Oklahoma	10	160
Oklahoma Heart Hospital	Oklahoma	78	7,410
Oklahoma Spine Hospital	Oklahoma	18	1,769
Orthopedic Hospital	Oklahoma	8	190
OU Medical Center	Oklahoma	587	30,203
St. Anthony Hospital	Oklahoma	499	19,212
Unity Health Center	Pottawatomie	160	6,464
TOTAL Non-NPHO Hospitals		**3,988**	**193,375**

Table 2
NPHO Service Area Acute Inpatient (Non-Federal) Facilities, 2006

Acute Care Facility	County	Beds	Admission
Service Area Market			
Norman Regional Hospital	Cleveland	365	17,293
Lindsay Municipal Hospital	Garvin	26	1,034
Pauls Valley Hospital	Garvin	50	1,840
Total NPHO Hospitals		**441**	**20,167**
Total Non-NPHO and NPHO Combined		**4429**	**213,542**
NPHO Percentage of Total Service Area		**9.96%**	**9.44%**

Table 3
Discharges by Acute Care Hospital and County, 2006
(NPHO Hospitals Highlighted)

Hospital	Cleveland	Garvin	Grady	McClain	Oklahoma	Pottawatomie	Subtotal
Bone and Joint	62	17	27	9	334	40	489
Community Hospital	272	46	88	34	438	38	916
Deaconess Hospital	648	47	195	65	9,423	137	10,515
Edmond Medical	102	10	40	9	2,681	47	2,889
Grady Memorial	3	43	2,063	4	23	1	2,137
Healdton Municipal	0	1	0	0	1	0	2
Integris Baptist	1,716	274	636	211	13,163	431	16,431
Integris Southwest	2,638	84	574	190	10,782	211	14,479
Lakeside	231	9	89	11	1,581	22	1,943
Lindsay Municipal	351	96	10	1	21	48	527
McBride Clinic Orthopedic	236	56	92	42	904	116	1,446
Mercy Health Center	737	87	305	57	10,914	175	12,275
Mercy Memorial	12	117	4	0	28	6	167
Midwest Regional	1,173	29	60	25	12,906	846	15,039
Moore Medical	2,312	29	119	33	792	48	3,333
Norman Regional	10,979	1,293	1,197	998	810	406	15,683
Northwest Surgical	45	2	17	5	288	12	369
Oklahoma Center for Ortho	36	5	8	3	51	7	110
Oklahoma Heart	282	180	340	60	2,059	351	3,272
Oklahoma Spine	117	34	71	19	557	48	846
Orthopedic Hospital	26	2	5	0	80	11	124
OU Medical Center	2,072	306	574	187	17,341	789	21,269
Pauls Valley General	9	1,598	8	18	18	0	1,651
Purcell Municipal	326	268	25	710	26	37	1,392
Seminole Medical	4	1	0	0	3	31	39
St. Anthony	1,559	155	434	92	12,976	626	15,842
Unity Health	63	3	1	3	68	4,283	4,421
All Other	571	113	693	78	2,988	359	4,802
TOTAL	26,591	5,300	7,677	2,893	101,276	9,199	152,936
NPHO Market Share	51%	30%	17%	60%	2%	5%	13%

The data in the tables show significant competition and suggests a high cross-elasticity of demand between the hospitals operating in the six-county area. By any of these measures, NPHO Hospital market share is constrained by competitors in the Oklahoma City CSA.

C. Physicians in the Service Area

As with hospitals, when evaluating physician data, NPHO (whose physician members are members of the medical staff of NRHS or Purcell Municipal Hospital, with clinical privileges at one or more of the NPHO Hospitals), make up a small fraction of the greater Oklahoma City CSA physicians. Specifically, as shown in Table 4 below, as of August 1, 2010, 237 physicians participated in NPHO. Information obtained from the Oklahoma Board of Medical Examiners and Oklahoma Osteopathic Association indicates that approximately 2,950 active physicians under the age of 75 are licensed to practice medicine in the NPHO six-county service area. Thus, physicians affiliated with NPHO currently comprise about 8% of service area physicians. Approximately 53% of active physicians under the age of 75 practicing in Cleveland and McClain counties are NPHO providers.

Many NPHO participating physicians also hold medical staff appointments at other hospitals in the Oklahoma City metropolitan area, exercise clinical privileges at other area hospitals, admit patients at other area hospitals, and provide patient care services at other area hospitals. For example, NPHO participating physicians hold medical staff appointments, exercise clinical privileges, admit patients and provide patient care services at INTEGRIS Southwest Medical Center (Oklahoma City); Midwest Regional Medical Center (Midwest City); OU Medical Center (Oklahoma City); St. Anthony Hospital (Oklahoma City); INTEGRIS Baptist Medical Center (Oklahoma City); Mercy Medical Center (Oklahoma City); Deaconess Hospital (Oklahoma City); Oklahoma Heart Hospital (Oklahoma City); Pauls Valley General Hospital (Pauls Valley); Grady Memorial Hospital (Chickasha); Unity Health Center (Shawnee); and other area hospitals. Additionally, NPHO participating physicians hold medical staff appointments, exercise clinical privileges, admit patients, and provide patient care services at a number of ambulatory surgery centers in the Oklahoma City metropolitan area

Table 4 below provides a breakdown of the number of participating NPHO physicians by specialty. It does not include physicians employed or assigned by NorStar (the company responsible for providing emergency physician coverage at the Hospital) who work on a part-time basis at the Hospitals.

Table 4
Norman Physician Hospital Organization
Participating Providers by Specialty
August 1, 2010

Specialty	Providers	Specialty	Providers
Primary Care		***Medical Specialists***	
Family Medicine	30	Cardiology	9
Internal Medicine (General)	18	Dermatology	3
OB/GYN	17	Endocrinology	1
Pediatrics (General)	11	ENT	6
Surgical Specialists		Gastroenterology	6
Thoracic Surgery	1	Geriatrics (IM)	1
General Surgery	9	Infectious Disease	1

GS/Vascular Surgery	3	Neonatology	5
General Surgery/Breast	1	Nephrology	2
Neurosurgery	2	Neurology	4
Ophthalmology	5	Oncology/Hematology	5
Orthopedic Surgery	10	Physical Medicine/Rehabilitation	3
Plastic & Reconstructive Surgery	1	Podiatry (DPM)	3
Urology	3	Psychiatry	7
Hospital Based		Pulmonology/Critical Care/Intensivist	7
Anesthesiology	11	Radiation Oncology	4
Anesthesiology (CRNA, MSN)	17	Rheumatology	3
Emergency Medicine	12	Wound Care	3
Hospitalist (IM)	6	Other	0
Pathology	4		
Radiology	8	**TOTAL**	237

Table 5 below sets forth information about all physicians under 75 years of age across the six-county NPHO Service area, broken down by specialty area.

Table 5
Service Area Physicians by Specialty (Age <75)

Specialty	Providers	Specialty	Providers
Primary Care		***Medical Specialists***	
Family Medicine	461	Cardiology	97
Internal Medicine (General)	342	Dermatology	34
OB/GYN	156	Endocrinology	16
Pediatrics (General)	180	ENT	42
Surgical Specialists		Gastroenterology	34
Thoracic Surgery	14	Geriatrics (IM)	9
General Surgery	116	Infectious Disease	12
GS/Vascular Surgery	4	Pediatric - Neonatology	16
General Surgery/Breast	112	Nephrology	17
Neurosurgery	36	Neurology	50
Ophthalmology	86	Oncology/Hematology	23
Orthopedic Surgery	135	Physical Medicine/Rehabilitation	17
Plastic & Reconstructive Surgery	27	Pediatric Medical Subspecialty	32
Urology	48	Podiatry (DPM)	NA
Hospital Based		Psychiatry	157
Anesthesiology	223	Pulmonology/Critical Care/Intensivist	39
Anesthesiology (CRNA, MSN)	NA	Radiation Oncology, Therapeutic Rad	20
Emergency Medicine	151	Rheumatology	18
Hospitalist (IM)	6	Wound Care (Multiple Specialties)	NA
Pathology	81	Other	102
Radiology	153	**TOTAL**	**2,950**

Further information regarding medical, surgical, diagnostic, and ancillary services provided by participating Hospitals is available at **Exhibit VI.F.** Information regarding other ancillary service providers is available at **Exhibit VI.G.** Information reflecting physician shortages in selected specialties as applied to the 2010 estimated population of the NPHO service area is compiled in **Exhibit VI.H.**

III. CLINICAL INTEGRATION PLAN

A. Purposes and Background

While NPHO has not fully reached its potential for clinical integration, clinical integration has been a major focus of NPHO almost from its inception. For many years, the high cost and limitations of the resources available to support clinical integration served as barriers to plan development and implementation. During a planning retreat five years ago, the NPHO Board of Managers initiated a detailed evaluation of the potential benefits of clinical integration and concluded that clinical integration would result in the following benefits to patients, providers, and purchasers of health care services:

- Improved care through the rapid electronic transfer of patient clinical information among the participating providers responsible for the diagnosis of illnesses, injuries, and diseases, along with collaborative development and implementation of treatment guidelines and plans.
- Improved patient outcomes through the development, implementation, and monitoring of evidence-based clinical practice guidelines that reflect good practices. Guidelines established and actual performance would be benchmarked against NPHO provider peers at the regional and national levels.
- Improved utility of data resulting from NPHO's ability to collect, analyze, and communicate data compiled from providers and Payers.
- Reduced cost of care through sharing of laboratory, imaging, and other tests and corresponding elimination of the unnecessary duplication of these services.
- Improved patient satisfaction through the elimination of repetitive completion of registration paperwork, and timely provision of information regarding current treatments, resulting in more effective care management.
- Improved care and reduced cost of care by reduction in medical errors, better infection control rates, shorter hospital stays, lower Hospital re-admission rates, earlier disease detection, and better disease control procedures.
- Improved patient access to care through immediate referrals, electronic patient file sharing, and e-prescribing.
- Elimination of the need for Payers to complete independent and redundant credentialing and peer review processes.
- Elimination of the need for Payers to create, implement, and monitor independent and redundant quality improvement processes, while improving provider participation.

- Creation of a competitive advantage for Payers and self-insured employers through documentation of enhanced outcomes, reduced cost, and increased patient satisfaction.
- Position NPHO to participate more fully with Medicare and Accountable Care Organizations.

Further, as a result of historic working relationships among NPHO Members, the Board recognized that NPHO was well positioned to rapidly implement and quickly achieve the benefits of clinical integration. Accordingly, the Board authorized the leadership of NPHO to move forward with the development of a plan to use the power of clinical integration to deliver better health care to patients.

During the subsequent planning process, NPHO Chairman Stephen Connery, MD and NPHO Executive Director Gary Clinton attended conferences in Las Vegas, Atlanta, and Orlando hosted by the American Association of Integrated Healthcare Delivery System that detailed the impact of clinical integration through the use of electronic medical records and better collaboration among physicians. These concepts were also discussed at numerous NPHO Board meetings and annual NPA meetings. Planning guidance was also requested of NPHO legal counsel.

Electronic Medical Records. Selection of an electronic medical record system has been a cornerstone of the NPHO Clinical Integration Plan to date. In 2007, after the NPHO staff evaluated several options for the electronic medical record and related electronic information interface, NPHO selected the Medicare-approved electronic medical record solution developed by eClinicalWorks, a company based in Westborough, Massachusetts, now serving 40,000 providers in all 50 states.

In addition, the company has developed an electronic information interface, Electronic Health Exchange (eEHX), which allows for the two-way communication of clinical information between a physician's office and hospital information systems. eEHX is the foundation of the Oklahoma Physicians Health Exchange (OPHX®). eEHX serves as a local "hub" for the coordination of patient data so that NPHO providers can collectively and more effectively monitor and manage patient care and promote patient safety, while reducing costs due to the continuity and coordination across providers. eClinicalWorks includes an electronic prescription system that interfaces with local pharmacies. OPHX® will allow NPHO providers to appropriately share outpatient information with participating providers across the state.

NPHO has linked its Electronic Health Exchange into [redacted]

In 2008, NPHO hired a full-time support person to service its network members by assisting with the installation of the technology, training physicians and staff, and providing ongoing maintenance and support to physicians for eClinicalWorks and eEHX. In addition to purchasing the software licenses for its network providers, including ancillary providers, NPHO pays the 18% annual maintenance fee for the electronic data services. NPHO plans to continue offering this support to its network members at its expense, while participating physicians incur the installation costs for their individual offices. NPHO's financial investment in eClinicalWorks and eEHX was approximately [redacted].

NRHS has also committed to facilitating NPHO's utilization of electronic medical records. In 2007, NRHS purchased and implemented the Medi-Tech System to transition the NRHS facilities to an electronic medical record system. NRHS, in conjunction with NPHO, has been able to provide interfaces between eClinicalWorks and Medi-Tech so physicians have bi-directional reporting on laboratory, radiology, and other hospital reports. NRHS also hosts the eEHX® (OPHX®) software for exchange of information between physicians, the hospitals, and emergency departments. OPHX® is also connected to the RHIO (Regional Health Information Organization) through SMRTNET, providing NRHS with a single source for information about patient care delivered by health care providers that do not participate in NPHO.

Clinical Practice Guidelines. NPHO is currently utilizing the Healthcare Effectiveness Data and Information Set (**"HEDIS"**) for clinical practice guidelines. HEDIS is a comprehensive set of standardized performance measures developed by the National Committee for Quality Assurance. HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

The primary goal of the NPHO Clinical Integration Plan is to improve patient care and resulting clinical outcomes. Secondary goals include increased efficiency of care delivery and corresponding reductions in the cost of providing care. The electronic medical record system sets the framework for continued and enhanced clinical integration. But the full benefits of clinical integration have not yet been achieved.

Organizational Structure. In support of the clinical integration plan, NPHO has created a separate organizational structure for clinical integration that will work under the direction of the Board of Managers to accomplish identified goals. Key organization steps that NPHO has taken thus far include:

- Appointed Jim Love, MD, to serve as Medical Director;
- Contracted with Brian Yeaman, MD to serve as the Medical Informatics Officer;
- Hired a registered nurse to serve as the Quality Assurance Director;
- Established a "Mentor's Committee" to oversee global quality improvement planning including approval of protocols, monitoring of implementation and enforcement of adherence to guidelines; and
- Created "Specialty Advisory Groups," which include all members of NPHO, to establish specialty specific clinical practice guidelines and consult on tracking, collection, and analysis of data to identify improvement opportunities.

B. Plans for Continued and Enhanced Clinical Integration Going Forward.

Attached as **Exhibit VII** to this letter is a copy of the proposed, new Participation Agreement that NPHO plans to distribute to its members. The NPHO board has approved the new form of Participation Agreement, but NPHO has not yet entered into the new Participation Agreement with any member. Under the proposed, new Participation Agreement, each participating physician must agree to actively participate in, and fully comply with, NPHO's clinical integration plan, policies and procedures, including:

- participate in NPHO's electronic medical record and electronic information interface or an acceptable data equivalent;
- participate in quality assurance and utilization management programs;
- comply with clinical practice protocols and guidelines;
- participate in peer review; and
- utilize NPHO physicians and practitioners, as well as NPHO hospitals and health care facilities, for the care and treatment of patients, subject to the patients' medical needs and preference.

In the new Participation Agreement, NPHO will [redacted]

The NPHO Board of Managers and Members believe that continued and enhanced clinical integration will allow NPHO to reduce waste and improve communication among practitioners, with resulting improvements in patient care, reduction in health care costs, and enhanced competition with other area health care providers. It will also provide NPHO with a built-in mechanism to achieve a *community* electronic medical record system at low cost and with local technical support. As the AMA has recognized, clinical integration may offer the most efficiency in multi-specialty settings (like NPHO) "in which primary care physicians coordinate patient care with specialists and the various specialists coordinate care among themselves."[1]

While clinical integration is a somewhat imprecisely defined concept within the health care industry, NPHO believes that its goals for clinical integration can best be achieved if certain core elements are included:

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[1] *See* American Medical Association, "Competing in the Marketplace: How Physicians can Improve Quality and Increase their Value in the Health Care Market through Medical Practice Integration," at 16 (2nd Ed.) 2010, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/368/competing-in-market.pdf.

- a unified electronic medical record links each participating physician and provider, offering the potential for improved patient care, reduction in waste, reduction in medical errors, better assessment of care, and enhanced communication among practitioners;
- all participating physicians and providers participate in meaningful and ongoing improvement activities, including developing and utilizing clinical practice guidelines, monitoring patient care outcomes, and sharing data with other participating physicians;
- the organizations hold physicians and other providers accountable for achieving efficiencies in providing care, continuously assessing care in an effort to improve care processes and reduce waste;
- all participating physicians and providers demonstrate a significant commitment of time and financial resources; and
- all participating physicians and providers are required to participate in all agreements with Payers.

The following sections address how NPHO plans and proposes to achieve these objectives.

1. Realizing the Full Potential of an Electronic Medical Record System

A robust electronic medical records system will allow physicians to share clinical information concerning patients and enable physicians to collaborate in and coordinate patient care by providing immediate access to medical data. Going forward, NPHO's electronic medical record system will be a critical component of NPHO's infrastructure to facilitate implementation of NPHO's clinical integration plan. It will facilitate data collection, outcomes measurement, utilization management, and performance reporting required by Medicare and other Payers.

As of this time, NPHO has invested in 130 licenses for its participating physicians to install and use eClinicalWorks and eEHX on their office systems. To date, 130 physicians and other health care professionals have purchased those licenses. Upon implementation of the proposed, new clinical integration plan, all physician members will be required to install and use eClinicalWorks and eEHX (or an acceptable data equivalent). As explained below, to do so Physicians will be required to make a significant financial investment to update their existing hardware and office computer systems, and then install the technology for use. They will also be required to invest significant "sweat equity" and staff time in terms of training, implementation, and use in order to take full advantage of the benefits of the electronic medical records system.

While in its early stages of use, when fully implemented the electronic medical record system developed by eClinicalWorks will enable health care providers and professionals to manage patient flow, immediately access patient records in-house or remotely, electronically communicate with referring and consulting physicians, and securely send clinical data. Unified with its practice management solution, the electronic medical record system will allow users to easily review and complete patient histories, past visits, current medications, allergies, laboratory tests, and diagnostic tests. Its registry reporting and clinical decision support features elevate the role of the system from passively collecting information to actively helping physicians provide optimal medical care.

With eClinicalWorks, physicians will be able to [redacted] The system will capture as much information as practicable concerning the care provided to NPHO patients. The system also will also provide the tools needed for [redacted]

With increased use of eClinicalWorks, physicians should be better able to monitor and manage care for patients, promote patient safety, reduce costs, and improve overall patient health because of better continuity and coordination in patient care. NPHO will have mechanisms in place to monitor individual physician use of electronic medical records, and eClinicalWorks will allow performance reports based in part on practice patterns. Data on NPHO physicians (including utilization, outcomes, etc.) will be made available to the NPHO board, the Quality Assurance Committee, and the entire panel of participating physicians. NPHO staff, at the direction of the NPHO board, will track and identify the data, and share the aggregate data among the appropriate parties. Key components of the electronic medical record system include:

[redacted]

The Oklahoma Physicians Health Exchange (OPHX®) will allow NPHO to extend the benefits of the electronic medical records beyond the participating physicians to include hospitals and potentially other providers. The interface creates the ability for health care providers to securely share facets of patient care, including electronic referrals, patient record summary, lab results and registry reporting. Using the OPHX®encourages community-wide reporting and registry that facilitate outcomes analysis and increases compliance by measuring actual time and cost performance and care improvements, creating efficiencies that benefit purchasers of health care and their recipients.

Use of eClinicalWorks as a common platform for a community-wide health record creates the possibility of realizing some unique efficiencies. First, eClinicalWorks has built-in software (eEHX®) that [redacted] OPHX® will facilitate referrals among participating physicians, minimize errors in

sharing medical history and demographic data, and minimize duplication of laboratory and radiology testing. This capability will enhance care with every patient referral.

Further, use of OPHX® will allow NPHO to [redacted]

Additionally, OPHX® plans to participate in SMRTNET, a statewide network that is being developed in Oklahoma. SMRTNET affiliation will allow further savings by allowing access to some patient medical information that is generated or maintained by health care providers who do not participate in NPHO. Because many NPHO patients receive care outside of the NPHO network, inevitably important medical events (such as surgeries, allergic reactions, immunizations, ER visits, and other events) occur without the knowledge of NPHO network providers. SMRTNET will provide an additional opportunity for NPHO physicians to access that information and, thus, to improve care for patients. OPHX® allows the Nurse Director of Quality Assurance to examine patient files and make sure that physicians are following HEDIS protocols, which is performance evaluation based on applicable evidence-based clinical performance measures and benchmarks.

By joining the SMRTNET network, NPHO anticipates realizing even greater efficiencies arising from expanded use of electronic records management. For example, participation in SMRTNET will improve the coordination of patient care among patients in the Oklahoma City metropolitan area, reducing the likelihood of unnecessary laboratory testing, improving medication reconciliation, reducing hospital readmissions, decreasing some practice administrative costs, and improving patient satisfaction, while lowering the cost of health care in the region overall.

Continued investment from and participation of NRHS and other ancillary service providers will also help to ensure that improvement initiatives cross the entire continuum of care, improving access to all services, while better managing their utilization.

2. Selectivity of Physician Members

NPHO recognizes that the ongoing selectivity of only those physicians who are committed to NPHO's goals and requirements is essential to the Clinical Integration Plan's success. The proposed, new Participation Agreement will require participation in the Clinical Integration Plan as a condition of membership in NPHO. Once implemented, the new Participation Agreement will obligate physicians to participate in all NPHO agreements, care improvement activities, and electronic medical record initiatives described in this letter. NPHO will also require that physicians agree to implement and be subject to performance evaluation based on applicable clinical performance measures and benchmarks.

Physicians will initially be allowed to participate in or continue to participate in NPHO if they satisfy the credentialing criteria, but their membership will be denied if they do not enter

into the new Participation Agreement, and expelled if they sign the Participation Agreement but ultimately and chronically fail to comply with that Agreement. While NPHO is not being especially "selective" *per se* in the first instance – by excluding in a significant way local physicians from participation in the proposed program – NPHO's new, proposed program will impose a number of requirements that are likely to discourage some physicians who are not fully committed to the program from continuing participation and, thus, assure that those who do choose to participate will be fully committed to its goals and requirements.

NPHO physicians will at first be largely *self*-selected by those physicians who recognize the efficiency, value, and clinical benefits of an integrated practice and, therefore, agree to the proposed, new Participation Agreement. Then, going forward, NPHO anticipates that some NPHO physicians will "opt-out" on their own accord, as some physicians may not want to be subject to the participation obligations. Importantly, in addition to this form of self-selection, NPHO will implement comprehensive review processes to ensure physician commitment to NPHO's objectives. These measures will largely take place under the auspices of the Quality Assurance Committee, which will endeavor to be a fair arbiter of the Quality Assurance Plan.

3. Development of Clinical Performance Measures – Quality Assurance Committee

NPHO plans to expand current quality improvement initiatives to accelerate improvements in the delivery of health care services that could not be achieved if physicians worked independently. NPHO will obtain input, advice, direction, and recommendations from all NPHO participating physicians to ensure that the measures tracked are appropriate and meaningful. To this end, NPHO has already formed a Quality Assurance Committee and has recently hired a full-time nurse to help design and implement the program. Going forward, NPHO expects that the Quality Assurance Plan will include incentives and mandate corrective action, potentially including education, counseling, financial withholds or penalties, and, in some cases, expulsion from NPHO for physicians whose practices are incompatible with NPHO's objective of offering high-quality, clinically integrated care in an efficient manner.

Clinical Practice Guidelines and Disease Management. As noted above, NPHO is currently utilizing HEDIS clinical practice guidelines. While the details remain to be specified, NPHO is in the process of developing clinical practice guidelines and believes that the utilization of the electronic medical record system by the Quality Assurance Committee and NPHO staff will allow it to supplement nationally-recognized performance measures with additional evidence-based practice guidelines across a number of specialties.

For example, NPHO is beginning the process of implementing disease management processes for reducing health care costs, improving quality of life for individuals, and preventing or minimizing the effects of a disease (usually a chronic condition) through integrative care. To date, NPHO staff, through its recently hired quality assurance nurse, has acted primarily in a data-collecting mode. Going forward, NPHO initially will consider monitoring some of the chronic disease processes that most affect its patients: coronary heart disease, chronic obstructive pulmonary disease, kidney failure, hypertension, heart failure, obesity, diabetes mellitus, asthma, cancer, arthritis, and other common ailments. NPHO envisions health care costs decreasing and quality of care improving as a result of this effort. NPHO also believes that

the collaboration required for implementing the benchmarks and disease management processes will be an excellent means of fostering interdependence between NPHO physicians.[2]

Quality Assurance Committee. As previously noted, a Quality Assurance Committee will manage and oversee quality improvement activities. At least one full-time quality assurance nurse will review patient charts and records for adherence to the HEDIS disease-state, evidence-based medicine guidelines adopted by NPHO and the Quality Assurance Committee. The Quality Assurance Committee will seek to identify instances of both overutilization and underutilization of services, and work with physicians to address these issues. For its disease management program, NPHO will begin with nine disease states, with an expectation of increasing to as many as 50 disease states over time.

The NPHO will develop clinical guidelines with the goal of reducing morbidity and mortality and minimizing unnecessary costs. NPHO will initially focus on disease states that affect the largest number of patients (such as hypertension) and on diseases that carry the highest morbidity (such as diabetes). The selection of specific disease states will be made at the physician specialty level. For example, the primary care specialists may choose to focus on diabetes care, while the surgeons may decide to focus on post-operative infection issues, and obstetricians may choose to focus on C-section rates. This will ensure broad participation by participating physicians and will ensure that guidelines are developed by those with the expertise to implement them. The Quality Improvement Committee will provide input and oversight, but the initial oversight will be placed on the specialists. NPHO expects that over time new guidelines will be established as old ones become incorporated into standard practice, thus ensuring ongoing improvement.

The Quality Assurance Committee will provide the general management and oversight of the clinical practice guidelines and disease management processes. The Quality Assurance Committee, with the use of *ad hoc* sub-committees as necessary, will:

(a) set the measures for individual and group performance;

(b) monitor individual physicians' compliance with the network's standards;

(c) counsel physicians to improve their performance, as necessary; and

(d) evaluate aggregate network performance against stated goals and, as necessary, re-evaluate and modify the stated goals and processes.

In the process of establishing the performance goals and standards, specialists will have the opportunity to participate in the Quality Assurance Committee's (and any sub-committees')

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[2] [redacted]

development and implementation of the measures. Committee participation will be mandatory, which should assure broad participation in the development of clinical practice guidelines.

To facilitate monitoring, NPHO staff, at the direction of the Quality Assurance Committee, will perform medical records audits remotely via the Electronic Health Exchange software (eEHX/OPHX®). NPHO will generate regular reports on individual and aggregate physician compliance rates. NPHO anticipates that the reports will include the following information: (a) individual physicians' compliance rates under applicable measures; (b) comparison of the physicians' compliance rate with their previous performance (*i.e.*, an individual baseline comparison) and with their peers; and (c) calculation of a cumulative compliance rate for each clinical measure for all physicians for whom the measure is applicable.

To ensure compliance, reports will be shared with NPHO physicians as a group. Internal publication of this data should not only make individual physicians and NPHO as a whole accountable for their performance, but will also highlight the benefits of NPHO's practices to the marketplace and facilitate physician interdependence. Moreover, in recognition of the fact that an inability to consistently enforce the Clinical Integration Plan would frustrate the NPHO's stated goals, NPHO will require, as a condition of participation, that physicians agree to be subject to performance evaluations based on compliance with appropriate and applicable clinical performance guidelines.

While NPHO is in the earliest stages of determining the precise metrics that will be measured, it expects to identify physicians who appear to be high-cost providers or inappropriate users of resources, to measure physicians' compliance with clinical practice guidelines, and to track intra-network referral rates. After the precise metrics are determined, NPHO anticipates that physicians will receive regular performance evaluations from NPHO staff, and those who do not adhere to guidelines will be formally subject to a series of progressive corrective steps, beginning with education, counseling, and corrective action plans, and, as necessary, moving on to reprimands and financial penalties, with removal from NPHO as the ultimate action. Historically, NPHO has not had to deal with physicians who perform at unacceptable levels. However, NPHO will implement an active and ongoing program to evaluate participating physicians and create a high degree of interdependence, interaction, and cooperation among the physicians to control costs and ensure high standards of care. Non-compliance may also be managed using financial withholds or penalties.

To further encourage compliance with the Clinical Integration Plan, NPHO anticipates the use of appropriate incentives. For example, based on data collected, NPHO may seek to negotiate with Payers for fee increases based on its efficiency and quality initiatives, for sharing in cost savings, or other financial incentives. Moreover, if the Clinical Integration Plan is successful, NPHO as a whole expects to be able to receive higher physician reimbursement rates from Payers because of the demonstrated benefits to patients and Payers. To be clear, NPHO's anticipated higher fee levels or shared cost savings are part of a program that seeks, and has the real potential to achieve, overall greater efficiency and improved care, resulting in ultimately lower costs of medical care for Payers. Increased reimbursement rates, as part of a clinical integration plan, should not raise a concern for competition if it is part of an overall goal of providing improved patient outcomes and lower total costs. Cost savings and quality improvement require a significantly higher use of physician resources to achieve. Increased

reimbursement will be justified in part because of the increased use of resources, including increased physician and staff time commitments and technology costs.

The comparison and evaluation of aggregate network performance data will be an essential component of NPHO's Clinical Integration Plan. The Quality Assurance Committee will review regular reports on the Plan's progress, and will periodically re-evaluate whether the standards of care and efficiency goals are being achieved. The Committee will retrospectively review whether particular measures were effective in modifying physician behavior, and whether such measures and processes helped NPHO reach its goals of improved and more efficient patient care.

[redacted]

3. The Costs of Clinical Integration

Although NPHO physicians will not operate under common ownership, some level of financial integration and interdependence will occur by virtue of required investment in the electronic medical records system, withholds (which will likely increase depending on the revenues generated as a result of the new plan), membership dues, and time commitment. Financial integration will likely be increased to some degree, as the percentage of revenues generated by NPHO increases and is specifically linked to quality through clinical integration.

While the Clinical Integration Plan is still in many respects in the early stages of development, NPHO believes that full implementation of the Clinical Integration Plan will require that NPHO retain at least two specified full-time-equivalent employees – one quality assurance nurse and one eClinicalWorks trainer – dedicated to the implementation and execution of the Plan. This will come at an estimated annual cost of approximately $150,000 for salaries and benefits. In addition, it will cost each physician approximately [redacted]

Each physician who plans to become or continue as a member of NPHO going forward will be encouraged to obtain a license for the electronic medical record and electronic interface software and, as further described below, will also be required to make upfront and ongoing investment. [redacted]

One-Time Costs for Electronic Medical Records System

[redacted]

[redacted]

Annual Costs

[redacted]

In addition, each physician that obtains a license for the eClinicalWorks software will also have to obtain extensive training for the physician, office manager, nurse, receptionist, and billing person. The time commitment and allocation of staff resources for implementation is substantial. NPHO estimates that the dollar value of lost patient revenue due to time spent on training of physicians and their staff in the utilization of the electronic medical records system will exceed $3,000 per physician.

Finally, physicians will be required to commit substantial time in developing, implementing, and monitoring compliance with clinical practice guidelines. As noted above, NPHO will initially take volunteers to participate in the Quality Assurance Committee and assist the Committee on an ad hoc basis with such tasks as providing medical education and information about clinical practice guidelines and disease management protocols; conducting medical records audits and making recommendations for improvement; assisting with risk management; and mentoring other NPHO physicians. NPHO expects that virtually all of NPHO's members will actively participate in the implementation of some component of the Quality Assurance Plan. It would require speculation in advance of the implementation of the Quality Assurance Plan to estimate the time commitment required. NPHO believes that, on average, this commitment will be equal to or greater than the requirements for implementing the electronic medical records system.

C. Organizational Arrangements for Clinical Integration

NPHO leadership, designated members of NPHO committees, and mentors, along with NPHO staff (including the additional staff members that NPHO proposes to be hired), will be responsible for implementation of the Clinical Integration Plan. Their duties will be as follows:

- The ***Medical Director*** will provide medical leadership for the Clinical Integration Plan working with NPHO participating providers, committees, and staff to direct timely and consistent implementation.

- Chaired by the Medical Director, the ***Mentor's Committee*** will oversee global quality improvement planning. Membership of the committee will be comprised of physician leaders elected by their respective clinical departments within NRHS.

    - The members will include one General Internist, one Family Practitioner, one General Surgeon, one Obstetrician/Gynecologist, one Pediatrician, one specialty

Surgeon (representing, but not limited to, one of the following surgical specialties: Cardiovascular Surgery, Otorhinolaryngology, Neurosurgery, and Orthopedic Surgery), one specialty Internist (representing, but not limited to, one of the following medical specialties: Cardiology, Nephrology, Neurology, Endocrinology, Gastroenterology, and Pulmonology) and one Emergency Medicine specialist.

- The Mentor's Committee will be responsible for establishing and approving evidence-based medicine clinical guidelines that may cross specialty lines, approving performance targets and enforcing adherence to approved guidelines through mandated educational activities, increased monitoring, financial withholds and, if necessary, removal from participation in NPHO.
- The Mentor's Committee will continue to approve additional clinical practice guidelines. The Mentor's Committee may also develop a patient satisfaction survey. The results of this survey may be used as one measure of quality of care for NPHO providers.

- ***Specialty Advisory Groups*** (SAGs) will be established for each medical department of NRHS and will be chaired by the chief of each department. All of the NPHO physicians will be members of the appropriate SAG and will be required to actively participate in the SAG. The groups will meet at least once annually to establish or review clinical practice guidelines and performance targets applicable to their respective specialties and report their decisions and performance targets to the Mentor's Committee. Meetings will also serve as a forum for monitoring peer performance and working with peer's to address significant deviations.

- ***The Medical Informatics Officer*** has specialized in the management and processing of data, information, and knowledge in the health care arena and will help to transition the NPHO participating physicians who invest in electronic medical records and electronic interface from their current data and record-keeping environment. The current Medical Informatics Officer also serves in a similar capacity for the Oklahoma Hospital Association and will ultimately assist NPHO to network with the local RHIO and other RHIOs across the country.

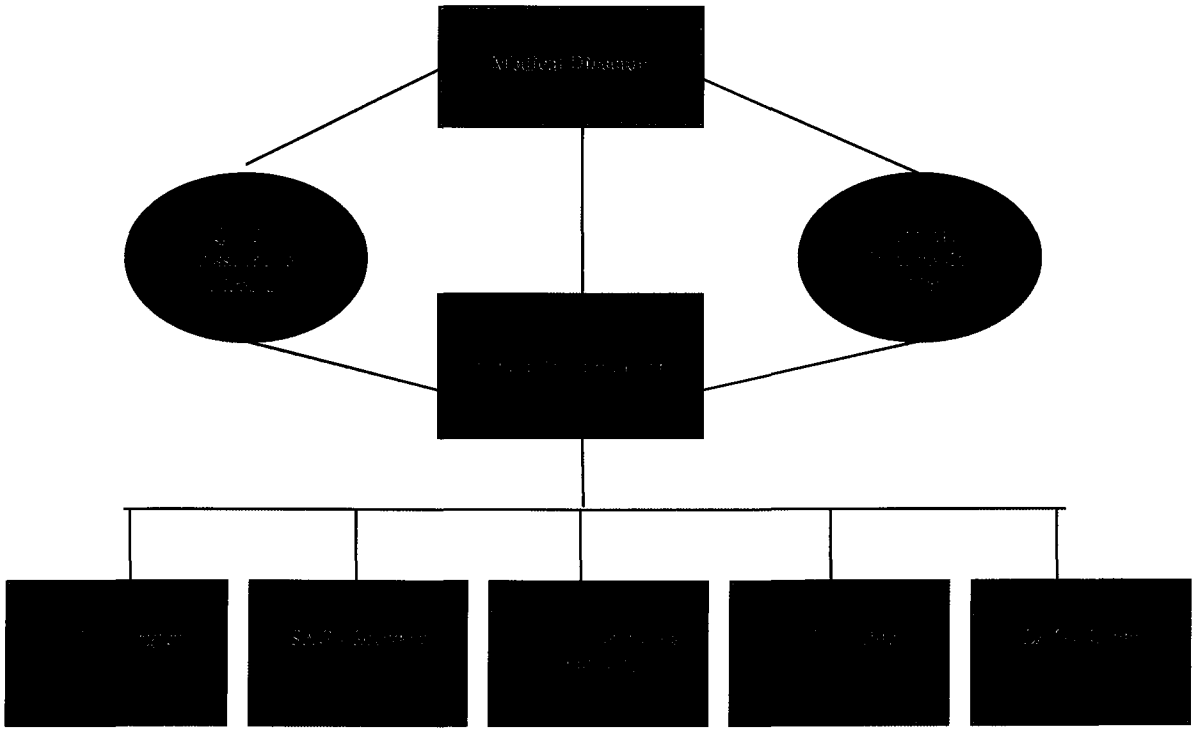
- The ***Director of Quality Assurance*** will assist the Mentor's Committee and support the activities of each SAG. The Director of Quality Assurance will participate as a non-voting member of each SAG.

  - She has begun supervising the collection of performance data, and will report summary results to the Mentor's Committee and individual data to individual providers.
  - As clinical practice guidelines are developed, she will also perform chart audits to assess compliance with guidelines.
  - In addition, she will assist with the promotion of the benefits of clinical integration by engaging in discussions with Payers to maximize understanding and use of clinical integration.

- The Director of Quality Assurance will also work with the NRHS Utilization Review/Quality Assurance Department to facilitate improvements in care and utilization where appropriate.
- Additionally, she may work to develop programs to promote the mission of NPHO, including direct patient education, a disease registry to target high risk populations of patients for special intervention, disease management programs, readmission prevention protocols, and physician education.

- The ***Executive Office*** of NPHO will be responsible for the administrative functions of the Clinical Integration Plan, including the coordination of personnel managing the clinical integration process, maintaining membership rosters and status, administering annual payouts of earnings to successful providers based on pre-determined criteria and formulas established by the quality improvement team members, cataloging of all protocols, preparing minutes of meetings of the SAGs and Mentor's Committee, conducting contract negotiations, arranging withholds to create a reimbursement pool, and recruiting and supervising additional support staff as needed. The Executive Office will also work with purchasers of health care to elicit feedback on the utility of current efforts and to guide future efforts at improvement in care. At the discretion of the Board, NPHO may pursue public relations and advertising activities designed to bring quality initiatives to public attention.

NPHO Organizational Chart



An extensive time commitment will be required on the part of physicians serving in leadership positions and as members of the various committees identified. NPHO pays Board members a nominal fee for attendance at Board meetings. With the exception of the PHO Board Chair and the Director for Medical Informatics, NPHO does not compensate physicians for their administrative services.

Clinical integration is a complex endeavor. It requires planning, expenditures and implementation at multiple levels of medical practice. NPHO has hired four full-time staff members for electronic medical records management and training, rewritten its Physician Participation Agreement to increase physician involvement and facilitate contracting on behalf of member physicians, developed the OPHX® system, affiliated with SMRTNET, developed outlines for organization of contracting specialty and quality improvement committees, and begun "dry run" data extraction in anticipation of monitoring clinical quality data.

NPHO has yet to complete a number of important activities, such as:

- Establishing the Mentor's Committee and recruiting physicians to serve on the committee.
- Developing the final details on clinical practice guidelines.
- Establishing the Specialty Advisory Groups (SAGs) and coordinating an annual meeting.
- Determining membership for the Quality Improvement Committee.
- Deciding the details relating to reimbursement for practitioners comply with clinical practice guidelines and other aspects of the Clinical Integration Plan.
- Marketing the Clinical Integration Plan to physicians and other providers.
- Executing the new Physician Participation Agreement.

D. Community Impact of Clinical Integration

Clinical integration should have a favorable impact on NPHO participating providers, Payers who contract with NPHO and patients in the community served by NPHO providers.

- Participating health care providers should experience increased practice efficiency through consolidated NPHO contracting efforts, reduction of paperwork, greater ease of scheduling, improved patient diagnosis and treatment plans through timely receipt of diagnostic information and availability of patient care guidelines, seamless referrals to specialists and admission to ancillary and hospital providers, reduction of staff time required to duplicate medical records, and timely scheduling of patient care services.
- Payers should experience an immediate benefit from centralized NPHO credentialing and contracting, as well as increased satisfaction among beneficiaries. In addition, over time, NPHO's improvement initiatives should help to eliminate unnecessary duplication of services, avoid preventable hospitalizations, reduce medical errors, improve infection control rates, decrease hospital length of stay, lower re-admittance rates, and provide for earlier disease detection, resulting in lower cost of care.
- Patients should benefit from all of the above with the overarching benefit of improved levels of care and better patient outcomes. Patients should also experience more

timely scheduling of primary and specialty care appointments, reduction of repetitive completion of registration paperwork, and improved access to medications through e-prescribing. Patients should also see improved adherence to preventive service, such as mammograms and colonoscopies. The community should also benefit from clinical integration efforts through an overall improvement in community health status. In addition, enhanced control over health care costs and the potential for cost reductions will serve as economic development tool for the recruitment of new businesses and jobs.

By way of example of the community benefits to be achieved as a result of NPHO's clinical integration, NPHO is currently participating with the University of Oklahoma in a $500,000 Agency for Health Care Quality grant to assess the impact of the use of an electronic medical record on quality improvement and cost reduction. This should help to demonstrate the favorable impact for the benefit of Payers and patients alike. A copy of the research study summary is provided as **Exhibit VIII** to this letter.

NHRS has also been awarded a Beacon Community Grant to demonstrate the impact of electronic medical record and electronic health information exchange on the quality and cost of healthcare. The Health-E Pyramid Project builds on current adoption of electronic medical record by NHRS and NPHO to integrate a Personal Health Record (PHR) interface with unique, patient-interactive features into SMRTNET. The PHR will provide patients with one centralized location to digitally access their health care information and services, increasing patient education, awareness, accountability and compliance with treatment plans. A detailed narrative for the Beacon Community Grant and Health-E Pyramid Project is provided as **Exhibit IX**.

IV. CONTRACTING ISSUES

NPHO currently contemplates that it will establish a contracting committee with primary care and specialty representation. NPHO believes that the benefits of clinical integration will be enhanced by allowing a contracting committee to commit all members of NPHO to those contracts that the committee believes serve the best interests of NPHO members, with reimbursement levels reflecting these improvements in cost and quality. The contracting committee will be charged with evaluating each proposed agreement to determine whether NPHO goals can be achieved within the framework of each specific plan.

The plan for future Payer contracting through NPHO encompasses the following steps. First, a Payer would contact NPHO with respect to a contract. The NPHO Executive Director will obtain information about contract terms from the Payer and will inform the Payer that NPHO is contracting as a single integrated network of providers. If NPHO is able to reach agreement with the Payer following negotiations, then NPHO would enter into the contract, requiring all NPHO participating physicians, Hospitals, and ancillary providers to participate.

NPHO believes that this should create efficiencies for the Payers in terms of contract negotiations, provider credentialing, and network development. In addition, for reasons addressed above, Payers and their beneficiaries should benefit from better and more efficient clinical care.

A. Historical Approach to Contracting

From inception, NPHO used a messenger model to facilitate contracting between participating providers and professionals, on the one hand, and area insurers, health plans, third-party administrators, and employers, on the other.

The NPHO Executive Director has served as the messenger. The Executive Director meets with the individual Payers and discusses economic and non-economic terms of the contract. If specific provisions raise a concern to of the Executive Director, a change or clarification may be requested. After this process is complete, the Executive Director sends a letter to NPHO physicians summarizing the terms of the contract and the fee schedule that the Payer has offered. An Accept/Reject form with the name of the participating physician is included with the summary, giving the physician the opportunity to either accept or reject participation in the offering. The physician is not considered to have accepted until the form has been returned. The Executive Director does not participate in price negotiations or make any recommendations regarding fees and charges.

NPHO has signed agreements with a variety of Payers, including PPOs, HMOs, and Medicare Advantage plans, and directly with employers that are large enough to be partially self-insured and utilizing third-party administrators. These are fee-for-service arrangements. As of August 1, 2010, NPHO has 24 separate agreements with various Payers. **Exhibit X** includes a table showing the number NPHO physicians participating in the various networks, which ranges from 107 to 237.

B. Proposed Approach to Contracting

Going forward, physicians will continue to join NPA and NPHO through the NPA application process described above. NPHO proposes that it will manage and direct the contracting process with Payers, including negotiation of all contract terms.

Physicians, hospitals, and other health care providers and professionals who are interested in participating (or continuing their participation) in NPHO will be required to enter into a new Participation Agreement with NPHO. Under the proposed, new Participation Agreement, health care providers and professionals will be required to actively participate in quality assurance programs and activities of NPHO. Historically, NPHO has not required participating health care providers and professionals to participate in any specific provider network. Instead, NPHO health care providers and professionals have historically decided independently whether or not they wish to participate in any specific network or networks.

The proposed, new NPHO Participation Agreement provides that participation in NPHO is non-exclusive so that each health care provider and professional may contract directly with health insurers, health plans, third-party administrators, and employers to participate in their respective networks. NPHO will not require any participating physician to negotiate and contract exclusively through NPHO. As a result, NPHO health care providers and professionals may continue to provide care to patients outside the provider networks established by NPHO.

As noted in Part III.B above, the NPHO board has approved the new form of Participation Agreement (*see* **Exhibit VII**), but NPHO has not yet entered into the new Participation Agreement with any member yet. If a physician who is a member of NPHO plans to continue as a member of NPHO, the physician will be required to enter into the new form of Participation Agreement.

Under the proposed, new Participation Agreement, in addition to the electronic medical record and clinical commitments noted in Part III.B above, each participating physician must agree that if NPHO has entered into an agreement with a Payer, the physician will provide covered services under NPHO's agreement with the Payer and will not separately contract with that Payer for the provision of covered services. Additionally, the participating physician must accept the terms and conditions of each Payer agreement, including terms relating to prices, fees, charges, reimbursement, withholds, and risk pools, where applicable. The Participation Agreement further provides that a participating physician may otherwise participate in any other health network and provide medical services independently of NPHO, as long as such participation does not preclude the physician from complying with the terms of the NPHO Participation Agreement.

The proposed, new Participation Agreement will permit NPHO to market products to Payers that are approved by its Board of Directors; use its best efforts to enter into Payer agreements with financial incentives for use of participating physicians; and use its best efforts to secure agreements that require Payers to provide members a greater level of coverage of services, if such services are obtained from participating health care providers.

C. Joint Contracting is Subordinate, Ancillary, and Reasonably Related to the Clinical Integration Plan

NPHO believes that this proposed joint contracting with Payers on behalf of its competing physician members is subordinate, ancillary, and reasonably related to its plan to clinically integrate its members' provision of services and to deliver coordinated care by a group of health care providers committed to the Plan because it will provide a stable and identifiable roster of physicians and facilitate in-network referrals, thus increasing patient volume and harnessing network effects and economies of scale, while providing efficiencies and reducing transaction costs to both physicians and Payers. Finally, NPHO will take steps to limit any anticompetitive "spillover" effects from the proposed joint contracting.

Providing a Stable and Identifiable Roster of Physicians. All NPHO physicians will be required to participate in all Payer contracts negotiated by NPHO, and NPHO believes that clinical integration will be facilitated by this requirement. Specifically, NPHO believes that this requirement will help to assure that the panel of physicians providing services under the program is clear, identifiable, and consistent and unlikely to vary from contract to contract.

Ensuring a consistent panel of physicians will necessarily be complicated by periodic physician attrition, as well as the periodic addition of new physicians and perhaps dismissal of non-compliant physicians, but the fundamental goal of having a stable, clearly identified, and consistent panel of physicians will not change. In any event, joint contracting would be better in this regard than the nearest alternative – the messenger model.

Facilitating In-Network Referrals. After the new Participation Agreement is in place, NPHO will operate as a single integrated network with all participating providers working together to achieve clinical integration. Accordingly, NPHO physicians will be required to refer patients to other NPHO physicians when it is medically appropriate to do so and the patient is amenable to the referrals. NPHO believes that joint contracting will reinforce the in-network referral requirement because, if different physician panels represented a subset of NPHO's membership for each Payer contract, physicians are more likely to have to refer to physicians outside the NPHO network.

Increasing Patient Volume and Harnessing Efficiencies of Scale. Related to the topic of in-network referrals, to best integrate the program's quality improvement initiatives into the physicians' practices and to reap the full benefit of the network effects of the electronic medical records system, NPHO believes is desirable to maximize the number of patients in each physician's practice. In this regard, the more patients that each NPHO physician sees, the more interdependent they become with other participating physicians, because all physicians indirectly benefit from the network effects of additional data points and experience gained from treatment of each patient. With increased patient volume, joint contracting will necessarily encourage increased information (and improved clinical practice). Each additional data point provides broader benefits to all network physicians, patients, and Payers. Without joint contracting, NPHO's ability to obtain information on both patients and physicians would be more difficult, the results of its data collection less robust, and its evaluation of that data and implementation of practice protocols – key components all – would be undermined and rendered less effective.

Absent joint contracting, the physicians may lack the patient volume that would provide sufficient incentives for their substantial investment in the success of the integrated program. NPHO believes that the more patients a physician sees in the proposed program, the more likely the physician will be willing to invest the necessary time and effort in the various aspects of the program's operation.

Providing Efficiencies and Reducing Transaction Costs to Payers and Physicians. Joint contracting as part of a broader suite of clinically integrated services should be attractive to Payers not only because it helps to control costs and minimizes transaction costs, but also because it provides going-forward accountability to health plans by providing one point of contact. As evidence of these benefits, [redacted]

Joint contracting will likewise provide an incentive to physicians to join the network, as physicians will not only benefit from the clinical network effects, but will also be able to delegate this function to a central organization and avoid the negotiation process, which is often disruptive to their practice as it requires them to get up to speed on various contractual matters. On the whole, this allows doctors to focus their time and energies on patient care, rather than contracting matters, which should ultimately benefit both patients and their physicians.

Limiting Anticompetitive "Spillover" Effects. The FTC has noted that it would have serious concerns if a proposed clinical integration would facilitate physicians' agreements to sell their services outside of the joint venture network.[3] To be clear, NPHO physicians will not collectively set the prices they will charge to any patients who are not covered by the health plans with which NPHO bargains. NPHO will take steps to ensure this, including limiting its physician members' access to competitively sensitive information (such that only non-physician staff will see actual physician prices). Additionally, NPHO will inform physicians of restrictions to ensure that harm to competition does not occur from the possibility of coordinated interaction. Finally, NPHO hospitals and physicians do not have a large market share in the NPHO service area, and NPHO is a non-exclusive network. It would make little sense for a non-exclusive network with very limited, if any, ability to exercise market power to go to the expense of implementing a clinically integrated collective negotiation arrangement in order to reduce output or increase prices if, as here, Payers could simply avoid contracting with NPHO.

In sum, the success of NPHO's program depends significantly on all of its physician members participating in all of its contracts. Achieving NPHO's goals – collecting and harvesting robust and meaningful data, providing practical and effective clinical guidelines and disease management protocols, and ensuring efficient care – would be far more difficult if different physicians were participating in different Payer contracts, referral patterns had to be adjusted accordingly to keep patients within the applicable network, patient volume was lower, and information on patient treatments and health care provider behavior were less robust and uniformly available. Absent the joint contracting, the planned benefits, while theoretically possible, are not practical given business realities.

V. LEGAL STANDARD AND CONCLUSION

The FTC and DOJ's 1996 *Statements of Antitrust Enforcement Policy in Health Care* (*"1996 Health Care Statements"*) explain that clinical integration may be demonstrated, by way of example:

> by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.[4]

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[3] *See, for example,* the FTC/DOJ 1996 *Statements of Antitrust Enforcement Policy in Health Care,* Statement 8, § B, available at http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm.

[4] Joint 1996 Health Care Statements 8, § B.1. The *Joint 1996 Health Care Statements* emphasize that these are only examples, rather than "the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis."

NPHO submits that, with implementation of its Clinical Integration Plan, it will be a fully clinically integrated, centrally managed joint venture offering substantial market efficiencies and facilitating innovation in the delivery of health care services to patients as described in Statements 8 and 9 of the *Health Care Statements*. Its proposed joint contracting system is not inherently anticompetitive and should be analyzed under a truncated rule of reason analysis, rather than *per se* prohibited.

Specifically, and by way of review, through its electronic medical records system, proposed clinical guidelines, disease management program, Quality Assurance Committee, monitoring and enforcement mechanisms, and substantial financial and "sweat equity" commitments, NPHO will operate in a manner that creates a high degree of interdependence, interaction, and cooperation among participating physicians and health care providers in order improve access to care, enhance quality of care, and control costs. NPHO has created an infrastructure of pooled resources; has approved and is beginning to monitor and establish protocols and evidence-based clinical practice guidelines; and has formulated a plan that should result in delivery of improved quality of care in a more efficient manner that the participating providers and professionals could not otherwise achieve independently.

NPHO is implementing an active, dynamic, and ongoing Clinical Integration Plan. Components of the Plan include outcomes reporting, managing the care continuum, reducing costs, information sharing, creating clinical practice guidelines, monitoring utilization, controlling compliance with clinical practice guidelines and related protocols in an effort to provide better patient care and treatment, and taking corrective action when necessary. The anticipated results include improving access to care, enhancing quality and efficiency of care, and ultimately improving the health of the communities served. Participation requires a significant investment of time and capital in the necessary infrastructure and capability to realize the anticipated benefits and effectiveness. The use of the eClinicalWorks electronic medical record is critical to clinical performance and organizational viability. It positions the participating providers and professionals to better manage patients, successfully control costs, limit practice variations, and achieve significant differentiation in the market. Also, the electronic medical record will enable the participating providers and professionals to adopt and effectively execute clinical practice guidelines and new concepts anticipated from comparative effectiveness research initiatives.

The attributes of NPHO under the Clinical Integration Plan will transform from a traditional physician-hospital organization into one with:

- Information continuity
- Care coordination and transition
- Peer review and teamwork for high-value care
- Easy access to appropriate care
- System accountability
- Continuous innovation

The Plan allows the participants to re-position their services to align with market trends, as well as transparency in quality and cost in order to demonstrate better outcomes and successfully compete in a value-based purchasing environment. It facilitates meaningful use by

participating hospitals, physicians, and others of a fully integrated and coordinated electronic medical record. It bears the commitment from medical leadership to share outcomes data – peer to peer – and evaluate the findings in a coordinated and quality-focused manner. It presents an opportunity for medical leadership to intervene and make improvements where outcomes data reveal that quality is not at targeted or required levels. And it ensures that medical leadership will receive continuing and useful training, education, and support to successfully manage high integration and top quality challenges.

The proposed collective negotiations with Payers, including price negotiations, are subordinate and reasonably necessary to achieve substantial efficiencies arising from clinical integration. Joint negotiation through NPHO will ensure that a sufficient, stable, and identifiable number of physicians across multiple specialties will continue to participate in NPHO. It will facilitate in-network referrals and ensure adequate patient volume to benefit from economies of scale and incentivize physician involvement. It will allow participating physicians the opportunity to reduce transaction costs, including costs of legal review, that are incidental to the contracting process, in part offsetting the substantial time and financial investment made in connection with NPHO participation. Additionally, collective negotiations will allow NPHO to offer a single, comprehensive, integrated network, allowing for pricing in the aggregate, instead of separate contracts. Finally, NPHO will take steps to limit any anticompetitive "spillover" effects from the joint contracting, such as coordinated physician agreements with regard to non-network Payers.

NPHO's proposed, new Clinical Integration Plan involves a powerful platform for hospitals, physicians, other health care professionals, and other health care facilities and institutions to build relations and foster integration. NPHO believes that its proposed joint contacting should be considered ancillary and subordinate to the joint venture, reasonably necessary to the Clinical Integration Plan's success and the efficiencies it will make possible, and thus analyzed under the rule of reason.

REQUEST FOR ADVISORY OPINION

On behalf of NPHO, we request an advisory opinion as to how the FTC would analyze NPHO's activities if, based on the foregoing information and proposed clinical information plan, NPHO develops contract proposals, negotiates contract terms (including price terms), arranges contract participation, and enters into contracts on behalf of NPHO participating health care professionals and providers.

If you have any questions, please contact either me or Dan Loeffler (dan.loeffler@mcafeetaft.com, (405) 301-7406).

Very truly yours,

Michael E. Joseph

Michael E. Joseph

cc: Mr. Markus H. Meier
Mr. David Narrow
Mr. Daniel A. Loeffler

Exhibit I

Organizational Structure

The following chart shows the organizational structure and relationships among NPHO members:

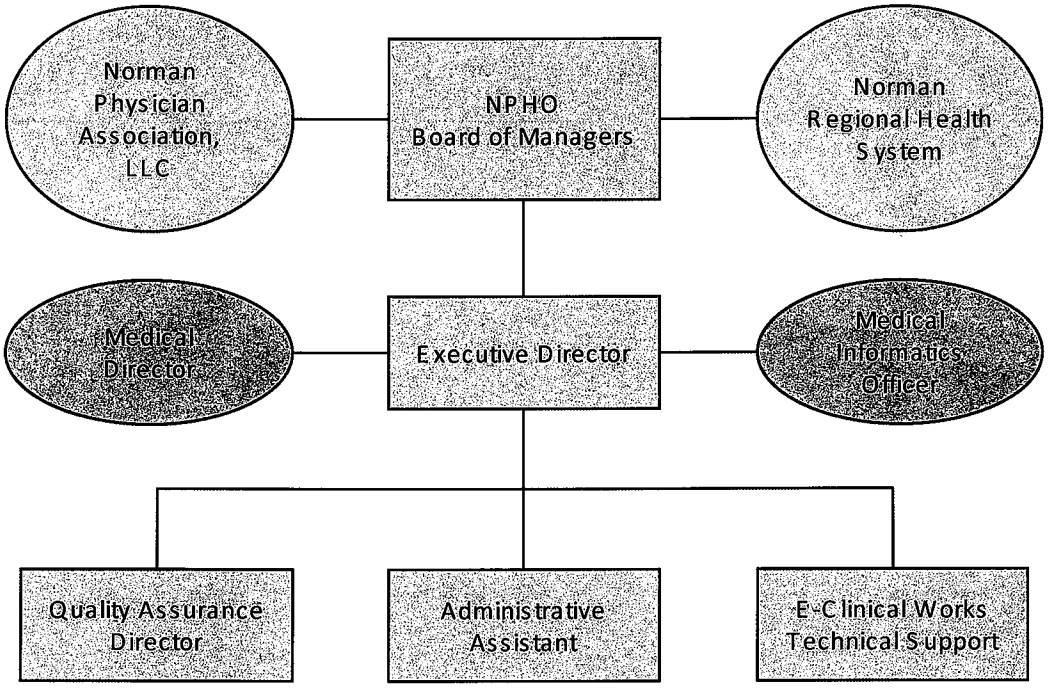

Exhibit II

[redacted]

Exhibit III

NPHO Board of Managers

The following table lists the members of the NPHO Board of Managers.

Norman Physician Hospital Organization
2009 Board of Managers

Name	Term Expires
Stephen Connery, M.D., Family Practice (Chairman)	2011
Robert Holbrook, M.D., Gastroenterologist	2011
Tadgy Stacy, M.D., Pediatrician	2011
Joe Voto, M.D., Anesthesiologist	2011
Carol Anderson, D.O., Ob-Gyn	2012
Tom Connally, M.D., General Surgeon	2012
James Love, M.D., Internal Medicine	2012
Chris Paskowski, M.D., Otorhinolaryngologist	2013
Meegan Carter, VP Revenue Cycle	NRHS Board Representative
David Whitaker, President & CEO	NRHS Board Representative

Exhibit IV

Norman Physicians Hospital Organization Staff

A brief overview of the background of each NPHO staff member appears below.

Gary P. Clinton, D.Ph. has served as the Executive Director of NPHO since 1995, helping to guide and manage the organization through various stages of evolution and growth. Beginning his healthcare career as a pharmacist, he has owned or managed several healthcare organizations including a pharmacy, durable medical equipment provider, and home health agency providing him with the clinical and business backgrounds necessary to function as an effective leader of NPHO. He is a graduate of the University of Oklahoma.

Stephen E. Connery, MD has chaired the NPA and NPHO since 2004. Board certified in family practice, Dr. Connery has operated a private practice in Norman since 1989 and maintains medical staff privileges at Norman Regional Hospital, and Seminole Hospital in Seminole, Oklahoma. He also serves as chairperson of the medical staff evaluation committee at Norman Regional Hospital. Dr. Connery received his graduate medical education and family practice residency training at the University of Oklahoma College of Medicine. Professional memberships include the American Medical Association, Oklahoma State Medical Association, and American Association of Family Practice.

Kathryn Roberts, R.N. has served as the Director of Quality Assurance for NPHO since February, 2009. In this role, she is responsible for the design, development, implementation, maintenance, and evaluation of all quality improvement programs and initiatives for NPHO. She develops all policies, procedures, protocols, and guidelines, utilizing national standards of evidence-based medicine. Additionally, she assists the NPHO Board regarding performance improvement. As the Director of Quality Assurance, she also plays a primary role in all clinical integration efforts.

Audene Eubanks is the Supervisor, Contracts and Accounts Payable for NPHO. She also coordinates special NPHO projects and serves as a liaison with the physician members. In addition, she is responsible for the NPHO website encompassing: links to the NPHO participating providers; a health resources guide for patients and family members; and secured physician access to NPHO information. Before joining NPHO, Ms. Eubanks worked for 11 years as a medical assistant with responsibility for patient evaluation and treatment, billing office management, and employee training.

Lynnette Chafin brings over 20 years of clinical and physician practice management experience to her position as eClinicalWorks Trainer. She is certified as an eClinicalWorks trainer and provides physician practices with the support necessary to evaluate, tailor, implement, and operate the eClinicalWorks electronic medical record system.

Leigh Anne McGregor brings over 20 years of clinical and physician practice management experience to her position as eClinicalWorks Trainer. She is certified as an eClinicalWorks trainer and provides physician practices with the support necessary to

evaluate, tailor, implement, and operate the eClinicalWorks electronic medical record system.

Rhonda LeMay is a trained eClinicalWorks "super user" who assists with the initial implementation of the electronic medical record in physician practices and provides ongoing staff and physician support. She has 16 years of experience in the medical field and uses her knowledge of front office, back office, and clinical functions to ensure smooth physician office transition to electronic medical record.

Brian Yeaman, MD is the director of physician informatics for NPHO and installation of eClinicalWorks in Norman. He is leading the effort in Norman to create the local network through NRHS and NPHO and has played a key role in the quality improvement and quality assurance processes of the clinical integration model. The local network design and governance has been facilitated by SMRTNET and NPHO. Dr. Yeaman is also the chief medical information office at the NRHS and is the Medical Director for the GOCHC SMRTNET effort. Dr Yeaman trained at Tufts University in Boston and continues to operate a family practice at the Norman Clinic.

Exhibit V

[redacted]

Exhibit VI

Market and Demographic Information

Exhibit VI.A
Norman Physician Hospital Organization
Service Area Profile

Characteristic	NPHO SA Counties					
	Oklahoma	Cleveland	Pottawatomie	Grady	Garvin	McClain
Population, 2000	660,450	208,016	65,519	45,513	27,210	27,742
Population, 2008	706,617	239,760	69,616	51,066	27,247	32,365
Land area, 2000 (square miles)	709.9	536.1	787.7	1101	807.5	569.7
Persons/square mile	931.5	388.1	83.1	46.4	33.7	48.7
Persons 65+, 2007	12.4%	9.1%	13.9%	12.4%	17.6%	13.0%
White persons, 2007	74.5%	83.1%	79.6%	88.2%	85.9%	89.7%
Black persons, 2007	15.5%	4.9%	3.3%	3.0%	3.0%	0.9%
American Indian & Alaska Native persons, 2007	3.3%	7.9%	11.4%	5.2%	7.7%	5.6%
Persons of Hispanic or Latino origin, 2007	12.3%	7.2%	3.1%	4.3%	4.3%	5.7%
Foreign born persons, 2000	7.2%	4.4%	1.1%	1.1%	1.6%	2.6%
High school graduates (age 25+), 2000	82.5%	88.1%	79.3%	79.5%	73.0%	79.3%
Bachelor's degree or higher (age 25+), 2007	25.4%	28.0%	15.5%	14.4%	12.0%	15.7%
Mean travel time to work (min., workers age 16+), 2000	20.9	22.3	25.0	26.9	23.4	27.3
Homeownership, 2000	60.4%	67.0%	72.1%	75.7%	73.8%	81.4%
Median household income, 2007	$41,598	$51,052	$38,614	$43,341	$38,360	$48,654
Persons below poverty, percent 2007	15.9%	10.0%	18.8%	14.1%	16.6%	10.0%

Exhibit VI.B
Norman Physician Hospital Organization
Profile of the Oklahoma City Metropolitan Area and NPHO Service Area

County	2000 Population	2008 Population	2000-2008 Population change	Land Area (square miles)	2008 Persons per Square Mile
NPHO Service Area					
Cleveland	208,016	239,760	15.3%	536.1	447.2
McClain	27,742	32,365	16.7%	569.7	56.8
Garvin	27,210	27,247	0.1%	807.5	33.7
Grady	45,513	51.066	12.2%	1,101.0	46.4
Oklahoma	660,450	706,617	7.0%	709.9	995.4
Pottawatomie	65,519	69,616	6.3%	787.7	88.4
SA Total	1,034,450	1,126,671	8.9%	4,511.8	249.7
OKC Metropolitan Area					
Canadian	87,697	106,079	21.0%	899.71	117.9
Cleveland	208,016	239,760	15.3%	536.1	447.2
Grady	45,513	51,066	12.2%	1101.0	46.4
Lincoln	32,080	32,153	0.2%	957.7	33.6
Logan	33,924	38,102	12.3%	744.5	51.2
McClain	27,742	32,365	16.7%	569.7	56.8
Oklahoma	660,450	706,617	7.0%	709.9	995.4
OKC MA Greater OKC	1,095,422	1,206,142	10.1%	5,519	218.
OKC Combined Statistical Area – Addition of Shawnee Micro Urban Area/Pottawatomie County					
Pottawatomie	65,519	69,616	6.3%	787.7	88.4
OKC CSA Total	1,160,941	1,275,758	9.9%	6,306.2	202.3

Exhibit VI.B (Cont'd)
Norman Physician Hospital Organization
Profile of the Oklahoma City Metropolitan Area and NPHO Service Area

Oklahoma City

Oklahoma City is the capital and largest city in Oklahoma, with city limits extending beyond Oklahoma County into urban, rural, or suburban areas in Canadian, Cleveland, and Pottawatomie counties. The city's estimated 2008 population was 551,789. Of the city's land area of 607.0 square miles, 322.3 square miles are urban, resulting in 871.5 residents per square mile. Oklahoma City is one of the most important livestock markets in the U.S. and receives economic and employment support from several prominent energy companies, varied light and heavy industries, Tinker Air Force Base, and the federal government. Oil, natural gas, and petroleum products are major components of the economy.

Moore

Moore is a suburb with estimated 52,361 residents in the south Oklahoma City metropolitan area with city limits extending into southwestern Oklahoma County and northern Cleveland County. The city surrounds I-35 between Oklahoma City and Norman. Moore's population density has grown from 1,892.8 residents per square mile to an estimated 2,412.9 in 2009 reflecting a 27% population increase since the 2000 census. Moore is centrally located between the state's capital to the north and the University of Oklahoma to the south. The city has experienced recent growth in residential additions and commercial developments.

Norman

Norman is located in Cleveland County, approximately 20 miles south of downtown Oklahoma City and immediately south of Moore. Norman is a well-established "college town" with approximately 30,000 students. It is also the state's third largest city with a growing full-time population of over 106,000 residents. The city's 2006 estimated population density was 540.6 residents per square mile.

Norman is the home of the National Storm Prediction Center, National Severe Storms Laboratory, the National Weather Center, and many weather-related private businesses. In addition to several research companies, the city has a variety of major employers and industries, including SouthWest NanoTechnologies, York International/Johnson Controls, Hitachi, Astellas Pharma, Albon Engineering, Xyant Technology and Office Max's National Sales Center.

Purcell

Purcell is south of Norman along the I-35 and US-77 corridors. The city is a retail hub of 45,600 residents, including residents of neighboring communities and unincorporated rural areas of McClain and southern Cleveland counties. The area's commerce benefits from several multi-million dollar horse farms.

Exhibit VI.C
Patient Populations and Insurance Coverage Estimates

As illustrated in the table below, U.S. Census data indicate that median household incomes in the service area range from a low of $38,360 in Garvin County to a high of $51,052 in Cleveland County. Consistent with median household income data, almost 40% of Garvin County households earn less than $25,000 per year as compared with about 25% of Cleveland County households. Pottawatomie County has the highest percentage of persons living in poverty.

Norman Physician Hospital Organization
Median Household Income & Poverty

County	Median HH Income 2007	% Households HH Income <$25,000	Persons below Poverty 2007
Service Area Market			
Cleveland	$51,052	24.7%	10.0%
Garvin	$38,360	39.1%	16.6%
Grady	$43,341	31.8%	14.1%
McClain	$48,654	27.4%	10.0%
Oklahoma	$41,598	29.9%	15.9%
Pottawatomie	$38,614	34.4%	18.8%
State Average	**$41,551**		**15.8%**

Resident age distribution and household incomes drive the percentage of county residents covered by Medicare and Medicaid. According to the Oklahoma Health Care Authority, almost 220,000 NPHO service area residents were covered by Medicaid in 2007, with another 134,000 covered by Medicare. The estimated percentage of residents who are uninsured approximates 200,000, ranging from a low of 15.8% of McClain County residents to a high of 19.6% of Pottawatomie County residents. The economic downturn in the last two years has likely increased the percentage of uninsured in all NPHO service area counties.

Norman Physician Hospital Organization
Insurance Coverage Estimates

County	Uninsured	Medicare	Medicaid	Insured
Service Area Market				
Cleveland	16.4%	14.3%	9.7%	75.8%
Garvin	17.3%	24.6%	17.5%	57.7%
Grady	16.0%	19.6%	13.6%	66.6%
McClain	15.8%	14.2%	12.9%	72.7%
Oklahoma	18.2%	21.6%	12.2%	66.0%
Pottawatomie	19.6%	25.0%	14.1%	60.7%

NPHO serves the entire population of the NPHO service area, including the under-insured, uninsured, indigent, and self-insured through many forms of medical care. Among the most frequently used facilities are the Emergency Departments of NRHS and Moore Medical Center. Indigent patients and self-insured with limited resources can also utilize the Health for Friends Clinic across the street from Norman Regional Hospital.

Most, if not all, NPHO participating physicians participate in Medicare and serve the Medicare population, but the Medicaid population is not as well served. This is primarily due to the fact that Medicaid is difficult to work with and hard to obtain reimbursement for services. Most physicians would prefer to see a patient on Medicaid without compensation in their offices, rather than work through the process of securing payment from Oklahoma's Medicaid program.

Norman Physician Hospital Organization
2008 Market Discharges by County and Payer Class

County	Commercial	Medicare	Medicaid	Uninsured/ Self -pay	VA/ Military	Workers Comp	Other payers	Total
Cleveland	10,369	10,948	4,566	1,291	1,065	239	843	29,321
Garvin	1,162	2,489	905	320	40	57	40	5,013
Grady	1,905	2,809	1,181	341	95	72	41	6,444
McClain	1,545	1,868	683	225	51	42	36	4,450
Oklahoma	26,336	38,128	24,319	6,099	2,415	680	1,277	99,254
Pottawatomie	2,533	3,962	2,110	508	152	101	325	9,691
Grand Total	43,850	60,204	33,764	8,784	3,818	1,191	2,562	154,173
Percent Total	28.3%	39.5%	21.7%	5.6%	2.4%	0.8%	1.6%	100.0%

Exhibit VI.D
Service Area Employers and Employees

Nearly 525,000 individuals in the NPHO service area were employed as of February 2008, with the unemployment averaging 3.5%. In Oklahoma County, Tinker Air Force Base, the U.S. Postal Service, INTEGRIS Health, City of Oklahoma City, Oklahoma City School District, W.H. Braum & Company, OU Medical Center, Federal Aviation Administration, AT&T, OGE Energy, SSM Health Care of Oklahoma, Putnam City Independent School District, Edmond Public Schools, Mercy Health Center, Moore Public Schools, Homeland Stores, and United Parcel Service each employ 2,000 or more individuals and collectively represent 29% of total county employment.

In Cleveland County, the University of Oklahoma is the largest employer in the area, followed by Norman Regional Hospital. Other major employers in Cleveland County include Norman Public Schools, Chickasaw Nation Industries (Riverwind Casino), York International, and the City of Norman. The top 23 employers in Cleveland County collectively employ only 14.5% of county employees. A large percentage of employers in Cleveland County employ fewer than 50 employees. Chickasaw Nation Enterprises is one of the largest employers in McClain County, along with Purcell Municipal Hospital.

Although a few manufacturing companies are located in the service area, the largest employers typically include local government, small community hospitals, small businesses, and farms.

Based on the experience of NPHO, an increasing percentage of area employers, both large and small, obtain insurance coverage for their employees through health plans and networks established by third-party administrators, with a decreasing percentage of employers maintaining self-funded plans.

NPHO currently serves as the primary healthcare provider network for the PPOs of three employers in the service area, including NRHS, Oklahoma Electric Coop, and the student population of the University of Oklahoma's Norman campus. NPHO also serves as the secondary healthcare provider network for several employers with employees in the service area.

Exhibit VI.E
Health Insurance Plans, HMOs, Discount Medical Plans, Third-Party Administrators

Information regarding employee enrollment by health insurer is generally viewed as proprietary and not readily available. However, health insurance plans, HMOs, Discount Medical Plans, and third-party administrators are regulated by the Oklahoma State Department of Insurance. While the data obtained from the Department of Insurance and provided below reflect the state as a whole, the information is illustrative of the market served by NPHO.

According to the 2009 Annual Report and Directory issued by the Department of Insurance, the following top 10 accident and health insurance companies have a combined market share of over 70% of the $1 billion in premiums written in Oklahoma for group accident and health insurance policies.

Norman Physician Hospital Organization
Top Oklahoma Accident and Health Insurance Companies

Company	Direct Premiums	Market Share	Cumulative %
United Healthcare Insurance	249,245,727	23%	23%
Aetna Life Insurance	169,289,023	16%	39%
Principal Life Insurance	169,112,491	16%	55%
Time Insurance	31,295,034	3%	58%
Metropolitan Life Insurance	29,279,597	3%	61%
American Fidelity Assurance	28,403,124	3%	64%
Hartford Life & Accident Insurance	26,882,047	3%	66%
Connecticut General Life	22,749,114	2%	68%
Golden Rule Insurance	22,285,619	2%	70%
Unum Insurance of America	22,212,976	2%	72%
All Other	292,844,420	28%	100%
Total	1,03.599.172	100%	

HMOs in Oklahoma wrote about $2.9 billion in health benefit premiums in 2009 including:

- $1.4 billion in premiums for group and individual coverage
- $.59 billion in premiums for federal employees health benefits
- $.7 billion in premiums for Medicare beneficiaries

Exhibit VI.E (Cont'd)
Norman Physician Hospital Organization
Top Oklahoma HMOs

Company	Direct Premiums	Market Share	Cumulative %
Healthcare Service Corporation	1,366,531,365	47%	47%
CommunityCare	626,017,668	22%	69%
PacifiCare	340,528,140	12%	81%
Aetna Health, Inc.	137,163,761	5%	86%
GlobalHealth, Inc.	100,553,538	3%	89%
HCHC Insurance Services Company	67,207,526	2%	91%
Delta Dental Plan of Oklahoma	65,828,369	2%	94%
Sterling Life Insurance Company	55,958,412	2%	96%
Coventry Health and Life Insurance	51,478,375	2%	97%
BlueLincs Inc.	22,717,209	1%	98%
All Other	54,040,248	2%	100%
Total	2,888,024,611	100%	

The Department of Insurance also regulates discount medical plan organizations that contract on behalf of plan members, in exchange for fees, with a healthcare provider or provider network for access to medical services at a discounted rate and third-party administrators that collect premiums and settle claims for health or life insurance coverage. The Department of Insurance 2009 report lists 26 discount medical plans and 288 third-party administrators. NPHO has helped to facilitate agreements between NPHO members to participate in the provider networks established by CommunityCare, Aetna, BlueLincs, and PacifiCare, as well as other smaller insurance plans.

Information regarding enrollment by specific insurance plan is considered proprietary by most plans and is not readily available. However, based on data obtained from the Oklahoma State Department of Health, residents of the service area generated about 154,000 hospital discharges in 2008. Of these, about 40% were covered by Medicare, 2% by Commercial carriers including managed care plans, and 22% by Medicaid. About 6% were classified as uninsured/self-pay.

Exhibit VI.F
Norman Physician Hospital Organization
Medical and Surgical Services Provided by Participating Hospitals

Hospital Service	Norman Regional Health System (NRH & MMC)	Norman Regional Hospital (NRHS)	Moore Medical Center (NRHS)	Purcell Municipal Hospital
Medical/Surgical Services				
Anesthesiology	X	X	X	X
Bariatric/Weight Control Services	X			
Cardiovascular Services	X	X		
Cardiology	X	X	X	
Cardiac Catheterization Laboratory	X	X		
Thoracic Surgery	X	X		
Cardiac Rehabilitation	X	X		
Chemotherapy	X			
Medical/Surgical Critical Care	X	X	X	
Cardiac Intensive Care	X			
Neonatal Intensive Care	X	X		
Geriatric Services	X			
Hemodialysis	X			
Endoscopic Department	X	X	X	
Obstetrics/Gynecology	X	X	X	X
Birthing Room/LDRP	X			X
General Medicine	X	X	X	X
General Surgery	X	X	X	X
Ambulatory Surgery Center	X			
Oncology	X	X		
Outpatient Surgery	X	X		X
Orthopedic Services	X		X	X
Computer Assisted Orthopedic Surgery	X			
Orthopedics	X			
Pediatrics	X	X	X	
Pediatric Medical Surgical Care	X	X		X
Behavioral Health Psych Consultation	X			
Psychiatric Emergency Services	X			
Psychiatric Geriatric Services	X			
Tobacco Treatment/Cessation Program	X			
Neurological Services	X	X		
Nuclear Medicine	X	X		
Pain Management	X	X	X	
Pulmonary Medicine	X	X	X	
Shaped Beam Radiation System	X			
Tissue Transplant	X			
Trauma Center (Certified)	X			
Urology	X	X	X	

Exhibit VI.F (Cont'd)
Norman Physician Hospital Organization
Diagnostic and Ancillary Services Provided by Participating Hospitals

Hospital Service	Norman Regional Health System (NRH & MMC)	Norman Regional Hospital (NRHS)	Moore Medical Center (NRHS)	Purcell Municipal Hospital
Diagnostic Services				
Diagnostic Imaging	X	X	X	X
Diagnostic Radioisotope Facility	X			
Breast/Mammography	X	X		
Full Field Digital Mammography	X			
CT Scanner	X			X
MRI	X			
Ultrasound	X	X	X	X
Pathology		X	X	
Ancillary Support & Other Services				
Occupational Health	X			X
Occupational Therapy	X	X		
Physical Therapy	X	X	X	X
Physical Rehabilitation Outpatient Services	X	X		X
Respiratory Therapy	X	X	X	X
Renal Dialysis	X	X		
Intermediate Nursing Care	X			
Swing Bed Services	X			X
Sleep Disorder Center	X	X		
Speech Therapy	X	X		
Ambulance Services	X			
Ambulatory Surgery Center	X			
Hospital-Based Outpatient Care Services	X			X
Freestanding Outpatient Care Center	X			
Immunization Program	X			X

Exhibit VI.G
Ancillary Service Providers

As noted in the table below, other healthcare providers affiliated with NPHO include a wide array of outpatient diagnostic, treatment, and rehabilitation services providing Payers and patients with increased access to care.

Norman Physician Hospital Organization
Ancillary Service Providers

Ambulatory Surgery/Endoscopy	**Community Clinics**
Medical Plaza Endoscopy Unit	Maysville Rural Health Clinic
Physicians Surgical Center	Immediate Care of Oklahoma (3 locations)
West Norman Endoscopy Center	Pulmonary Clinic
Norman Endoscopy Center	
Behavioral Health Care	
Norman Behavioral Health	
DME	**Imaging**
Apple Medical	Brookhaven Diagnostic Imaging Center
Norman Regional DME	Moore Medical Center Diagnostic Imaging
	Norman Open MRI
	Norman Regional HealthPlex
Home Health	Norman Radiology Services, Inc.
Lifecare Oklahoma, Inc.	Norman Regional Hospital Diagnostic Services
Home Health Care	Norman Regional Radiology Services
Hospice	Norman Regional PET/CT Center
Lifecare Oklahoma Hospice, Inc.	Orthopedic & Sports Medicine Center
Laboratory	
Moore Medical Center	
Norman Regional Hospital Diagnostic Services	Purcell Municipal Hospital Radiology
Norman Regional HealthPlex	**Rehabilitation**
Norman Regional Lab Service (3 locations)	Norman Regional Cardiac Rehabilitation
Norman Regional Hospital	Norman Regional Occupational Medicine
Purcell Municipal Hospital Laboratory	Norman Regional Physical Performance Center

Exhibit VI.H
Physician Shortages in Selected Specialties

Application of physician demand models based on the current utilization and distribution of physicians across the U.S. to the NPHO service area population suggests that there are currently shortages of selected physician specialties. Shortages have been exacerbated by the growth of specialty hospitals and ambulatory surgery centers in the market, making it difficult to maintain specialty coverage for the general, acute care hospitals. In addition, about 20% of NPHO service area physicians are age 60 and over, and they are likely to retire in the next five to ten years when demand for healthcare services by the Baby Boom generation will reach its peak.

Physician supply and demand reports published by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services in October 2006 and December 2008 indicate that the supply of Total Patient Care Physicians (including residents) in the U.S. will increase by 13% from 2005 to 2020, falling short of the projected required growth rate of 22%. Given changing physician practice patterns and the potential for early retirement, these estimates may be conservative.

The table below applies HRSA current supply requirements to the 2010 estimated population of the NPHO service area and indicates that the market may already be experiencing shortages in internal medicine, pediatrics, general surgery, and obstetrics/gynecology before consideration of the broader service area population that relies on the Oklahoma City Metropolitan Area for healthcare services. Continued population growth, combined with physician retirement and aging of the population, will extend physician shortages across many other specialties.

Norman Physician Hospital Organization
NPHO Service Area Physician

Active Physicians by Specialty (Age<75)	Current Supply	2010 SA Requirements	
		Baseline	High Economic Growth
Total		3,177	3,304
Total Non-Patient Care		178	179
Total Patient Care		3,000	3,125
Primary Care		1,108	1,140
General Family Practice	461	449	462
General Internal Medicine	342	460	473
Pediatrics	180	199	205
Medical Specialties		375	391
Cardiology	97	90	93
Other Internal Medicine		285	298
Surgical Specialties		670	704
General Surgery	120	167	175
OB/GYN	156	167	171
Ophthalmology	86	79	86
Orthopedic Surgery	135	102	108
Other Surgery		70	74
Otolaryngology	42	41	45
Urology	48	45	45

Note: Numbers in red indicate current shortage areas.

Exhibit VII

[redacted]

Exhibit VIII

[redacted]

Exhibit IX

Exhibit X