IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

FEDERAL TRADE COMMISSION **and** **STATE OF NORTH DAKOTA,** **Plaintiffs,** **v.** **SANFORD HEALTH,** **SANFORD BISMARCK,** **and** **MID-DAKOTA CLINIC, P.C.,** **Defendants.**	**Case No. 1:17-cv-00133-ARS** **UNDER SEAL**

DEFENDANTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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FINDINGS OF FACT

I. Sanford And Mid Dakota Clinic ("MDC").

A. Sanford

1. Sanford is a not-for-profit, integrated health care system chartered in North Dakota and headquartered in Sioux Falls, South Dakota. Krabbenhoft, Nov. 2 Tr. 9:5-17; 10:10-12. Consistent with its charitable mission, Sanford treats "all patients who come to us regardless of their ability to pay or any other condition." Krabbenhoft, Nov. 2 Tr. 9:20-10:10-12. Moreover, as a non-profit with no shareholders, Sanford can devote revenue to expanding healthcare access, improving quality, benefiting the health of patients in the communities its serves, and research initiatives. Sanford also relies on philanthropy to advance its mission, most prominently Mr. Denny Sanford, who has donated at least $800 million to the organization that now bears his name. Krabbenhoft, Nov. 2 Tr. 10:3-9.

2. There are two business divisions within Sanford relevant to this matter: Sanford's Health Services Division (HSD) provides healthcare services to patients, and Sanford Health Plan (SHP) offers health insurance products. JX00007_004, Leclerc IH Tr. 9:16-11:1.

3. Sanford employs approximately 29,000 people, about 12,000 of whom are in North Dakota (making Sanford the largest non-governmental employer in North Dakota). Krabbenhoft, Nov. 2 Tr. 10:18-11:2. Through its HSD, Sanford employs approximately 1,500 physicians across multiple states in over 80 specialties, including its cancer, pediatric, heart, orthopedics/sports medicine, and women's health practices. DX6024_001 (About Sanford Health); Krabbenhoft, Nov. 2 Tr. 10:18-11:2. The Edith Sanford Breast Center leads the system's cancer research and care practice. DX6026_002 (About Edith Sanford). In 2016, SHP had 80,358 covered lives, including 66,602 through North Dakota's Public Employees Retirement System ("NDPERS"), DX2011_061 (Sanford Responses to FTC Civil Investigative

Demand), and Sanford's own employees. DX6005_003 (Town Appendix A); JX00007_015, Leclerc IH Tr. 55:12-56:13.

4. Sanford operates several dozen hospitals in five states: Iowa, Minnesota, Nebraska, North Dakota, and South Dakota. DX6004_001 (Town Appendix B). In North Dakota, Sanford operates hospitals in Bismarck, Fargo, Hillsboro, and Mayville. *Id.* In Bismarck, Sanford Medical Center includes a Level 2 trauma center, a tertiary center for acute care, and a children's hospital. *Id.*; JX00004_009, Lambrecht IH Tr. 29:4-14; JX000021_025-26, LeBeau Dep. 96:13-97:11.

5. In addition to its hospitals, Sanford has over 200 non-hospital healthcare facilities offering services in eight states: California, Iowa, Minnesota, Nebraska, North Dakota, Oklahoma, Oregon, and South Dakota. DX6004_001 (Town Appendix B). In North Dakota, Sanford operates approximately 100 such facilities, including multi-specialty or specialty clinics (including those offering walk-in care), birth centers, cancer treatment centers, dialysis centers, eye care centers, pediatric psychology centers, and surgical centers. *Id.* In Bismarck, Sanford operates 19 multi-specialty or specialty clinics, one birth center, two cancer treatment centers, one dialysis center, and three surgical centers. *Id.*

6. In 2016, Sanford generated approximately [redacted] in total revenue in North Dakota and [redacted] in Bismarck from providing inpatient, outpatient, physician services, and services by other health care professionals to patients covered under governmental and commercial plans as well as from other forms of payment. *Id.*

7. Governmental payers include primarily Medicare and Medicaid. Commercial payers in North Dakota include Noridian Mutual Insurance Co., which operates as Blue Cross Blue Shield of North Dakota ("BCBS-ND"), SHP, Medica, Cigna, Aetna, and UnitedHealthcare ("United")

as well as others. DX6000_011 (Town Rpt.) ¶ 21; Krabbenhoft, Nov. 2 Tr. 31:25-32:2**.** Among these commercial payers, BCBS-ND is the largest by far. DX6000_018 (Town Rpt.) ¶ 36 (Table IV.2). In 2016, Sanford's total revenue from serving patients covered by various [redacted] plans was [redacted]. DX6000_11 (Town Rpt.) ¶ 21. Of that revenue, [redacted] in North Dakota, including [redacted] in Bismarck, came from serving patients insured by [redacted] commercial plans. DX6004_005 (Town Appendix B) Table B.5.

8. Sanford's growth and development strategy is based on the premise that the most successful and recognized healthcare organizations in the country from a quality of care standpoint, are significant in size (and thus able to serve large geographic areas) and integrated with components of hospitals, physicians, research, and/or insurance. JX00028_022, 31 Krabbenhoft Dep. 84:10-19; 119:3-120:11; Krabbenhoft, Nov. 2 Tr. 22:6-24:10. Such systems have resources, levels of integration, and an emphasis on innovation/excellence comparable to Sanford. Smaller clinics can provide quality healthcare but lack the personnel or technological resources to innovate in a way these larger organizations do. Krabbenhoft, Nov. 2 Tr. 13:6-14:7; Hocks, Nov. 2 Tr. 214:24-215:8, 223:9-224:16, 227:22-228:14.

9. Accordingly, Sanford benchmarks itself against other nationally recognized medical centers and health systems, which Sanford considers to be its primary competitors. Krabbenhoft Nov. 2 Tr. 25:6-13; Hocks, Nov. 2 Tr. 204:2-206:5; DX2081_004 (Jan. 1, 2017 N. Peterson Email); DX2131_13 (Virtual Care at Sanford Health); DX2003_008-30 (June 1, 2017 D. Berkland Email). One of those systems—CHI—has significant operations in Bismarck-Mandan.

10. In Sanford's view, the quality of healthcare in the regions in which these organizations operate will continue to improve as these integrated systems compete against one another and bid for various forms of healthcare-related business (e.g., commercial, governmental).

JX00028_022-23, 46, Krabbenhoft Dep. 83:21-85:6, 178:3-180:3; Krabbenhoft, Nov. 2 Tr. 25:25-26:7 ("[T]he real competition now and in the future will go on between these integrated systems.").

11. Sanford is a physician-driven organization that ensures that those closest to patients play a central role in driving and delivering quality. LeBeau, Nov. 2 Tr. 69:25-70:23; Hocks, Nov. 2 Tr. 199:25-200:14. For example, each Sanford region has a Physician Executive Council ("PEC") comprised of local doctors to provide oversight for the physicians in that region. LeBeau, Nov. 2 Tr. 69:5-12; Hocks, Nov. 2 Tr. 200:20-201:12. Officers of each PEC comprise the Council of Governors, an enterprise-level leadership body with complete authority and responsibility for the conduct and activities of all Sanford physicians. LeBeau, Nov. 2 Tr. 69:5-12; Hocks, Nov. 2 Tr. 200:20-201:12.

12. A central principle of Sanford's organizational ethos is its "promises made, promises kept" philosophy. Sanford has a proven track record of achieving efficiencies, including in the Bismarck region. Krabbenhoft, Nov. 2 Tr. 16:23-17:10 ("[W]e understand the scrutiny and the -- and the attention given to us when these kinds of things happen, that the benefits have to be enumerated, the benefits have to be transparently provided to the community, and then they have to be delivered on. . . . The value proposition of these changes becomes a pact, a trust between the public and our organization."). This is evidenced by the substantial investments Sanford has made in and around Bismarck-Mandan since its acquisition of Medcenter One in 2012, the new $500 million Sanford medical center in Fargo, and in the clinics it has opened in places like Dickinson and Minot. Krabbenhoft, Nov. 2 Tr. 16:10-22, 21:23-22:5; LeBeau, Nov. 2 Tr. 71:19-73:19; DX2029_002-6 (May 4, 2016 T. Flagstad Email).

13. For example, within two years of acquiring Medcenter One in Bismarck, Sanford had already made $65 million in capital investments, DX2029_002 (May 4, 2016 T. Flagstad Email); Krabbenhoft, Nov. 2 Tr. 18:18-23, and as of today has made over $100 million in such investments, Krabbenhoft, Nov. 2 Tr. 18:24-19:5. In connection with these investments, Sanford Bismarck: (a) increased physician recruitment by over 28% per year; (b) more than doubled average annual capital spending; (c) expanded services in a variety of disciplines; (d) expanded outreach services in central and western North Dakota; and (e) increased the proportion of employees in direct patient care positions. DX2011_048 (Sanford's March 24, 2017 Narrative Responses to FTC Civil Investigative Demand, Response No. 21); Krabbenhoft, Nov. 2 Tr. 19:6-20:11.

14. Similarly, Sanford's 2011 acquisition of North Country Health Services in Bemidji, MN resulted in a significant expansion of services and access, and meaningful cost savings, including: (a) a [redacted] increase in the number of providers; (b) a new orthopedic and sports medicine center; (c) construction of a new [redacted] clinic in Bagley, MN for family, internal medicine and other services; and (d) a reduction in supply costs of over [redacted] per year. DX2022_016 (Sanford's Responses and Objections to Plaintiffs' First Set of Interrogatories); Krabbenhoft, Nov. 2 Tr. 20:12-21:22 ("[T]hese transactions create momentum, interest otherwise that wouldn't be there, and it makes it a lot easier to recruit physicians and develop services.").

B. Mid Dakota Clinic

15. MDC is a physician-owned multi-specialty clinic in Bismarck with deep roots in the Bismarck-Mandan community and over 60 physicians and almost 500 other healthcare professionals and employees. DX2012_002 (March 2017 Board Presentation). MDC physicians have admitting privileges at one or more of the hospitals in the area, including both CHI's St. Alexius Medical Center and Sanford Bismarck Medical Center.

16. MDC prides itself on providing quality healthcare for the patients in the Bismarck-Mandan area and values the collaboration of physicians for the sole purpose of delivering quality care. JX00002_053, Lein IH Tr. Dep. 206:18-24. MDC has received awards for the quality of healthcare it provides to patients in the Bismarck-Mandan area, including the NCQA's Patient-Centered Medical Homes Recognition. JX00002_053, Lein IH Tr. 208:1-9.

17. MDC operates 10 healthcare facilities in 5 locations in Bismarck—specifically, 3 multi-specialty clinics (two of which include "TODAY" Clinics accepting walk-in appointments); 5 specialty clinics focusing on Dermatologic Surgery, Dermatology, OB/GYN, Pediatrics, and Physical Therapy; a Student Health center; and an Ambulatory Surgery Center, known as a Surgicenter, where MDC offers same-day surgery. DX6002_001 (Town Appendix D).

18. Following the Sanford-MDC merger, MDC physicians would retain the ability to continue their admitting privileges at CHI/St. Alexius. Krabbenhoft, Nov. 2 Tr. 31:17-21. Moreover, Sanford physicians can, and regularly do, refer patients to non-Sanford physicians and facilities; the Sanford-MDC merger would not change this practice. Krabbenhoft, Nov. 2 Tr. 31:22-24.

19. In 2016, MDC generated about [redacted] in revenue from providing physician services and services provided by non-physician practitioners to patients insured by all types of payers and self-pay patients. DX6002_002 (Town Appendix D). In 2016, MDC's total revenue from serving patients covered by various commercial and governmental [redacted] plans, as well as the [redacted] plan, was [redacted]. DX6000_013 (Town Rpt.) ¶ 23. Of that revenue, [redacted] came from serving patients insured by BCBS-ND commercial plans. DX6002_003 (Town Appendix D).

II. MDC Sought to Sell Its Practice Because It Believed It Was The Only Way For Its Practice To Remain Financially Viable.

20. MDC is governed by a board of directors, consisting of shareholders elected by MDC's shareholders. Seifert, Nov. 3 Tr. 161:9-14; JX00011_009, Seifert IH Tr. 30:8-14. Dr. Shelly Seifert serves as Board Chair, a position to which she was elected in 2013. Seifert, Nov. 3 Tr. 161:11-14; JX00011_009, Seifert IH Tr. 30:8-14. Marvin Lein, MDC's Chief Executive Officer, reports to the Board and to Dr. Seifert as Board Chair. Lein, Nov. 2 Tr. 88:8-10.

21. Craig Schaaf, MDC's Chief Financial Officer, prepares written reports concerning MDC's financial condition and reports at board and staff meetings on a regular basis regarding MDC's financial condition. Seifert, Nov. 3 Tr. 166:17-25; JX00024_033, Lein Dep. 125:1-19; *see also* PX05114_001 (Jan. 23, 2017 Mid Dakota Clinic Financial Update).

22. In 2014, MDC's board of directors began a process of strategically reviewing MDC's future prospects. JX00002_039-40, Lein IH Tr. 150:17-155:10. The healthcare market in Bismarck changed significantly over the past several years, after Sanford acquired Medcenter One and Catholic Health Initiatives ("CHI") acquired St. Alexius. JX00011_065, Seifert IH Tr. 253:15-254:12. Both Sanford and CHI have resources orders of magnitude greater than MDC.

23. Financial projections prepared by Mr. Schaaf project a generally declining trend for MDC. JX00024_033, Lein Dep. 126:5-16; JX00002_040, Lein IH Tr. 154:19-156:22; JX00012_031-33, Schaaf IH Tr. 120:14-125:4; PX05114_007 (Jan. 23, 2017 Mid Dakota Clinic Financial Update) (showing service line contributions). In particular, revenue from ancillary procedures—*i.e.*, services provided by MDC that are something other than physician services, such as revenues from MDC's ambulatory surgical center, lab, and imaging—which had historically provided MDC with the ability to compensate its physicians at levels higher than the national average, have been in decline. Seifert, Nov. 3 Tr. 164:15-165:12; JX00011_017-19,

Seifert IH Tr. 67:7-70:4; PX05114_001 (Jan. 23, 2017 Mid Dakota Clinic Financial Update). MDC's ancillary production has dropped by [redacted], and MDC expects to see another [redacted]. JX00011_017-19, Seifert IH Tr. 67:7-70:4; PX05114_007 (Jan. 23, 2017 Mid Dakota Clinic Financial Update).

24. In addition, MDC has been experiencing a decline in physician productivity. JX00011_011, Seifert IH Tr. 39:7-40:1; JX00012_016, Schaaf IH Tr. 58:19-59:22. Older physicians who have been major producers have become less productive as they near retirement, and new physicians who have joined the practice have generally not produced at [redacted], as had historically been the case. JX00012_016, Schaaf IH Tr. 58:19-59:22; JX00011_011, Seifert IH Tr. 39:7-40:1.

25. MDC is at a disadvantage with respect to recruiting when compared with Sanford and CHI. MDC's experience has been that doctors who have more recently completed their residency are less likely to be interested in becoming an owner of an independent clinic and are more likely to prefer the stability of working for a large, integrated health system. JX00002_058, Lein IH Tr. 225:23-24, 226:23-227:13; JX00011_018-19, Seifert IH Tr. 68:25-69:15; JX00022_039-40, Seifert Dep. 152:24-153:9. Unlike Sanford and CHI, MDC does not employ any in-house recruiters. Seifert, Nov. 3 Tr. 165:2-7; JX00011_037-38, Seifert IH Tr. 144:18-145:6, 225:23-24, 228:20-229:14. Unlike Sanford and CHI, MDC is unable to employ physicians who are in the United States on an H1B visa because MDC is unable to guarantee long-term employment. JX00002_058, Lein IH Tr. 225:23-24, 227:14-228:5. MDC also is unable to offer large signing bonuses, loan forgiveness, and other perks that larger organizations can provide. Seifert, Nov. 3 Tr. 165:2-7; JX00011_010, 18-19, 20, Seifert IH Tr. 34:7-19, 67:7-

69:15, 76:3-19; JX00002_058, Lein IH Tr. 225:23-24, 228:6-228:19; JX00025_032, Helbling Dep. 128:18-129:22.

26. MDC hired several family practice physicians two to three years ago to work in MDC's urgent care clinic, but they do not provide primary care. JX00022_039, Seifert Dep. 149:9-151:17. MDC continues to have difficulty recruiting primary care physicians. Seifert, Nov. 3 Tr. 165:20-24.

27. MDC's ability to pay physicians at levels above the national average has, in the past, provided it with a significant recruiting advantage. Seifert, Nov. 3 Tr. 164:10-14. However, MDC is unlikely to continue that trend in light of its declining financial circumstances, thus eliminating what has historically been its most potent recruiting tool. Seifert, Nov. 3 Tr. 164:15-165:1; JX00011_046, Seifert IH Tr. 177:19-178:9.

28. MDC will experience several retirements in the near future, including in primary care and general surgery, and will, for the reasons discussed above, likely find it very difficult to replace those retiring physicians. Seifert, Nov. 3 Tr. 165:13-24; JX00011_045, Seifert IH Tr. 174:3-176:14; JX00025_035, Helbling Dep. 133:4-134:14.

29. If MDC is unable to replace departing physicians, this will increase the call burden on those who remain because there will be fewer physicians to cover patients. Seifert, Nov. 3 Tr. 165:2-12. This increasing workload, coupled with declining compensation, is anticipated by MDC's leadership to cause further physician departures, including physicians who may decide to leave the Bismarck area altogether, resulting in a downward spiral. Seifert, Nov. 3 Tr. 167:17-168:14; JX00011_028, 45, 51, Seifert IH Tr. 111:15-112:4, 177:19-179:9, 204:22-206:25; JX00025_043, Helbling Dep. 168:19-170:12.

30. The question of MDC's future prospects was a matter of vigorous debate among MDC's shareholders over the course of numerous meetings. Seifert, Nov. 3 Tr. 162:21-163:25. Ultimately, the MDC shareholders reluctantly reached the conclusion that, although many would prefer to continue as an independent clinic, MDC's independent business model would not remain viable in the future. Seifert, Nov. 3 Tr. 163:21-164:9; JX00011_011, Seifert IH Tr. 40:2-22; JX00025_043-44, Helbling Dep. 168:19-170:12. Although MDC, today, is financially stable, the Board determined that it would be irresponsible to wait any longer before taking action. Seifert, Nov. 3 Tr. 168:2-7; JX00011_029, Seifert IH Tr. 111:15-112:16.

31. Dr. Bury, the only practicing MDC physician to testify that she believed it was not necessary to sell the clinic, did not attend the meetings where these issues were discussed. Bury, Oct. 31 Tr. 21:20-22:19, 37:21-38:6; JX00014_041, Bury IH Tr. 159:17-160:8.

32. MDC also considered possible alternatives to a sale. JX00024_031, Lein Dep. 117:14-118:2. To that end, MDC considered entering into a professional services agreement with either Sanford or CHI, but determined that there was no interest on the part of either Sanford or CHI and no support among MDC's physicians for this theoretical option. Seifert, Nov. 3 Tr. 170:15-25; JX00011_011, Seifert IH Tr. 38:16-39:4. MDC also explored entering into a relationship with an investment bank but determined that it was not appropriate for MDC's circumstances. Seifert, Nov. 3 Tr. 170:2-14; JX00002_042, Lein IH Tr. 163:8-164:23.

33. Dr. Jha's opinion that MDC does not need to merge is not supported by any analysis of MDC's finances or the combination of factors that provided the basis for MDC's decision. PX06002, 27-42 (Jha Rpt.) ¶¶ 63-96. Dr. Jha bases his opinions primarily his perception of national trends in healthcare, not on MDC's particular circumstances. *Id*.; Jha, Oct. 31 Tr. 273:13-276:18. Dr. Jha has not performed any study of healthcare delivery in North Dakota;

indeed, prior to the hearing, he had never been to North Dakota. Jha, Oct. 31 Tr. 276:7-18, 273:13-16. Dr. Jha has never spoken with anyone at MDC. Jha, Oct. 31 Tr. 273:17-19. Dr. Jha's opinions do not outweigh the thoroughly considered decisions of MDC's owners, who have been running their clinic in Bismarck for decades and who made the judgment that they needed to sell.

34. Dr. Jha points to evidence that MDC provides high quality patient care to argue that MDC does not need to merge with Sanford. PX06002_34-39 (Jha Rpt.) ¶¶ 81-88. This misses the point. That MDC is currently providing high quality care is not disputed. The MDC physicians based their decision not on a present inability to provide high-quality care but on its judgments about its ability to remain viable over the long-term. By merging with Sanford, MDC will be able to secure its financial footing while gaining the benefits of many Sanford programs and practices that will enhance MDC's ability to provide high-quality patient care, as discussed in greater detail below. Seifert, Nov. 3 Tr. 181:24-182:7.

III. CHI Declined The Opportunity To Acquire MDC.

35. In connection with its decision to offer the clinic for sale, MDC obtained a valuation of the clinic from Wipfli, an independent firm. JX00002_037, Lein IH Tr. 147:18-25; Seifert, Nov. 3 Tr. 168:19-24; PX04192_001 (Wipfli Valuation).

36. After obtaining a valuation, MDC prepared term sheets that set forth certain "must haves" that, from MDC's perspective, would be necessary for MDC to agree to a sale. Seifert, Nov. 3 Tr. 169:18-23; DX2013_001 (MDC to Sanford Ltr. RE: Proposal to Acquire Mid Dakota Clinic); DX4078_001 (MDC to CHI Ltr. RE: Proposal to Acquire Mid Dakota Clinic). MDC chose CHI and Sanford as potential buyers because they were the only integrated health systems with hospitals in Bismarck. Seifert, Nov. 3 Tr. 168:15-18, 170:2-7, 171:6-11.

37. MDC selected CHI over Sanford because CHI and MDC had a long history of working together and also because CHI agreed to meet all the requirements of MDC's term sheet. JX00002_044, Lein IH Tr. 170:1-171:2; Seifert, Nov. 3 Tr. 171:12-23. MDC and CHI subsequently agreed to the terms of a letter of intent. Seifert, Nov. 3 Tr. 172:7-13; DX4008_001 (MDC-CHI Ltr. of Intent). Thereafter, the parties engaged in negotiations and were close to signing a deal. JX00011_060, Seifert Dep. 236:14-21; Seifert, Nov. 3 Tr. 172:18-23.

38. On or about March 28, 2016, representatives of CHI were to meet with the MDC board and then speak to the MDC doctors at a staff meeting. Seifert, Nov. 3 Tr. 172:24-173:15; *see also* DX4079_001 (CHI-MDC Termination Ltr.); JX00011_060-61, Seifert IH Tr. 236:25-238:5. CHI's representatives at the meeting at MDC were Jeffery Drop, Senior Vice President of Operations for CHI's Fargo Division, and Kurt Schley, CHI St. Alexius's President. Seifert, Nov. 3 Tr. 172:24-173:6; JX00024_024, Lein Dep. 89:8-90:24.

39. Prior to the meeting with the board, Mr. Drop and Mr. Schley unexpectedly informed MDC's CEO that CHI would not proceed with the purchase of MDC. JX00011_061, Seifert IH Tr. 237:5-238:22; Seifert, Nov. 3 Tr. 172:24-173:6; Lein, Nov. 2 Tr. 92:23-94:7.

40. [redacted]

41. MDC subsequently received a letter from CHI dated March 28, 2016, signed by Mr. Schley, confirming CHI's decision to terminate the transaction with MDC. Seifert, Nov. 3 Tr. 173:7-15; DX4079_001 (CHI-MDC Termination Ltr.). [redacted]

[redacted] DX4079_001 (Letter from CHI terminating MDC transaction, dated Mar. 28, 2016). [redacted] Seifert, Nov. 3 Tr. 173:16-21.

42. MDC responded on April 25, 2016, with a letter signed by its board chair. [redacted] In its letter, [redacted] DX4080_001 (Ltr. from Seifert to Schley re termination of MDC transaction). MDC's letter further stated that CHI's actions had [redacted]

43. [redacted]. JX00016_114-16, Schley Dep. 114:21-116:3.

44. A few weeks after the meeting where CHI informed MDC that it would not proceed with the transaction, Dr. Seifert was contacted informally by Dr. Tim Bopp, president of the Medical Executive Committee at CHI St. Alexius, who asked how MDC would respond if negotiations with CHI re-opened. Seifert, Nov. 3 Tr. 175:2-9; JX00011_062, Seifert IH Tr. 242:10-19. Dr. Seifert responded that she would take it to her partners but that she could not predict how they would respond. Seifert, Nov. 3 Tr. 175:9-10; JX00011_062, Seifert IH Tr. 242:10-243:18. Since then, CHI has done nothing to follow up on Dr. Bopp's informal contact or to otherwise

re-initiate discussions about a possible acquisition of MDC. Seifert, Nov. 3 Tr. 175:11-12; JX00011_062, Seifert IH Tr. 242:10-243:18.

45. On June 22, 2017, CHI published an email, ostensibly from Kurt Schley, to "CHI St. Alexius Medical Staff Members." DX3010_001 (Email from Kurt Schley to CHI St. Alexius Medical Staff Members). In this email, CHI expressed its support for the Government's action seeking to bar Sanford's acquisition of MDC, and stated that the transaction "would harm the community by increasing physician fees, reducing quality and eliminating choice." DX3010_001 (Email from Kurt Schley to CHI St. Alexius Medical Staff Members). [redacted]

46. The June 22 email came to the attention of MDC physicians almost immediately. Seifert, Nov. 3 Tr. 175:24-177:8; Lein, Nov. 2 Tr. 94:24-95:9. The email was very upsetting to MDC physicians, who saw CHI's assertion that the transaction with Sanford would have the effect of reducing quality as an attack on their professionalism. Seifert, Nov. 3 Tr. 176:22-177:13, 183:25-184:6; Lein, Nov. 2 Tr. 95:25-96:20. As explained by Dr. Seifert, medicine is a "humanitarian effort," and doctors make decisions about how to provide care based on their professional judgment about the patient's best interests, not on competition. Seifert, Nov. 3 Tr. 183:25-184:6; *see also* JX00025_025, Helbling Dep. 98:16-99:2. MDC's physicians found Mr. Schley's claim that they would provide lower quality care because of a change in the name on their paychecks to be offensive. Seifert, Nov. 3 Tr. 183:17-22. The effect of this email was to exacerbate the distrust that MDC's physicians already felt towards CHI as a result of CHI's abrupt termination of the previous acquisition discussions. Seifert, Nov. 3 Tr. 175:13-178:10.

47. [redacted]

48. [redacted]

49. [redacted]

50. [redacted]

[redacted]

51. [redacted]

[redacted]

[redacted] Schley, Oct. 30 Tr. 126:15-18. It also would be fundamentally unfair to allow the Government and CHI to claim that a CHI-MDC deal is a realistic possibility while blocking discovery into the reasons for CHI's decision to terminate its efforts to acquire MDC and whether those reasons persist.

52. [redacted] JX00016_111-12, Schley Dep. 111:15-112:24; Schley, Oct. 30 Tr. 126:6-14; DX4008_008 (MDC-CHI Ltr. of Intent). [redacted] JX00016_114, Schley Dep. 114:3-20. [redacted] Lein, Nov. 2 Tr. 99:19-100:3; Schley, Oct. 30 Tr. 128:19-21. [redacted] Schley, Oct. 30. Tr. 146:9-17; Bury, Oct. 31 Tr. 23:17-24.

53. As importantly, [redacted] Seifert, Nov. 3 Tr. 175:13-19; JX00002_045, Lein IH Tr. 174:10-175:25.

IV. Following CHI's Abandonment of MDC, Sanford And MDC Agreed To Merge.

54. During the spring and summer of 2016, Sanford and MDC representatives discussed whether the parties were an appropriate fit. JX00021_27, LeBeau Dep. 104:1-8; DX3007, (Aug. 4, 2016 Krabbenhoft Email).

55. On August 22, 2016, MDC and Sanford signed a term sheet to merge. DX2014, (Sanford and MDC Term Sheet). During negotiation of the final agreement, they identified numerous synergies and efficiencies the merger will enable them to achieve. PX04045_024-31, (Mid Dakota Clinic Board of Directors March 2017 Presentation); DX4018_004 (Deloitte Efficiency Analysis); *see also id*. at 006.

56. At its March 2017 meeting, the Sanford Health Board of Trustees considered the merits of Sanford's proposed acquisition of MDC, including summaries of synergies the parties believe could be achieved and the independent efficiencies analysis prepared by Deloitte. DX2012, (March 2017 Board Meeting materials) (containing the *Stronger Together: Synergy* Book at 021 and executive summary of Deloitte analysis at 037); JX00028_16, Krabbenhoft Dep. 57:22-24; JX00008_006, Hocks IH Tr. 19:17-20:4.

57. The expected realization of these synergies and efficiencies was one of the factors that led Sanford's board to authorize the transaction, and management did not seek such authorization until it was confident in these efficiencies. JX00005_042-43, Cristy Dep. at 163:7-165:2; JX00008_007-8, Hocks IH Tr. 24:15-27:8; Krabbenhoft, Nov. 2 17:11-24.

58. During the March 2017 meeting, the Sanford Board of Trustees approved the transaction. DX2056 _006 (June 2017 Board Book and Retreat Materials); Krabbenhoft, Nov. 2 16:4-9.

59. On June 19, 2017, the parties executed the Stock Purchase Agreement. DX2015_001, (Final Stock Purchase Agreement); DX2016_001, (Signature Pages for Final Stock Purchase Agreement).

V. Sanford And MDC Will Not, And Could Not, Increase Prices Post Transaction.

A. There Is No Evidence That Sanford Or MDC Plan To, Or Believe They Could, Increase Prices Or That This Transaction Was Motivated By A Desire or Plan To Do So.

60. Since the Government's investigation of this transaction commenced, Sanford and MDC produced over one million documents, and their fact witnesses sat for 149 hours of on-the-record questioning.

61. Despite this extensive record, there is no evidence that Sanford or MDC intends to increase prices to any health insurer ("payer") post-transaction or even believes it is a possibility. Nor is there any evidence that Sanford or MDC undertook the transaction, even in part, to enable them to receive higher reimbursement rates.

B. The Transaction Will Not Cause [redacted] Pay Higher Prices.

1. Summary

62. The evidence—both qualitative and quantitative—establishes that this transaction will [redacted]

[redacted] The only other affected payer, [redacted] during which time CHI estimates it will recruit physicians in all of the relevant service areas. A price increase is thus unlikely even [redacted] and would be no more than *de minimis* even if it occurred and even assuming no competitive entry at all.

2. "Bargaining Power" and "Bargaining Leverage" Are Distinct Economic Concepts, and Both Must Be Taken Into Account In Measuring Potential Price Effects Of A Merger.

63. Though often used interchangeably in common parlance, "bargaining power" and "bargaining leverage" are distinct economic concepts. Bargaining leverage refers to the respective walk away points of negotiating parties, here the provider and the payer. DDX002 (Town Demonstrative) Slide 15; PDX002 (Sacher Demonstrative) Slide 8. A walk away point is the price at which a party will no longer be interested in entering into a contract. If the price is lower than the walk-away point, the seller will not enter into the agreement because the revenue from the contract will not exceed its costs. If the price is higher than the walk away point, the seller will enter into the agreement because its revenues will exceed costs. Similarly, if the price is higher than the buyer's walk-away point, the buyer will not contract because it will not be able to earn a return, and if the price is lower than this point, the buyer will contract. Bargaining leverage thus frames the range of prices at which two parties may potentially agree. DDX002 (Town Demonstrative) Slide 15; Town, Nov. 3 Tr. 54:18-25, 55:10-25.

64. By contrast, bargaining power determines where the final negotiated price falls along the range established by the parties' respective bargaining leverage. Town, Nov. 3 Tr. 54:14-25,

56:9-57:3; DDX002 (Town Demonstrative) Slides 14, 16; PDX002 (Sacher Demonstrative) Slide 8; Sacher, Oct. 31 Tr. 129:3-8 ("[W]hen the price is determined, that determines how the surplus is split."). Bargaining power consists of various factors, including the relative importance of each party to the other's business and the respective market power or size of each party. Town, Nov. 3 Tr. 61:4-62:12; 101:23-104:9; DDX002 (Town Demonstrative) Slide 23; DX6000_024-25 (Town Rpt.) ¶53.[1]

65. A payer with high bargaining power can set prices below those paid by competing payers. [redacted] "High bargaining power" or "all the bargaining power," as phrased by Professor Town, are used interchangeably to mean that providers cannot translate leverage into increased rates, [redacted] Town, Nov. 3 Tr. 76:12-18, 114:1-23, 119:25-120:17; DX6015_005-6 (Town Appendix G) Tables G.1 to G.2 (showing regression results).

66. The effect of payer bargaining power on provider reimbursement rates is consistent with the large body of literature showing that "higher payer concentration" is "associated with lower provider reimbursement rates." DX6000_041-42 (Town Rpt.) ¶¶ 86-88 (collecting literature discussing the relationship between payer concentration and reimbursement rates). Relatedly,

[1] During the hearing, the Government tried to make a point of Professor Town's use of "stuff" when he defined bargaining power. Gov't Opening, Oct. 30 Tr. 37:13-16; Town, Nov. 3 Tr. 126:23-127:3. In doing so, it ignores that Professor Town would go on to provide a detailed and consistent definition of bargaining power. *See, e.g.*, JX00034_018, Town Dep. 66:3-16; *see also* Sacher, Oct. 31 Tr. 55:12-16 (explaining that his definition of bargaining power contains "things" that relate to negotiating).

the economic literature has shown that the impact of increases in provider concentration (*i.e.*, provider mergers) is lowered by higher payer concentration. DX6000_042-43 (Town Rpt.) ¶ 89.

67. Dr. Sacher does "not take issue by and large with Dr. Town's pronouncement that higher payer concentration tends to be associated with lower provider reimbursement rates." PX06003_036 (Sacher Rebuttal Rpt.) ¶ 87. He responds that there is literature showing that higher provider concentration can lead to higher reimbursement rates, but misses the point that *both* must be analyzed. *Id*. As discussed in Section V.D, *infra*, Dr. Sacher analyzes only half of the equation. By contrast, Professor Town accounts not only for increased bargaining leverage the merger will provide the merged entity, but also whether any payer can use its bargaining power to resist any attempt by the merged entity to use increased leverage to raise reimbursement rates. *See* DDX002 (Town Demonstrative) Slide 13 (blue line/red line chart); Town, Nov. 3 Tr. 49:22-51:19.

3. The Merger Simulation Model Used By Professor Town Takes Both Bargaining Power and Bargaining Leverage Into Account To Predict The Likely Price Effect Of A Merger.

68. The implications of payer bargaining power are commonly assessed in the economic literature by calculating bargaining power through the analysis of the relationship between bargaining leverage and price, as Professor Town did here. *See* DDX002 (Town Demonstrative) Slide 66; Town, Nov. 3 Tr. 101:23-107:7.

69. Bargaining power is measured and applied through merger simulation analysis. Professor Town, with a colleague, designed this method while at the Department of Justice. Town, Nov. 3 Tr. 43:7-25. The analysis has two steps. *First*, determine if a measure for bargaining leverage (willingness to pay) has any relationship to price in the market. Town, Nov. 3 Tr. 74:21-75:14; DDX002 (Town Demonstrative) Slide 36. That relationship measures bargaining power because it assesses whether increased provider leverage enables a provider to obtain higher prices or,

whether a payer can resist higher prices regardless of a provider's leverage. Town, Nov. 3 Tr. 73:21-74:20. *Second*, calculate how much the merger will increase bargaining leverage and then use the relationship calculated in the first step to simulate how much price will increase post transaction. Town, Nov. 3 Tr. 75:18-76:18; DDX002 (Town Demonstrative) Slide 37.

70. In the merger simulation model, if there is a relationship between bargaining leverage and price, then the model will predict a price increase. Town, Nov. 3 Tr. 74:21-75:14, 76:2-11; DDX002 (Town Demonstrative) Slides 37 & 39 (red line). If there is no relationship between bargaining leverage and price, then the model will predict no price increase and the buyer can be described as having "all the bargaining power" or "high bargaining power." Town, Nov. 3 Tr. 76:12-18; DDX002 (Town Demonstrative) Slides 38 & 39 (blue line).

71. This two-step merger simulation process has been widely adopted, including by the FTC and the U.S. Department of Justice Antitrust Division ("DOJ"). Aviv Nevo, when he was the Deputy Assistant Attorney General For Economics at DOJ describes virtually the same process of analysis. DX6144_008-9 (Article by A. Nevo, then Deputy Assistant Attorney General for Economics). The FTC's former chief economist likewise has published articles describing and advocating use of the two-step method of calculating bargaining power and then using that measure to simulate a price effect, if any. *See* DX6050_007-12 (Article by J. Farrell, then-Director of the FTC Bureau of Economics) (explaining the merger simulation model); DX6001_014-15 ¶¶ 28-29 (Town Rebuttal Rpt.) (discussing the literature).

72. Professor Town's merger simulation analysis was relied on by the Court in *ProMedica*, where he served as an expert for the FTC. Town, Nov. 3 Tr. 45:5-20; *FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *24, *54 (N.D. Ohio Mar. 29, 2011).

4. Application Of The Merger Simulation Analysis Shows That [redacted]

73. Following the merger simulation analysis process, Professor Town analyzed detailed statewide claims reimbursement data [redacted] to assess whether there is any relationship between [redacted] reimbursement rates and provider bargaining leverage as measured using one of the measures Dr. Sacher relies on – Willingness to Pay ("WTP"). DDX002 (Town Demonstrative) Slide 29; *see* PX06000_085 (Sacher Rpt.) ¶ 179 ("the change in willingness-to-pay is therefore a proxy for the change in the provider's bargaining leverage relative to that of the insurer"). [redacted]

DDX002 (Town Demonstrative) Slide 29.

74. [redacted]

75. Dr. Sacher also has not presented any empirical analysis that calls Professor Town's analysis into question. Sacher, Oct. 31 Tr. 117:12-15 ("Q. Have you done any empirical analysis regarding the variability in reimbursement rates to physicians in North Dakota [redacted]? A. Does not appear in my report.").

5. High Concentration In The Provider Market [redacted]

76. Professor Town also analyzed [redacted] to evaluate the relationship between reimbursement rates and provider concentration in North Dakota to assess [redacted] changes in provider concentration [redacted] Town, Nov. 3 Tr. 62:2-63:4; DDX002 (Town Demonstrative) Slide 24; DX6000_032 (Town Rpt.) ¶ 69. [redacted]

DX6000_033 (Town Rpt.) ¶ 70.

77. This finding in Minot and Grand Forks is particularly noteworthy because each has a dominant provider with . In Minot, Trinity Health has of primary care, of pediatrics, of OB-GYN, and of general surgery. DX6000_047-48 (Town Rpt.) ¶ 99, Table V.5. In Grand Forks, has of primary care, of pediatrics, of OB/GYN, and of general surgery. *Id.*

78. In addition, the geographic areas of Minot and Grand Forks have characteristics comparable to the geographic market the Government has alleged here. Town, Nov. 3 Tr. 63:7-64:13. The Government does not dispute the similarity of either Minot or Grand Forks to its proposed markets here or the results of Dr. Town's analysis.

79. Minot and Grand Forks thus serve as "natural experiments" that demonstrate [redacted] Town, Nov. 3 Tr. 92:18-98:25 [redacted] DDX002 (Town Demonstrative) Slides 54-60 [redacted]; DX6000_032 (Town Rpt.) ¶ 70 [redacted]

6. Ample Additional Evidence [redacted].

a. [redacted]

80. BCBS-ND is the largest commercial payer in North Dakota by a wide margin. *See* DX6000_017-18 (Town Rpt.) Tables IV.1 & IV.2.

81. If the NDPERS account is treated as a commercial health plan, [redacted] DX6000_017 (Town Rpt.) Table IV.1; DDX002 (Town Demonstrative) Slide 25. NDPERS, however, is not a traditional commercial plan since [redacted] Leclerc, Nov. 2 Tr. 167:17-168:17. In addition, the benefit structure and process for award and oversight of the contract are imposed by political bodies which make it more akin to a

government plan than a private commercial insurance product. Leclerc, Nov. 2 Tr. 167:17-23; DX6005_003-4 (Town Appendix A) ¶¶ 7-8.

82. If NDPERS is excluded, as is more appropriate if the market is limited to commercial plans, [redacted]. DX6000_018 (Town Rpt.) Table IV.2. [redacted] JX00015_039, [redacted] Dep. 151:4-14 [redacted]). Even the Government asserted in its opening brief that [redacted] and only changed its position on this point to support its reply.[2] *See* Gov't Br. [Dkt. 71-2] at 23 n.60 ([redacted]); *see also* Gov't Reply Br. [Dkt. 85-2] at 10 [redacted]).

83. [redacted] DX6000_016-17 (Town Rpt.) ¶ 35 (citing DX6046 [redacted]

84. Sanford and MDC earned [redacted]. DX6000_011-13, Town Rpt. ¶ 21, 26. [redacted] Leclerc, Nov. 2 Tr. 139:5-15 [redacted]; DX6000_11 (Town Rpt.) ¶ 21.

85. [redacted] Leclerc, Nov. 2 Tr. 155:2-16. If Sanford were to terminate [redacted]

[2] It is not necessary to resolve whether NDPERS is classified as commercial or governmental [redacted] Town, Nov. 3 Tr. 67:8-18.

[redacted] Leclerc, Nov. 2 Tr. 155:23-156:6.

86. Consequently, as reflected in the unchallenged testimony of both Sanford and MDC witnesses with ultimate responsibility for payer relationships, [redacted] *Id.*; Lein, Nov. 2 Tr. 104:13-15; Krabbenhoft, Nov. 2 Tr. 31:25-32:22.

87. The revenue Sanford obtains [redacted]. DDX002 (Town Demonstrative) Slide 27.

b. [redacted]

88. [redacted]

89. [redacted]

[redacted]

90. [redacted]

91. [redacted]

92. [redacted]

- [redacted]
- [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

93. [redacted]

94. [redacted]

[3] [redacted]

[redacted]

95. [redacted]

[redacted]

96. [redacted]

97. [redacted] At the same time, the evidence is uncontradicted that Sanford does not believe it would or could ever credibly make such a threat. Krabbenhoft, Nov. 2 Tr. 31:25-32:22; Leclerc, Nov. 2 Tr. 160:17-161:21. [redacted]

98. The testimony of Sanford witnesses is reinforced [redacted]

99. [redacted]

100. [redacted]

101. The Government otherwise has pointed only to [redacted], *see* Section V.B.5; PX07096 ([redacted]); PX04220 (Nov. 15, 2013 Leclerc Email); JX00026_028-29, Leclerc Dep. 110:18-114:15; PX04221 (Nov. 20, 2013 Leclerc Email); JX00026_029-30, Leclerc Dep. 114:16-118:5; PX04222 (June 10, 2015 Leclerc Email); JX00026_033-35, Leclerc Dep. 132:2-137:9; PX04225 (Oct. 6, 2014 Leclerc Email); JX00026_032-35, Leclerc Dep. 125:18-135:1; (b)

documents built on templates used for interactions [redacted], Leclerc, Nov. 2 Tr. 180:15-181:18; PX04081_003 ([redacted]); (c) [redacted], *compare* PX03010_004 (Neuberger Declaration); PX05098 (Dec. 26, 2012 Neuberger email); JX00018_056, Neuberger Dep. 214:10-220:25 [redacted] (d) [redacted] JX00007_062-63, Leclerc IH Tr. 244:8-248:19 (PX04075 reflects erroneous perceptions of a relatively new Sanford participant [redacted] and (e) [redacted]. *Compare* PX04158_002 [redacted] *with* PX04225 (Oct. 6, 2014 Leclerc Email); JX00026_032-35, Leclerc Dep. 128:25-130:3 [redacted]

c. [redacted]

102. As Professor Town's empirical analysis establishes, and as testimony confirms, [redacted] DX6000_028 (Town Rpt.) ¶¶ 62-63 & nn. 100-101; [redacted]

103. [redacted] Town, Nov. 3 Tr. 69:13-71:17. [redacted] Town, Nov. 3 Tr. 71:1-17. [redacted] *Id.*

104. [redacted]

105. The Government argues *See* Section V.B.3-5

106. . Dr. Sacher does not suggest and undertook no analysis Sacher, Nov. 3 Tr. 225:20-22. *See also* Town, Nov. 3 Tr. 160:3-5.

107. Dr. Sacher's primary critique of Professor Town for assessing whether there is a relationship between WTP and reimbursement rates is that such an analysis is not meaningful PX06003_020 (Sacher Rebuttal Rpt.) ¶ 46 Town, Nov. 3 Tr. 122:17-23.

[redacted] *See* Section V(B)(6)(b), *supra*.

C. [redacted]

108. Medica's only analysis of the potential price effects of Sanford's merger with MDC shows that [redacted] DX4004 (Medica, "Sanford Merger with Mid-Dakota Clinic"). [redacted] DX4004 (Medica, "Sanford Merger with Mid-Dakota Clinic"); *see also* Lenz, Oct. 30 Tr. 200:17-24 ("[Y]es, this does look like one way of assessing an impact."). And this assessment does not take into consideration expansion of CHI. Lenz, Oct. 30 Tr. 214:13-17

109. [redacted]

110. The Government attempted to suggest through the testimony of [redacted] that the [redacted] does not protect [redacted] from an exercise of increased provider leverage by Sanford as a result of the merger. [redacted], however, had no "role in negotiating [the] agreement," [redacted] Tr. 191:23-192:2, and has not had any role in provider negotiations for at least five years. [redacted] Tr. 160:8-18; JX00015_006, [redacted] Dep. 19:1-7.

111. Mr. Lenz's assertions also are incorrect. He contends that Sanford could avoid [redacted] because [redacted]

[redacted] and "referral patterns" may change. Lenz, Oct. 30 Tr. 190:5-20. Physician referral patterns, however, cannot be adjusted based on the insurance coverage of individual patients or by the directive of personnel in the finance and reimbursement business unit but, rather are "clinical decisions…made at the bedside" where the focus is the best care. Leclerc, Nov. 2 Tr. 154:6-24. Moreover, as explained by Ms. Leclerc who, [redacted] Leclerc, Nov. 2 Tr. 153:21-154:4. Further, even under Mr. Lenz's formulation, increases in the "charge master"—*i.e.*, the charge that is multiplied by the percentage for certain types of reimbursements—have always been [redacted]. Lenz, Oct. 30 Tr. 194:1-12. If so, any such increase would not be a result of provider leverage and, thus, is not affected by the merger. The same is true of referral patterns.

112. [redacted], it is highly unlikely Sanford could use the number of physicians it has in four practice areas in Bismarck-Mandan [redacted] From [redacted] perspective, only approximately [redacted] are in the Bismarck-Mandan area. [redacted] Tr. 194:24-195:9. [redacted] does not even [redacted] Tr. 203:10-12. Indeed, [redacted] consistently emphasized the relative insignificance of the Bismarck-Mandan area to [redacted] Tr. 203:6-23; *id.* at 208:9-17. Likewise, from Sanford's perspective, the Bismarck-Mandan region accounts for just

[redacted] Leclerc, Nov. 2 Tr. 147:1-11. It therefore is a small part of a much larger negotiation in which both sides make tradeoffs within the context of a fixed budget cutting across the entire multi-state relationship. [redacted] Tr. 205:3-22; Leclerc, Nov. 2 Tr. 149:1-150:8, 150:24-151:3 [redacted]

113. Even assuming Sanford would attempt to increase prices to Medica, Professor Town's merger simulation—consistent with the reality that Medica has less bargaining power than BCBS-ND—simulates a price increase of [redacted] in the alleged product and geographic markets, even assuming no market entry by CHI. DDX002 (Town Demonstrative) Slide 40; Town, Nov. 3 Tr. 77:13-78:4; DX6001_062-64 (Town Rebuttal Rpt.) ¶ 138, Table III.7. When the (likely unduly pessimistic) estimates made by Mr. Schley regarding CHI recruitment in the practice areas at issue are factored into the analysis, the simulated price increase is [redacted] in the alleged product and geographic markets. DDX002 (Town Demonstrative) Slide 41; Town, Nov. 3 Tr. 78:12-25; DX6001_062-64 (Town Rebuttal Rpt.) ¶ 138, Table III.7. And any entry by CHI (or others) beyond Mr. Schley's conservative estimates would reduce this already small figure even further. Town, Nov. 3 Tr. 78:12-25.

114. Either simulated price increase is dwarfed by the efficiencies and synergies that will result from the transaction. *See* Sections VIII & IX. The non-entry simulated price increase for the alleged market, for example, represents [redacted] of the 340B cost savings alone. DDX002 (Town Demonstrative) Slide 44.

D. The Government and Dr. Sacher's Price Increase Analysis Is Flawed.

115. Professor Town and Dr. Sacher agree that bargaining power is a distinct concept from bargaining leverage and that bargaining power is what determines how two parties set a price in the range in which an agreement can occur. *See* Section V.B.2. They disagree on how this step of the analysis should be accounted for in the analysis of this transaction. Professor Town, as discussed above, measures it and uses it to simulate the price effect (if any) of the transaction as he has done in prior analyses when working for the federal government, including the FTC. *See* Section V.B.3-5. By contrast, Dr. Sacher's analysis is fundamentally flawed because the indicia he uses either ignore payer bargaining power entirely or assume it is equal to provider bargaining power. Further, he did not analyze the reimbursement rates actually paid by BCBS-ND to providers in North Dakota or empirically assess whether providers in highly concentrated markets or that have high bargaining leverage are actually able to obtain higher prices from BCBS-ND. *See* Section V.B.2-4.

1. Dr. Sacher Omits Bargaining Power From His Theoretical Framework.

116. Dr. Sacher ignores bargaining power in his theoretical framework for assessing whether a transaction will result in higher prices. His bargaining framework demonstrative titled "Increased Provider Bargaining Leverage Harms Consumers" omits bargaining power entirely from his graphical illustration of how prices may increase. PDX002 (Sacher Demonstrative) Slide 11. In explaining the demonstrative, Dr. Sacher made no mention of any role of bargaining power in assessing if a merger would result in a price increase. Sacher, Oct. 31 Tr. 58:2-14 (testifying that "the provider, as a result of the merger, has increased bargaining leverage. It now has both the incentive and ability to negotiate higher rates"). When asked "where on Slide 11 bargaining power is reflected," Dr. Sacher offered that "[i]t's not relevant to the merger" because it does not change. Sacher, Oct. 31 Tr. 131:14-24. Dr. Sacher thus assumes that any change in

leverage will result in a price increase, without any empirical evidence as to the relationship between provider leverage and BCBS-ND rates in North Dakota and in the face of empirical evidence [redacted] His model is therefore fundamentally unreliable. Town, Nov. 3 Tr. 92:4-94:14.

2. Three Of Dr. Sacher's Calculations Ostensibly Showing Competitive Effects Do Not Account For Bargaining Power.

117. Three of Dr. Sacher's calculations—WTP, HHI, and diversion ratios—do not account for payer bargaining power at all because they measure bargaining leverage only, as evidenced from Dr. Sacher's own reports and testimony.

118. WTP, as discussed above, "is a measure of the reduction in the insurer's walk-away point; it's an increase in the providers' bargaining leverage." Sacher, Oct. 31 Tr. 132:10-12. It therefore does not account for bargaining power.

119. HHI "does not make any assessment of the relative bargaining power of the market participants." Sacher, Oct. 31 Tr. 136:19-23.

120. Diversion ratios (without the additional UPP analysis) are solely a measure of "closeness of competition" between providers obtained by calculating "the substitution pattern of where patients would go absent the option to use one of the providers," Sacher, Oct. 31 Tr. 137:13-17, which means they do not include any measure of payer bargaining power because concentration of the payer market does not impact where patients would go if one provider becomes unavailable. PX06000_86 (Sacher Rpt.) ¶ 186 ("I will use inter-firm diversion ratios to assess the increase in leverage from the proposed transaction.").

121. Additionally, Dr. Sacher performed no analysis to even attempt to assess whether WTP and HHI are at all related to reimbursement rates paid to physicians in North Dakota. Sacher,

Oct. 31 Tr. 135:19-22 ("Q. Did you perform any empirical analysis of the relationship between willingness to pay and physician reimbursement in North Dakota? A. No, I did not."); Sacher, Oct. 31 Tr. 137:9-12 ("Q. Did you perform any empirical analysis of the relationship between HHI measurements and physician reimbursement in North Dakota? A. No, I did not.").

122. Moreover, neither WTP nor HHIs allow a calculation of potential price effects of a merger. Sacher, Oct. 31 Tr. 133:17-20 ("Q. Without more, can you use the willingness-to-pay measure to calculate to what extent, if any, prices will increase as a result of the merger? A. No, I cannot."); Sacher, Oct. 31 Tr. 137:3-8 ("Q. Without more, in other words, can the HHIs standing alone enable you to calculate to what extent, if any, prices will increase as a result of a merger? A. They, again, indicate strong competitive concerns, but more analysis is needed to predict a price increase from a merger.").

123. Dr. Sacher's conclusion that HHI, WTP or diversion ratios show price effects from this transaction depend on his comparison of the calculations of those metrics in this case to those in certain other proposed transactions that the FTC successfully stopped. PDX002 (Sacher Demonstrative) Slides 47, 56. Dr. Sacher never explained how he selected these cases. Nor did he undertake any analysis of whether the markets in those cases were similar to the North Dakota market alleged here. Indeed, he is not aware if any case involved a powerful payer that implemented and maintained statewide pricing as BCBS-ND does in North Dakota. Sacher, Oct. 31 Tr. 134:1-4 (Advocate/NorthShore); *id*. at 134:5-8 (ProMedica-St. Luke's); *id*. at 134:9-12 (OSF Healthcare/Rockford); *id*. at 134:15-18 (Evanston/Highland Park). Dr. Sacher thus again ignores bargaining power even in his comparisons to other cases.

3. Dr. Sacher's UPP Analysis Assigns An Arbitrary Number To Bargaining Power With No Empirical Analysis.

124. Dr. Sacher's only other measure used to assess the price effect of this transaction—and the only one that he even claims takes account of payer bargaining power—is called an upward pricing pressure analysis ("UPP").

125. Dr. Sacher used payer data to calculate diversion ratios and provider accounting data to calculate margins. Sacher, Oct. 31 Tr. 138: 15-21. Dr. Sacher made no effort to calculate bargaining power. He assumed that bargaining power is equal between providers and payers, with a value of ½. *Id*. 138:22-139:10. Dr. Sacher also assumed that all payers in North Dakota have the same bargaining power. *Id*. 140:22-141:12.

126. Assigning a value of ½ to bargaining power assumes, without testing, the answer to the question of whether the transaction will result in a price increase, as evidenced by his formula: "*Change in Price* = ½ * (*Upward Pricing Pressure*)." PDX002 (Sacher Demonstrative) Slide 48; DX6001_24 (Town Rebuttal Rpt.) ¶ 55 ("Making such an assumption without any empirical investigation of the relationship between bargaining leverage and reimbursement rates is far removed from the approach typically employed by economists and regulators.").

127. Upward Pricing Pressure is the product of diversion ratios multiplied by incremental provider margin. PDX002 (Sacher Demonstrative) Slide 48. As discussed, diversion ratios measure provider substitution, which is not affected by payer concentration. Similarly, incremental margins are "just the profit margin" on provider services, Sacher, Oct. 31 Tr. 95:6-11, which Dr. Sacher calculated using Sanford and MDC "accounting data," *id*. 138:18-21. If ½ is changed to zero, then there is no change in price. *Id*. 140:16-21. Thus, by assuming without analysis that it is not zero (here, ½), Dr. Sacher has assumed there will be a price increase. DX6001_024-25 (Town Rebuttal Rpt.) ¶ 54.

128. Dr. Sacher justifies the assumption that bargaining power is ½ by arguing that bargaining power is confined to "bargaining skill," which he defines as "those kinds of things that make you good at negotiating" and which he argues can properly be assumed to be equal between the parties. Sacher, Oct. 31 Tr. 55:12-16; 139:1-10, 140:22-141:12.

129. This definition leaves out various factors, including the impact of payer concentration, imposition of statewide pricing, and the impact of lost revenue outside of the four service areas, even though both experts agree that higher payer market concentration is associated with lower provider reimbursement rates. Town, Nov. 3 Tr. 101:23-104:9; DX6000_041-42 (Town Rpt.) ¶¶ 86-88; PX06003_036 (Sacher Rebuttal Rpt.) ¶ 87.

130. Dr. Sacher asserted in his rebuttal testimony that the impact of payer size is captured in incremental margin in the UPP analysis. Sacher, Nov. 3 Tr. 222:17-223:13. This purported explanation is found nowhere in his reports, including in his discussion of margins. PX6000_91 (Sacher Rpt.) ¶ 194; *see also* PX6000_092-93 (Sacher Rpt.) ¶ 197-98; *id*. 264-68 (Appendix VII & VIII). By failing to offer the explanation in his reports or in his initial testimony, the Government left Professor Town with no opportunity to respond to it.

131. Dr. Sacher also is incorrect in his belated attempt to find some way to assert that his model takes into account payer size. The UPP model is demonstrably unreliable in assessing the impact of payer size on rates because (by its very formula and thus regardless of the realities of the market under analysis) it predicts that the existence of any provider margin, together with any increase in diverted sales, will *always* result in a price increase. PDX002_48 (Sacher Demonstrative) Slide 48. It therefore cannot account for, *inter alia*, BCBS-ND's use of statewide pricing, which was adopted as an offset to provider leverage and which does not set rates according to each individual provider's costs. DDX002 (Town Demonstrative) Slide 31;

Town, Nov. 3 Tr. 69:11-71:17 (explaining that a cost of statewide pricing is paying more than the payer would if it negotiated). Likewise, the prediction that providers' earning of some level of incremental margin automatically reflects susceptibility to a rate increase ignores BCBS-ND's policy of setting rates based on evidence so as to ensure that providers can stay in business, the absence of any evidence that providers have used leverage to influence statewide reimbursement rates, and the absence of any empirical relationship between provider concentration and rates. Given these facts, there is no basis for assuming Sanford's and MDC's abilities to earn incremental margins mean that they will automatically be able to impose post-merger price increases on BCBS-ND as the UPP model assumes. Reliance on this model also is at odds with the standard merger simulation model and economic literature authored by FTC economists and relied upon by Dr. Sacher, both of which state that bargaining power can and should be calculated, not assumed. *See* Section V(B)(3) *supra*; DX6001_025 (Town Rebuttal Rpt.) ¶ 55 (citing DX 6149); Town, Nov. 3 Tr. 103:8-104:9; *see also* at 104:10-106:10 (explaining that it is only appropriate to assume bargaining power of ½ where bargaining power differential is not at issue or where one is trying to estimate different impacts under different scenarios).

132. Additionally, Dr. Sacher himself acknowledges that "bargaining ability" (which as noted, he assumes to be equal between payers and providers) is a separate input in his model. PX06000_094-95 (Sacher Rpt.) ¶ 203; Sacher, Oct. 31 Tr. 96:25-97:12; 138:10-14 ("The UPP model involves three different inputs, which are diversion ratios, profit margins, and bargaining ability."). This further demonstrates that margins do not account for everything that could influence the relationship between increased leverage and price because, if they did, there would be no need to have a separate input for bargaining ability. DX6001_022-23 (Town Rebuttal Rpt.) ¶ 50.

133. As an additional illustration of the inability of the UPP model to take into account real-world realities, Dr. Sacher's UPP analysis includes an estimated price increase for Sanford Health Plan. Sacher, Oct. 31 Tr. 125:21-126:12. [redacted] Leclerc, Nov. 2 Tr. 166:25-167:6; Town, Nov. 3 Tr. 83:13-17. Removing the price increase estimated for Sanford Health Plan from Dr. Sacher's analysis reduces his prediction by 21 percent. DX6001_031 (Town Rebuttal Rpt.) Table III.4.

134. The UPP model also contains numerous other errors and unsupported assumptions identified by Dr. Town in his rebuttal report, including the assumption that Sanford and MDC will bargain separately after the merger DX6001_017-18, 023-24 (Town Rebuttal Rpt.), 23-24 ¶¶ 36, 51-53, the failure to exclude data from government payers from his calculation *id*_027-31 ¶¶ 61-67, the illogical prediction of the model that provider mergers will result in higher reimbursement rates when the payer market is more concentrated, *id*_021-22 ¶¶ 47-49, and the failure to estimate UPP on a statewide basis consistent with how the parties contract, *id*_026-27 ¶¶ 59-60.

VI. The Transaction Will Not Have An Adverse Impact On Quality Competition.

135. The transaction will not have an adverse impact on non-price competition for two interrelated reasons. *First*, the evidence established that quality is primarily driven by a variety of factors unrelated to local competition. *Second*, as discussed in greater detail in section VII, CHI is well-resourced and has the ability, intent and incentive to compete vigorously in the relevant service areas. Thus, even assuming that there is a substantial degree of local competition, there is no reason to believe that having CHI as a competitor instead of MDC will

reduce Sanford's incentive to engage in non-price competition in the relevant service areas. The Government nowhere addresses the second point.

136. As reflected in the testimony of various physicians, including a Government expert and Government declarant, physicians are motivated primarily by the desire to provide the best possible care to patients, not by competition. *See, e.g.*, Jha, Oct. 31 Tr. 286:18-23 ("Q: And is it fair to say that you were motivated to provide high quality care primarily out of professionalism? A: I would say that is the primary motivation that most doctors feel for providing high quality care."); JX00019_010, Olson Dep. 34:5-35:3 (asserting he would do what he "thought the patient needed regardless of whether there was another podiatrist or someone out there that might take that patient away from" him); *see also* JX00025_026, Helbling Dep. 98:16-99:2 ("I think we're always seeking to provide the best high-quality care that we possibly can. Again, it's—to me, it's not a competition. It's we are providing service and we want to give the best service we possibly can. You can't worry about what other people are doing as long as you know you're doing the best you possibly can."); JX00017_070, Matter Dep. 276:14-277:22 (Blue Alliance measures were developed in collaboration with physicians since physicians already want to achieve these quality goals.).

137. To the extent that competition exists between physicians, it does not cease if they are employed by the same organization, but rather exists to the greatest extent between partners. LeBeau, Nov. 2 Tr. 86:25-87:8.

138. The role of local non-price competition is further minimized by Sanford's implementation of quality and service initiatives on a system-wide basis and its setting of standards for "performance expectations in the areas of clinical quality, operational excellence, communication, professionalism, and patient experience" that are "vetted, developed and

implemented across Sanford's [multi-state] footprint." DX2001_013 (Sanford Health Quality Cabinet Report June 2014); DX2002_003 (Sanford Quality Cabinet and Nurse Executive Council 2017 Annual Report); Hocks, Nov. 2 Tr. 194:23-195:3.

139. Sanford is a "physician-driven organization" where physicians play a significant role in setting benchmarks of quality and the standards to which physicians are held throughout the organization. LeBeau, Nov. 2 Tr. 69:25-70:23.

140. Quality initiatives are assigned and implemented at the system level. LeBeau, Nov. 2 Tr. 86:12-24. In particular, the Sanford Quality Cabinet sets performance goals, identifies enterprise strategies, analyzes standardized data to monitor and track the progress of initiatives, and communicates initiatives to improve, *inter alia*, "the patient experience of care" and "the health of the individual as well as the populations" they serve. DX2001_004 (Sanford Health Quality Cabinet Report June 2014); LeBeau, Nov. 2 Tr. 86:15-24; Hocks, Nov. 2 Tr. 194:10-16.

141. The Nurse Executive Council, another enterprise-wide group, addresses "enterprise clinical and care management standardization." DX2002_016 (Sanford Quality Cabinet and Nurse Executive Council 2017 Annual Report).

142. The Enterprise Clinical Practice Committee works "collectively as a health system to develop enterprise guidelines addressing proactive, consistent methods to address patient care." DX6009_020 (Sanford Health's Enterprise Clinical Practice Committee Charter).

143. The Council of Governors approves and endorses all quality initiatives before implementation, meets regularly with the above groups, and includes leaders from each Physician Executive Council, which are physician-driven groups from each local Sanford entity. Hocks, Nov. 2 Tr. 200:20-221:5; LeBeau, Nov. 2 Tr. 69:5-18.

144. In setting these standards and developing these initiatives, Sanford benchmarks itself as a system against top academic medical centers or other top community hospitals, not local competition. DX2003_0027 (Appendix Sanford Quality Report Executive Leadership Meeting, May 17, 2017); LeBeau, Nov. 2 Tr. 86:15-24; Hocks, Nov. 2 Tr. 204:8-205:8.

145. The protocols, standards, and quality initiatives are quite specific and are as varied as the rollout of new technologies such as 3D mammography throughout the Sanford footprint, to uniform policies on breast cancer-screening, Sanford's team-based care initiative, ensuring same-day access to clinics, integrating behavioral health therapists, and posting wait-times at walk-in clinics to enable consumers to know where they can obtain care most quickly across Sanford providers. Hocks, Nov. 2 Tr. 195:4-196:5, 202:13-204:1; DX6000_080-81, 83 (Town Rpt.) ¶¶ 167-68, 172.

146. Another example is Sanford's Vaccine Champion Initiative, which identifies key nurses in all clinics to become educated experts in immunization schedules, and then to work with clinicians to ensure patients receive vaccinations and also to help patients and families understand why the vaccine is recommended. Hocks, Nov. 2 Tr. 196:6-197:14.

147. Sanford also implements standardized processes to ensure assessment in less than 30 minutes in Sanford Emergency Departments and convenient clinic scheduling for patients. DX2002_004 (Sanford Quality Cabinet and Nurse Executive Council 2017 Annual Report and Strategic Plan).

148. The Council of Governors also sets target scores for various quality standards at the system level, including for diabetes, vascular, hypertension, and mammography screenings; Sanford then has a system-wide "Quality Accountability Structure for Low Performers" program to assist physicians in meeting these enterprise-wide initiatives. DX6010_009 (Minutes from

Council of Governors Meeting, August 6, 2015); DX6011_002 (Quality Performance and Upcoming Strategies).

149. Once developed, such standards are rolled out on an enterprise-wide basis. Hocks, Nov. 2 Tr. 199:14-201:5.

150. Sanford's approach is further reinforced by additional incentives that are unrelated to local competition from MDC, including statewide and national programs initiated by payers that link financial incentives to the quality of care. [redacted] DX6000_093 (Town Rpt.) ¶ 185.

151. The Government argues that the transaction could reduce competitive incentives to adopt new technologies. This argument fails for two reasons. *First*, the evidence established that local, head-to-head competition has not played a significant role in Sanford's decision to adopt new technologies. *Second*, even assuming it did, CHI is extremely well-resourced, and there is no reason to believe that Sanford would not respond to competitive pressure in the relevant service areas because CHI was its competitor rather than MDC.

152. The two examples identified by the Government (3D mammography and tower-free hysteroscopy) are illustrative. While certain documents mention competition with MDC as a reason to acquire 3D mammography, 3D mammography was adopted across the Sanford system

in a sequence that did not correspond to the significance of local competition. DX6000_077, 81-82 (Town Rpt.) ¶¶ 159, 167-169; DX2004_012 (Mammography Units Spreadsheet, Equipment Tab) ([redacted]).

153. Similarly, the tower-free hysteroscopy system—allowing certain gynecological procedures to be performed in an office setting rather than at the hospital—was a [redacted] DX2005_002 (Summary of FY15 Capital Commitments); DX2006_001 (Capital Request Form); DX6012_001 (Sanford Bismarck Medical Staff Meeting Women's Health Minutes). [redacted] DX2006_001 (Capital Request Form). [redacted] DX6000_082 (Town Rpt.) ¶ 170.

154. Further, even assuming that local competition with MDC plays a meaningful role in the adoption of technology, there is no reason to believe that Sanford would adopt such technology (or analogous future technologies) to care for its patients with MDC as a competitor but would refrain from doing so with CHI as a competitor. If anything, given its significant comparative resource advantage and the long-term challenges MDC confronts, CHI will be in a better position in the future to adopt new innovations than MDC.

155. In addition, specifically with respect to general surgery, the two primary ways that patients find general surgeons is a referral by a primary care provider or in the emergency room. JX00016_085-86, Schley Dep. 85:1-86:1. Thus, the transaction will not meaningfully change

the way that patients find or choose general surgeons because MDC primary care providers can still refer to MDC general surgeons, Sanford primary care providers can continue to refer to Sanford general surgeons, and patients can still choose the hospital they prefer. *See* JX00011_033, 55, Seifert IH Tr. 128:1-11, 213:1-14, 214:16-215:4; DX3002_003 (MDC Staff Physician Agreement); JX00014_049, Bury IH Tr. 190:20-191:14.

156. At the hearing, Dr. Sacher asserted that (1) he was not offering an opinion that quality would decline and (2) was instead only asserting that the "extra incentive" to "perform at your best, to get the latest technology, to expand convenience and access" would be lost by the transaction. Sacher, Oct. 31 Tr. 106:3-14. He offered no basis for asserting that this extra incentive was a meaningful driver of quality prior to the transaction. The only example he discussed at the hearing was 3D mammography, referring to documents where Sanford physicians expressed concern that MDC would acquire the technology first. Sacher, Oct. 31 Tr. 248:2-14. Dr. Sacher ignores the documents reflecting the system-wide approach that those who actually make the decisions at Sanford took in acquiring the technology. DX6000_77 (Town Rpt.) ¶ 159 (collecting sources, including DX6103_002 and DX6104).

157. Dr. Sacher also made no attempt to explain why the asserted "extra incentive" to compete on quality would be lost with CHI competing in all of the relevant service areas. Nor has the Government at any stage of this proceeding attempted to explain why Sanford's incentives to compete on quality would be meaningfully altered with CHI as a competitor given its demonstrated intent, incentives, and resources as discussed below.

158. The Government called Ms. Reichert from NISC, who admitted that she is not an expert on mergers and provided no information as to the transaction's competitive effects. Reichert, Oct. 31 Tr. 180:25-181:3. Indeed, because of her lack of expertise, she reached out to a contact

at UnitedHealthcare, who she believed to be a good source of information on the topic. Reichert, Oct. 31 Tr. 181:4-11. [redacted] Reichert, Oct. 31 Tr. 180:14-24; DX4190_001 (July 13, 2017 Jeanne Van Fleet Email). That non-answer is consistent with UnitedHealthcare's refusal to take a position on this transaction: [redacted] PX03015_002 (Link Decl.) ¶ 8. In addition, any testimony offered by Ms. Reichert should be weighed in light of the facts that (a) her boss at NISC, Vernon Dosch, is a St. Alexius director,[4] and (b) NISC is a corporate sponsor of St Alexius events.[5] In other words, the only employer witness the Government presented works for an organization that is closely tethered to CHI, the entity that has strongly opposed, while itself catalyzing, the Sanford/MDC transaction.

159. Professor Town also conducted empirical analysis that demonstrated more broadly a lack of relationship with physician concentration and quality. Using available data, Dr. Town examined whether there was a relationship between provider concentration and quality of care in North Dakota using quality metrics adopted by BCBS-ND in its Blue Alliance program and/or by Sanford's Enterprise Quality Initiatives and that could be measured using the data available in this case—specifically, Breast Cancer Screening, Comprehensive Adult Diabetes Care, Eye

[4] *See* http://990finder.foundationcenter.org/990results.aspx?action=Find&fn=&st=&ei=450226711 (identifying St. Alexius directors); https://www.nisc.coop/about/executive-team/ (identifying NISC leadership).

[5] *See* https://www.st.alexius.org/foundation/stars; https://www.st.alexius.org/foundation/sakt.

Exam, Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, and Colorectal Cancer Screening. DX6000_086-87 (Town Rpt.) ¶¶ 177-80. That analysis found no relationship between provider concentration and quality of care in these important areas. DX6000_086-87 (Town Rpt.) ¶¶ 178-81.

160. The Government has not disputed the importance of the measures of care addressed in Professor Town's regression analysis. Dr. Jha argues that Professor Town could have examined other factors as well, *see* DX6007_004-6 (Jha Reb. Rpt.) ¶¶ 7-9, Jha, Nov. 3 Tr. 240:20-241:23, but notably neither Dr. Jha nor the Government's economist, Dr. Sacher, conducted any regression analysis – or any empirical analysis at all – on the relationship between provider concentration and quality in North Dakota.

161. Dr. Sacher argued in his rebuttal report (but not at the hearing) that Professor Town himself has criticized this type of analysis. PX06003_52 (Sacher Reb. Rpt.) ¶ 130 n.182. As Professor Town explained at his deposition, however, that is not correct. JX00034_081, Town Dep. 318:12-319:22. Dr. Sacher notably did not repeat the criticism at the hearing.

162. As further explained by Professor Town, these results are consistent with academic literature finding an intrinsic desire to provide high quality care was four times more important to quality performance than financial motivation. *See* DX6000_091 (Town Rpt.) ¶¶ 181-82.

VII. CHI Has The Incentive, Ability, And Intent To Compete Vigorously In The Relevant Service Areas In A Timely Manner If The Merger Is Approved.

163. CHI will be highly motivated post-merger to add clinicians in all of the relevant services at issue. [redacted]. Schley, Oct. 30 Tr. 124:11-22; JX00016_032-33, 158, Schley Dep. 32:2-33:1, 158:8-21. [redacted]

[redacted] Schley, Oct. 30 Tr. 124:23-125:5; JX00016_036-37, Schley Dep. 36:20-37:6. [redacted] JX00016_041-42, Schley Dep. 41:5-42:8.

164. [redacted] JX00016_040-42, 43, Schley Dep. 40:25-42:18; 43:15-21; JX00027_006, 7, 16-17, 29-30, Kyaw Dep. 20:4-21:5, 22:22-23:3, 61:18-63:5, 112:13-114:5; Schley, Oct. 30 Tr. 139:5-8; DX4005_002 (Oct. 4, 2016 Chris Jones (CHI) Email, subject "Sanford MDC Situation").

165. [redacted] Schley, Oct. 30 Tr. 108:2-109:8 [redacted]; PX03009_012 (Schley Decl.) ¶ 48 [redacted]; PX03009_012 (Schley Decl.) ¶ 46; Schley, Oct. 30 Tr. 148:7-151:1 [redacted]; Schley, Oct. 30, Tr. 151:2-6; JX00016_087-88, Schley Dep. 87:16-88:2 [redacted].

166. [redacted], but there was no testimony from any payer that a physician group would have to have the same reputation as MDC to constitute a credible and marketable alternative. Schley, Oct. 30 Tr. 108:12-24. And, of course, St. Alexius already has a strong reputation in this community. Schley, Oct. 30 Tr. 77:5-12, 80:25-81:8; JX00030_017, S. McDonough Dep. 63:10-64:2.

167. There also are a number of reasons to believe that CHI's estimates are, if anything, and for obvious reasons, unduly pessimistic. In addition to its incentives to take positions that it

believes may block the transaction and its incentives to recruit if the transaction is consummated, CHI has ample resources and ability to recruit physicians to compete in these areas post-transaction. In the most recent fiscal year, CHI earned $15.5 billion in annual revenue and had $22.6 billion in assets, with a 16.4% improvement ($114.5 million) in EBIDA (Earnings Before Interest, Depreciation, and Amortization) over the prior fiscal year. DX4164_003, 4, 21 (CHI Financial Report). It is significantly larger than Sanford. Krabbenhoft, Nov. 2 Tr. 30:11-22.

168. CHI is the fourth largest non-profit hospital system in the country by revenue and is in merger talks with Dignity Health, the fifth largest such system. *See* Laura Dyrda, 10 Largest US Health Systems: Which Had The Biggest Revenue Increase In 2016?, Becker's Hospital Review (March 03, 2017), available at https://www.beckershospitalreview.com/hospital-finance/10-largest-us-health-systems-which-had-the-biggest-revenue-increase-in-2016.html (detailing the 2016 revenues of the ten largest health systems in the United States).

169. CHI also has a well-established brand locally and loyal patient following, both because of its religious affiliation and for other reasons. JX00016_039, Schley Dep. 39:9-12; JX00030_017, S. McDonough Dep. 63:10-64:2; JX00014_049, Bury IH Tr. 190:13-19; Bury, Oct. 31 Tr. 22:5-13.

170. CHI's ability to enter and recruit physicians in the relevant service areas is further demonstrated by the steps it already has taken to establish practices and the built-in advantages it had in doing so even in what its CEO has referred to as a passive recruiting mode. As a result of the announcement of the transaction, [redacted] JX00016_040-42, 43, Schley Dep. 40:25-42:18; 43:15-

21; JX00027_006, 7, 16-17, 29-30, Kyaw Dep. 20:4-21:5, 22:22-23:3, 61:18-63:5, 112:13-114:5; Schley, Oct. 30 Tr. 139:5-8; *compare also* DX4006_001 (CHI Fargo Division Open Positions Report 20160809) (recruiting report immediately prior to CHI learning about the transaction [redacted]) *with* DX4007_001 (CHI Fargo Division Open Positions Report 20161108) (recruiting report after CHI learned about the transaction [redacted]. [redacted] Schley, Oct. 30 Tr. 139:14-19; JX00016_043-46, 50, Schley Dep. 43:15-46:9, 50:16-24; JX00027_032, Kyaw Dep. 123:4-125:20.

171. In the area of adult primary care, and even without new entry, non-Sanford and non-MDC providers make up 23% of adult PCPs in the Bismarck-Mandan area. Compl. ¶ 38.

172. CHI already has a fully staffed family medicine clinic in Mandan in which three physicians have at least [redacted]. Schley, Oct. 30 Tr. 139:20-140:10; JX00016_055, Schley Dep. 55:1-18; JX00027_034, Kyaw Dep. 131:9-132:20; DX4010_001 (FY17 Mandan Clinic Visits); Compl. ¶ 38.

173. CHI recruited these doctors from the [redacted] Schley, Oct. 30 Tr. 139:24-140:5.

174. [redacted] Schley, Oct. 30 Tr. 141:12-20; *see also* DX8002_002 (D. McDonough Decl.) ¶ 4 (declarant's practice employs three family medicine physicians and one NP who "all provide primary care services for male and female patients of all ages").

175. If the transaction is completed, in Bismarck, CHI will have a primary care presence and [redacted] Schley, Oct. 30 Tr. 142:6-23; JX00016_063-64, Schley Dep. 63:23-64:12; JX00027_018-19, Kyaw Dep. 69:15-71:21.

176. CHI also is evaluating [redacted] Schley, Oct. 30 Tr. 113:3-12, 143:13-16; JX00016_064-65, 66-67, Schley Dep. 64:23-65:10, 66:12-67:1; JX00027_034, Kyaw Dep. 130:3-23.

177. CHI also is [redacted] Schley, Oct. 30 Tr. 112:20-113:2; JX00016_073-75, Schley Dep. 73:12-75:13; JX00024_061, Lein Dep. 238:9-16.

178. CHI is [redacted] Schley, Oct. 30 Tr. 142:24-143:6; JX00016_063-64, Schley Dep. 63:23-64:12.

179. CHI's CEO estimates [redacted] Schley, Oct. 30 Tr. 108:2-109:8.

180. CHI [redacted] Schley, Oct. 30 Tr. 143:7-12; JX00027_018-19, 58-59, Kyaw Dep. 69:15-71:13, 229:22-230:6.

181. Nurse practitioners in North Dakota may practice without supervision. Schley, Oct. 30 Tr. 142:2-5; JX00016_058, Schley Dep. 58:7-10.

182. [redacted] JX00016_057-58, Schley Dep. 57:10-58:21; Schley, Oct. 30 Tr. 110:17-22.

183. The Government offered testimony that nurse practitioners were not complete substitutes for adult primary care physicians and that payers cannot construct a marketable network consisting solely of NPs and no physicians. Schley, Oct. 30 Tr. 84:5-85:25. CHI, however, is not proposing to do that. Instead, as the foregoing testimony reflects, it is seeking to construct a network consisting of practices that contain both physicians and NPs.

184. The Government also offered testimony that CHI "at this point in time" is not a substitute for MDC. Matter, Oct. 30 Tr. 243:18-244:5, 269:6-9. This testimony did not address whether CHI would be a substitute in the near term in light of its expansion plans, and there is no reason to believe that CHI would not be a credible alternative under those circumstances.

185. Nor did the Government's witnesses address the ability to construct a network with an expanded CHI and the other independent PCP providers in the community, including the North Dakota Center for Family Medicine, which has 4-6 primary care physicians in addition to numerous residents practicing there, and smaller practices including Independent Doctors, P.C., Baker Family Medicine, the Glen Ullin Family Clinic, and Jeffrey Smith, M.D. Schley, Oct. 30 Tr. 152:7-25; Matter, Oct. 30 Tr. 241:7-15; Compl. ¶ 38.

186. CHI similarly intends and is well-positioned to recruit a sufficient number of OB/GYNs in a timely fashion to provide credible competition post-merger. [redacted] Schley, Oct. 30 Tr. 143:20-23; JX00016_090, Schley Dep. 90:4-14; JX00014_036-37, Bury IH Tr. 139:7-141:6.

187. [redacted] Schley, Oct. 30 Tr. 144:6-9; JX00016_090, Schley Dep. 90:4-14; JX00014_036-37, Bury IH Tr. 139:7-141:6; JX00027_057, Kyaw Dep. 224:2-4 [redacted]; *see also* JX00016_090, Schley Dep. 90:4-16 [redacted]

[redacted]; DX7004_021, S. McDonough Dep. 79:19-80:3.

188. [redacted] can take on "[a]s many" patients "as want to come." [redacted] expects the majority of her patients to follow her to CHI. [redacted] presence at CHI will "absolutely" make it "much easier" for CHI "to recruit OB-GYNs to come to join her" there. JX00027_057, Kyaw Dep. 224:5-9.

189. [redacted] Schley, Oct. 30 Tr. 144:10-145:2; JX00016_091, Schley Dep. 91:5-12; [redacted] JX00027_031, Kyaw Dep. 120:13-22.

190. [redacted] JX00027_033, 54, 31-32, Kyaw Dep. 126:4-23, 212:7-25; 121:21-122:18 (describing candidate who wanted to interview but could not because of government-induced uncertainty); [redacted]; Schley, Oct. 30 Tr. 145:3-21.

191. CHI also has ample physical space to host an OB/GYN practice. The new practice would perform procedures in the CHI OR, and has clinic space that is larger than the space she is in now as well as a whole wing to absorb new recruits. [redacted] Tr. 139:11-140:12, 141:17-25, 142:2-6.

192. For at least 2-3 years, CHI's new OB/GYN recruits also will be able to share call volume with [redacted] the MDC OB/GYN practice because Sanford lacks sufficient capacity to absorb the MDC volume. JX00014_035-36, 48, Bury IH Dep. 136:4-137:22, 185:11-186:15; JX00011_054, Seifert IH Tr. 209:21-210:18; JX00016_017-18, Schley Dep. 17:20-

18:16; Lein, Nov. 2 Tr. 89:15-90:4; Seifert, Nov. 3 Tr. 184:13-185:3; DX4055_002 (Feb. 7, 2017 Kurt Schley (CHI) Email, "MDC Transition of Services").

193. [redacted] PX03021_003 (S. McDonough Decl.) ¶ 5 ("In my experience, patients who deliver their babies with a physician practice are more likely to seek additional health care services from that same physician practice.").

194. [redacted] Schley, Oct. 30 Tr. 146:18-148:6. [redacted] Bury, Oct. 31 Tr. 23:17-24:7, 39:4-10, 40:24-41:2.

195. [redacted] PX03009_012 (Schley Decl.) ¶ 46; Schley, Oct. 30 Tr. 148:7-151:1.

196. [redacted] PX03009_002 (Schley Decl.) ¶ 5; *see also* DX8002_002 (D. McDonough Decl.) ¶ 4 (declarant's practice employs three family medicine physicians and one NP who "all provide primary care services for

male and female patients of all ages"); JX00011_006, 34, Seifert IH Tr. 17:3-6, 130:12-23; JX00030_012-13, S. McDonough Dep. 45:22-47:17.

197. Recruitment of general surgeons [redacted] JX00011_054, Seifert IH Tr. 209:11-20; JX00025_037, Helbling Dep. 143:8-144:5; JX00014_035-36, 48, Bury IH Tr. 136:4-137:22, 185:11-186:15; DX4055_002 (Feb. 7, 2017 Kurt Schley (CHI) Email, "MDC Transition of Services"); Lein, Nov. 2 Tr. 89:15-90:4; JX00016_016-17, Schley Dep. 16:22-17:19.

198. [redacted] *Contrast* Schley, Oct. 30 Tr. 97:15-98:13 *with* Lein, Nov. 2 Tr. 96:21-102:6. Regardless of the content of the conversation, however, the evidence showed that there is insufficient space at Sanford for MDC OB/GYNs currently, that the glide path is a function of mutual self-interest, and that the OB/GYN and general surgery groups at MDC thus intend to continue to practice at CHI until Sanford constructs new facilities. JX00014_035-36, 48, Bury IH Tr. 136:4-137:22, 185:11-186:15; JX00011_054, Seifert IH Tr. 209:21-210:18; JX00016_017-18, Schley Dep. 17:20-18:16; Lein, Nov. 2 Tr. 90:13-91:22, 103:1-20; Seifert, Nov. 3 Tr. 184:13-185:3.

199. [redacted]

[redacted]

200. CHI also can recruit locum tenens surgeons in the interim to make up for any shortfall. JX00016_087-88, Schley Dep. 87:16-88:2; *see also* JX00028_052, Krabbenhoft Dep. 204:12-19.

201. CHI's ability to recruit is further demonstrated by the success that Sanford has had in recruiting to the Bismarck-Mandan area, as well as in smaller North Dakota communities where recruiting challenges are greater. CHI is far larger than Sanford by various metrics and, like Sanford, CHI is an integrated health-care system with a strong reputation in the community. *See* Krabbenhoft, Nov. 2 Tr. 19:24-20:3, 30:11-31:2 (noting that Sanford recruits about 150 physicians per year and is about a quarter of the size of CHI whereas CHI recruited over 600 physicians last year on top of the ability to recruit in locum tenens physicians).

202. Since the Medcenter One acquisition, Sanford has been able to recruit an average of 24 physicians per year to Bismarck, an over 28% increase in physicians being recruited to the community. Krabbenhoft Nov. 2 Tr. 19:6-20:3; DX2011_048 (Sanford's Response to the FTC's CID; Annual Growth Chart). Further, Sanford's ordinary course projections anticipate recruiting 136 physicians over the next five years in Bismarck. DX2063_061 (FY18-22 CLT Forecast Review, May 22, 2017). Sanford has had similar success in communities such as Minot and Dickinson. DX6000_068-69 (Town Rpt.) ¶¶ 137-38. Sanford's experience further explains and supports the confidence of Sanford CEO Kelby Krabbenhoft that CHI could readily replicate its success. *See* JX00028_035, Krabbenhoft Dep. 134:1-6 (stating that the "ability of someone of the size, scope and reach of CHI to replicate anything they need in primary care is among the easier tasks that I, as a CEO, know exists in healthcare today.").

VIII. Efficiencies

203. Sanford counsel retained Deloitte Consulting ("Deloitte") to quantify certain financial efficiencies anticipated from the Sanford/MDC transaction and, potentially, for Deloitte's team leader to testify as a fact witness. Ahern, Nov. 3 Tr. 6:8-18; 7:17-8:11. The Deloitte team was led by Ms. Lisa Ahern, an experienced professional who has performed similar analyses numerous times in connection with mergers and acquisitions in the healthcare industry. Ahern, Nov. 3 Tr. 7:8-16.

204. The starting point for the Deloitte analysis was the summary of merger-specific synergies identified through a collaborative process between Sanford and MDC clinical and administrative personnel, which culminated in the *Stronger Together: Synergy* document. DX2061_001 (identifying synergies for Sanford and MDC merger).[6] From that document, Deloitte worked with the parties to identify certain synergies that could be analyzed and quantified. That, in turn, led to Deloitte's creation of an *Efficiency Summary* which presented the results of its work on this engagement. DX4018_001 (Deloitte Efficiency Analysis).[7]

205. The overall process that Deloitte undertook is described in the *Efficiency Summary*, and was explained in Ms. Ahern's testimony. DX4018_002-3 (Deloitte Efficiency Analysis); Ahern, Nov. 3 Tr. 10:5-13:12. In brief, Deloitte identified eleven distinct service lines and

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[6] Dr. Jha tried to downplay the significance of *Stronger Together: Synergy* through pejorative commentary on its length and depth. Jha, Oct. 31 Tr. 243:1-10. Dr. Jha, however, ignores that there are limitations on the degree to which merging parties can share competitively sensitive information before a transaction is consummated. Hocks, Nov. 2 Tr. 240:22-241:3. Indeed, that is the reason why a third party like Deloitte—who lawfully can access information from both sides—is needed to quantify efficiencies or cost savings. Hocks, Nov. 2 Tr. 241:4-11. Moreover, Dr. Jha also overlooked the dozens of meetings and discussions that led to *Stronger Together: Synergy*. Hocks, Nov. 2 Tr. 217:1-219:5.

[7] A shorter version of the *Efficiency Summary*—which redacted out MDC-specific information Ahern, Nov. 3 Tr. 9:16-21—also was prepared for the Sanford Board of Trustees in connection with its review, and ultimately approval, of the transaction. *See* DX4017 (Summary Efficiency Report); DX2012_021, 37, (March 2017 Board Meeting Materials) (containing the *Stronger Together: Synergy* Book at _021 and shorter version of the *Efficiency Summary* at _037); JX00028_016, Krabbenhoft Dep. 57:22-24; JX00008_006, Hocks IH Tr. 19:17-20:4.

departments—grouped in clinical, ancillary and non-clinical categories—from which efficiencies, net of offsetting costs, are anticipated. "Many of the identified efficiencies come from the adoption of common platforms, accessing centralized corporate services, and elimination of unnecessarily duplicated costs between the two organizations." DX4018_002 (Deloitte Efficiency Analysis). Deloitte took a "conservative" approach in performing this exercise, Ahern, Nov 3 Tr. 23:10-17, 24:3-12, 35:5-12, making sure that any one-time and recurring costs were netted out against cost savings in order to produce an accurate assessment. Ahern, Nov. 3 Tr. 22:18-24:2, 28:4-18.[8]

206. The Deloitte team, over a period of months, had multiple conversations with representatives of both Sanford and MDC with requisite subject-matter expertise, obtained extensive documents and data from both parties, conducted site visits in Bismarck, and engaged in a variety of follow up discussions to verify information and obtain clarification as needed. DX4018_003 (Information Collected for Efficiency Report); Ahern, Nov. 3 Tr. 12:7-13:12.

207. The results of that process calculated [redacted] DX4018_004 (Efficiencies Overview from Efficiencies Report).

208. Those calculations are for the first three years after the transaction is consummated; Ms. Ahern expects annual recurring efficiencies (net of costs) of [redacted] to continue beyond that. Ahern, Nov. 3 Tr. 18:16-23. Thus, had Deloitte extended its calculation through year five post-closing, there would be an additional [redacted] in efficiencies. Ahern, Nov. 3 Tr. 18:24-19:1. Further, Deloitte's calculations did not include estimated incremental net revenue

[8] Ms. Ahern and Dr. Respess, the Government's efficiency expert, agree that it is appropriate to net expenses against savings when considering the efficiencies a merger may generate. Ahern, Nov. 3 Tr. 15:16-16:2; Respess, Oct. 31 Tr. 231:13-23.

anticipated from various service line expansions discussed in *Stronger Together: Synergy*. DX4018_036 (Deloitte Efficiency Analysis). Each of these facts underscores the conservative methodology Ms. Ahern described.

209. The efficiencies Deloitte calculated over the initial three-year period amount to [redacted], which is the appropriate reference point given the large portion of savings that are expected from MDC becoming part of Sanford and, thereby, gaining access to cost savings that are otherwise unavailable to it. DX4018_005 (Deloitte Efficiency Analysis); Ahern, Nov. 3 Tr. 16:16-17:7.

210. Approximately [redacted] of net savings per year (beginning in Year 3) on an annual basis is obtained by enabling MDC to take advantage of discounts under the 340B program, which allows qualifying facilities to purchase certain drugs at lower prices. DX4018_005, 9 (Deloitte Efficiency Analysis); Ahern, Nov. 3 Tr. 20:24-25:2. The savings actually begin in the middle of Year 2, after costs are incurred [redacted] DX4018_009 (Deloitte Efficiency Analysis); Ahern, Nov. 3 Tr. 22:18-23:17, 25:24-26:8.

211. The 340B program was created in 1992 by federal law to help hospitals that treat a higher percentage of low-income and Medicaid patients address the high cost of many prescription medications. Leclerc, Nov. 2 Tr. 126:11-127:2.

212. Under the program, drug manufacturers must sell certain medications to certain qualifying providers at significantly reduced prices. Leclerc, Nov. 2 Tr. 126:21-127:2.

213. Sanford Bismarck Medical Center qualifies for this program as a disproportionate share hospital ("DSH"). Leclerc, Nov. 2 Tr. 128:3-9; Respess, Oct. 31 Tr. 197:21-24.

214. MDC does not currently qualify for the 340B drug price discount, nor can it. JX00013_016, Ahern IH Tr. 57:20-58:3; Respess, Oct. 31 Tr. 197:25-198:6.

215. The formula for qualifying as a DSH hospital is: (the percentage of Medicare SSI hospital days / number of Medicare inpatient days) + (number of Medicaid inpatient days / total inpatient days), multiplied by an adjustment factor in certain circumstances. *See* Medicare Disproportionate Share Hospital 2, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf; *see also* Leclerc, Nov. 2 Tr. 128:10-25.

216. The DSH percentage required to qualify for participation in the 340B program as a DSH hospital is 11.75%. Leclerc, Nov. 2 Tr. 128:10-25. Sanford's FY 2016 percentage was [redacted] its FY 2015 percentage was [redacted], and its FY 2014 percentage was [redacted]. PX04280_010 (Sanford's Responses and Objections to the FTC's Second Set of Interrogatories); Leclerc, Nov. 2 Tr. 129:12-18. It increased its percentage significantly from 2014 to 2015 using various systems that allowed Sanford to ensure it is identifying all Medicaid and Medicare SSI patients. Leclerc, Nov. 2 Tr. 129:19-131:22.

217. The Government has argued, without any empirical analysis or support, that the composition of MDC referrals to Sanford post-merger could deprive Sanford Bismarck Medical Center of its 340B status. Ms. Leclerc explained, both at deposition and at the hearing, however, that there is no realistic scenario under which that could occur. JX00026_043, Leclerc Dep. 166:12-23 (explaining that the composition of the referred patient population "would have to be substantially different, very substantially different," for the MDC transaction "to even have an impact, and I can't imagine a situation where there would be enough volume to create an issue with meeting the benchmark"); Leclerc, Nov. 2 Tr. 131:23-132:9. One of Ms. Leclerc's

responsibilities is to ensure that Sanford obtains the benefits of the government programs for which it qualifies and to maintain that qualification. Leclerc, Nov. 2 Tr. 127:18-128:2. Her testimony demonstrated her strong knowledge of and responsibility for Sanford's participation in the 340B program. Leclerc, Nov. 2 Tr. 126:11-138:10. In this capacity, she explained that if there were a "remote possibility" that Sanford Bismarck would lose its DSH qualification, she would have raised the issue with Sanford executives. Leclerc, Nov. 2 Tr. 137:4-11.

218. Ms. Leclerc also performed a calculation using publicly available data to assess how much additional inpatient volume would need to come to Sanford as a result of the transaction before Sanford would be at risk of losing DSH status and found that it would take [redacted] Leclerc, Nov. 2 Tr. 133:15-137:3.

219. This calculation confirmed in two ways Ms. Leclerc's previously stated assessment that there is no realistic possibility that MDC referrals could alter Sanford's DSH status. *First*, even assuming such an influx were otherwise realistic, [redacted] Ms. Leclerc explained, for example, that Sanford's medical and surgical inpatient capacity currently runs at about [redacted] Leclerc, Nov. 2 Tr. 135:23-136:15. *Second*, the calculation itself did not just assume that MDC's referral population would have a lower percentage of Medicaid and Medicare SSI recipients than Sanford – instead, it unrealistically assumed an added patient population in which not a single one of the MDC inpatient referrals would be a recipient of Medicaid or Medicare SSI benefits. Leclerc, Nov. 2 Tr. 136:10-137:3.

220. Because this calculation was performed with publicly available data, the Government could have done the exact same calculation at any point in this proceeding. The Government

either chose not to do the calculation or chose not to present its own results. It neither disputed the validity of Ms. Leclerc's calculation, nor any of the reasons she provided independent of that calculation, to explain why a scenario in which Sanford lost its DSH qualification was completely implausible. The Government also did not request Ms. Leclerc's calculation, Leclerc, Nov. 2 Tr. 188:12-18, or offer any basis for disputing (wholly apart from the calculation) Ms. Leclerc's understanding that there was no realistic prospect that Sanford could lose its DSH status as a result of the merger. Further, when given the opportunity to call in rebuttal the one expert it had retained to opine on the 340B cost savings (Dr. Respess), it chose not to call him. This was noteworthy given that Dr. Respess remained in the courtroom through the end of the hearing and had specifically testified earlier in the hearing that a "sensitivity analysis" of just this sort would be appropriate to substantiate Ms. Leclerc's prior testimony. Respess, Oct. 31 Tr. 201:11-23.

221. Instead, the Government offered only Dr. Jha, whose scope of opinions and reports did not address 340B at all and who did not claim to have or identify any special expertise or knowledge regarding this very specific government program. Dr. Jha testified only that commercial days were a small part of the 340B DSH formula. Jha, Nov. 3 Tr. 235:12-17. This testimony ignored the point of Ms. Leclerc's calculation. Ms. Leclerc looked at the addition of "commercial days" (which would conservatively increase only the denominator in the equation) but not the addition of any Medicare SSI and Medicaid days (which would increase both the numerator and denominator). Leclerc, Nov. 2 Tr. 135:8-14. In other words, she looked at what it would take, in the most extreme and factually implausible scenario, to cause Sanford's DSH percentage to drop by one-fifth. As such, Ms. Leclerc's calculation simply demonstrated mathematically what her unchallenged expertise and experience with the 340B program and

North Dakota patient populations already made clear – that even if one adds thousands of days to the denominator of the Sanford 340B calculation but adds not even a single day to the numerator, the influx of referrals required to tip the balance to lose 340B qualification would exceed Sanford's capacity constraints. Dr. Jha thus offered nothing to counter Ms. Leclerc's testimony—rooted in both strong knowledge and experience with the program and Sanford's qualifications for it, as well as her unchallenged calculation performed with publicly available data—that Sanford would continue to qualify for 340B discounts post-merger.

222. The Government also pointed to a new rule issued by the Centers for Medicare and Medicaid Services ("CMS") on November 1, 2017, titled "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Program" was published in the Federal Register on November 13, 2017.

223. The Centers for Medicare & Medicaid Services ("CMS"), is a government payer through which Sanford is reimbursed for services under Medicare. In that capacity, it issues rules regarding reimbursements to hospitals such as the 2018 CMS Reimbursement Rule.

224. The CMS Reimbursement Rule does not alter the availability or magnitude of drug discounts that eligible providers such as Sanford receive under 340B. Instead, it only changed the methodology for calculating Medicare reimbursements to certain hospitals that receive those discounts to "allow the Medicare program and Medicare beneficiaries to pay less for drugs when hospitals participating in the 340B Program furnish drugs to Medicare beneficiaries that are purchased under the 340B Program."[9] The Rule thus does not affect Sanford entitlement to receive 340B drug discounts or the amount of such discounts.

[9] CMS, Final Rule, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 82 Fed. Reg. 52356, 52495 (Nov. 13, 2017) ("340B Rule").

225. Instead, the Rule facilitates the pass-through of such discounts to Medicare through lower reimbursements and to Medicare beneficiaries through lower co-payments. 340B Rule, 52495, 52496, 52498, 52503-52504. *See also* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-01-2.html. Thus, if anything, the new Rule confirms that the transaction will result in significant efficiencies that will benefit payers and patients by enabling MDC Medicare patients who are treated at Sanford's facilities after the transaction, but would have been treated at MDC facilities in the absence of the transaction, to benefit from Sanford's 340B qualification drug pricing.

226. Dr. Respess also asserted that the 340B savings from the transaction are speculative because the Affordable Care Act could be repealed. Respess, Oct. 31 Tr. 202:13-23. To the contrary, it is the Government that is speculating, not Defendants. A party need not guarantee that a law that facilitates a particular efficiency will never be repealed for that efficiency to be cognizable. Moreover, even if parts of the Affordable Care Act are repealed at some undetermined future point, such a repeal would not necessarily affect 340B, which reflects a far more engrained and longstanding federal statutory standard, enacted as part of the Public Health Service Act in 1992.

227. The cost savings achieved by post-transaction integration both from 340B and otherwise likely will pass through to consumers. Indeed, a Government declarant [redacted].[10] PX03009_009 (Schley Decl.) ¶ 35; JX00016_100-

[10] [redacted]

103, Schley Dep. 100:21-103:11. There is no reason why cost savings achieved post-merger by MDC and Sanford would be any different. Like CHI, Sanford is a non-profit hospital system. Krabbenhoft, Nov. 2 Tr. 9:20-10:9.

228. Professor Town also pointed to various sources and reports explaining that 340B savings in particular pass through to patients. DX6000_061 (Town Rpt.) ¶ 120. Mr. Lenz also acknowledged that payers such as Medica have access to public information regarding the 340B status of the providers with which they negotiate and can (and do) factor that in to their negotiating position on reimbursements to those providers. Lenz, Oct. 30 Tr. 217:12-218:4. Further, as already discussed, the CMS rule pointed to by the Government makes clear that the benefits from purchasing 340B drugs in connection with the treatment of Medicare patients (both from MDC and Sanford) will be passed through directly to Medicare recipients.

229. Beyond savings attributable to cancer care/340B, other notable examples identified by Deloitte include, by Year 3 post-closing, [redacted] in annual savings attributable to human resources DX4018_024, (Deloitte Efficiency Analysis), [redacted] in annual savings attributable to marketing and promotional expenses, DX4018_028, (Deloitte Efficiency Analysis), and [redacted] in annual savings attributable to revenue cycle, IT and infrastructure DX4018_034, (Deloitte Efficiency Analysis). These three categories alone amount to net efficiencies, by Year 3 post-closing, of [redacted] The underlying calculation for these, and the other efficiencies presented by Deloitte, can be found in the Deloitte work papers. Ahern, Nov. 3 Tr. 16:11-17:7;

[redacted]

DX4018_004-5, (Deloitte Efficiency Analysis); JX00071 (Deloitte Spreadsheet: Efficiency Summary).

230. Ms. Ahern was clear in her testimony that she does not believe MDC could achieve these cost savings on its own, or that there is any other realistic merger partner (given CHI's abandonment of a transaction with MDC) with whom MDC could achieve them. Ahern, Nov. 3 Tr. 20:3-10.

231. With respect to what MDC could do on its own, Ms. Ahern noted one area of cost savings (regarding lab services) where MDC was able to obtain standalone savings. Ahern, Nov. 3 Tr. 29:19-30:6. She explained that this would have the effect of reducing her overall efficiencies calculation by only [redacted] *Id*. 30:13-18. Importantly, she also explained why this example highlights the merger-specific nature of the remaining efficiencies, none of which MDC could achieve on its own in her informed judgment based upon, among other things, her discussions with MDC's Chief Financial Officer. *Id*. 30:19-31:16. Dr. Respess conceded he had not done any analysis as to whether MDC could achieve any of the Deloitte-identified efficiencies if MDC remained independent. Respess, Oct. 31 Tr. 210:20-211:8. He also agreed that rational businesses try to control their expenses, and that he had no basis to dispute that MDC's management team act as rational decision makers. *Id*. 211:21-212:3. Relatedly, he recalled that MDC's CFO is frequently attempting to identify cost-savings opportunities but could not recall any opportunities that had yet to be explored. *Id*. 212:4-10.

232. With respect to opportunities with another potential merger partner, Dr. Respess did not have any basis—beyond what Mr. Schley said—as to why CHI abandoned its efforts to acquire MDC, nor whether those circumstances had changed. Respess, Oct. 31 Tr. at 217:12-218:24. He also was not aware of any information that indicates another merger partner other than CHI

or Sanford had expressed an interest in acquiring MDC, but did acknowledge that Sanford and CHI are the only hospital systems in Bismarck. *Id*. at 219:9-16. Thus, as Ms. Ahern testified, any potential merger partner other than Sanford is simply "theoretical." Ahern, Nov. 3 Tr. 20:11-23. As such, when Dr. Respess concedes that MDC could achieve cost savings by merging with a hospital system, Respess, Oct. 31 Tr. at 217:2-11, Sanford, as a practical matter, is the only viable option.

IX. Sanford And MDC Have Identified Numerous Unique, Merger-Specific Synergies That Will Benefit Patients In The Bismarck-Mandan Community.

233. Sanford and MDC worked together to identify a blueprint of synergies that MDC and Sanford would implement after the merger that they otherwise could not accomplish, or could accomplish more quickly and inexpensively, post transaction. Hocks, Nov. 2 Tr. 217:9-18.

234. MDC and Sanford brought together representatives of specialist and primary care groups from both organizations to participate in these discussions, as well as IT personnel, administrators, and other ancillary service providers. Hocks, Nov. 2 Tr. 217:9-218:2. In all, there were around 75 meetings between October 2016 to January 2017, when the *Stronger Together: Synergy* document was finalized. Hocks, Nov. 2 Tr. 218:15-219:1.

A. Imagenetics

235. Imagenetics is a Sanford program that integrates genetic medicine into primary care through precision medicine research and Sanford-developed protocols and tests. Sanford's Imagenetics is a $125 million dollar program. Hocks, Nov. 2 Tr. 197:15-24. Sanford is poised to spend an additional $38 million annually over the next few years for this program, and the "Sanford Chip," which is used to identify genetic mutations, is proprietary to Sanford Health. Hocks, Nov. 2 Tr. 224:2-11. The Imagenetics program and the Sanford Chip are both customized and exclusive to Sanford. JX00008_025, Hocks IH Tr. 93:10-94:3.

236. Imagenetics provides prospective genetic counseling by identifying, (1) 59 disease-causing mutations, (2) 80 mutations that will affect a patient's ability to metabolize certain medications, and (3) various other risk factors, such as enabling patients to know if they are at higher risk of developing cardiac disease based upon the population of Sanford communities and their genetic makeup. Hocks, Nov. 2 Tr. 198:16-199:13; JX00008_024-25, Hocks IH Tr. 92:12-92:2; DX2061_004-5 (*Stronger Together: Synergy*). Sanford will provide the Sanford Chip that identifies these gene mutations to all patients for $40, starting in January 2018. Hocks, Nov. 2 Tr. 226:12-15. Genetic counselors also are embedded in primary care clinics to help patients understand the role genetics play in their healthcare, and to work with patients to develop alternative care pathways that account for the patient's genetic predisposition. Hocks, Nov. 2 Tr. 198:7-199:12; JX00008_025, Hocks IH Tr. 93:10-22.

237. Sanford has built its laboratories to perform the otherwise very expensive services in-house. Hocks, Nov. 2 Tr. 198:13-15. The Mayo Clinic's pharmacogenetic panel is $500-600 without returning it in a way that is incorporated into an electronic medical record, and such tests are not currently reimbursed by medical insurance. Hocks, Nov. 2 Tr. 224:12-16, 225:22-226:2.

238. MDC does not have genetic counseling services, access to the Sanford Chip, or any research function. JX0008_062, Hocks IH Tr. 242:22-244:15; JX00008_025, Hocks Tr. 93:10-94:3; JX00022_014, Seifert Dep. 51:15-22. Thus, the ability of its clinicians and patients to access these services post-transaction is inherently merger specific.

B. Behavioral Health

239. Behavioral health is recognized as an important way to improve patient health and improve the total cost of care. Hocks, Nov. 2 Tr. 221:2-9. There is a need for greater behavioral health services in the Bismarck-Mandan region. JX00008_011, Hocks IH Tr. 40:16-20.

240. Sanford has embedded behavioral health therapists in its primary care clinics, after years of testing and developing best practices for its behavioral health model. Sanford's program arose out of a CMS demonstration project that took five years to develop and three years to test. JX00008_010, Hocks IH Tr. 34:10-14. Sanford's pilot program achieved a 15 percent increase in quality composite scores compared to clinics without behavioral health specialists, and won a CMS Innovation Award. Hocks, Nov. 2 Tr. 203:1-12; JX00008_010, Hocks IH Tr. 34:18-20.

241. This program also has resulted in significant and measurable improvements in patient health, such as an [redacted] in optimal diabetes care, [redacted] in optimal asthma care, [redacted] in identification of anxiety disorders, [redacted] in identification of depression, [redacted] in avoidable hospitalizations, and [redacted] in total cost of care. PX04045_024, (MDC Board of Directors March 2017 Presentation). The program now consists of an organized system of 42 behavioral health therapists throughout Sanford primary care clinics who convene monthly for case reviews, as well as an extensive on-boarding program where they have mentors who help them as they are seeing their first patients. Hocks, Nov. 2 Tr. 222:21-223:2.

242. MDC does not have embedded behavioral health therapists. JX00011_067, Seifert IH Tr. 263:6-10; JX00008_012, Hocks IH Tr. 42:10-15. MDC doctors recognize that their current ability to help patients with behavioral health issues is limited. Seifert, Nov. 3 Tr. 186:10-187:7 ("that's one of the things I'm most excited about."). Creating an effective behavioral health program takes significant time and labor. Hocks, Nov. 2 Tr. 223:9-22 ("It's taken us six years to figure this out."). Like Imagenetics, this is something MDC and its patients can access only by joining Sanford.

C. Cancer Care

243. The merger will give MDC patients access to over [redacted] and treatments through its merger with Sanford. DX2061_005 (Stronger Together Synergy). These cancer trials are Sanford-specific, as part of its work in medical research, and MDC can only access them if it developed these same clinical trials. JX00008_032, Hocks IH Tr. 122:20-123:16. MDC does not have a research function. JX00008_032, Hocks IH Tr. 123:11-16; JX00022_014, Seifert Dep. 51:15-22. JX00008_032, Hocks IH Tr. 123:2-6.

244. The merger also will extend the reach of cancer care, as the combined Sanford and MDC oncology department will be large enough to expand beyond the Bismarck-Mandan area to patients in more remote areas to the north and west, who otherwise do not have access to nearby cancer treatment facilities. [redacted] JX00008_033, Hocks IH Tr. 127:8-20. [redacted] JX00008_033, Hocks IH Tr. 127:8-20.

245. [redacted] A broader panel of physicians is needed for adequate call coverage in the Bismarck-Mandan area, and sending physicians out to other portions of North Dakota removes that physician for a significant amount of time. JX00008_033-34, Hocks IH Tr. 127:8-129:2. By coming together, they will be able to do this—something the Government does not seriously dispute.

D. Electronic Medical Records

246. An electronic medical record, or EMR, operates system-wide, and is a repository for patient care, with patient history, clinician notes, lab results, radiology images, and billing images all integrated and accessible within the system. JX00008_058-59, Hocks IH Tr. 228:13-

229:15. It ensures that wherever a patient goes within Sanford the medical record is the same and accessible to anyone caring for the patient. Hocks, Nov. 2 Tr. 227:10-21; JX00008_058-59, Hocks IH Tr. 228:21-229:15.

247. Sanford spends about $40 million dollars a year supporting its EPIC EMR system, customizing it, and outfitting it with best practice alerts. Hocks, Nov. 2 Tr. 227:12-14.

248. Sanford also has significant experience in integrating clinics onto the EPIC system, having done so with many other clinics. Hocks, Nov. 2 Tr. 229:19-24.

249. MDC cannot afford or access the full benefits of Sanford's EPIC system without the merger. It would cost MDC at least $2-3 million a year for the upkeep, even without the expense of implementing EPIC for the first time. Hocks, Nov. 2 Tr. 228:1-14. [redacted] JX00008_060, Hocks IH Tr. 235:1-18 [redacted] JX00008_059, Hocks IH Tr. 231:3-4. Here too, the Government does not seriously dispute this, going no further than to suggest the mere possibility that MDC might be able to enhance its EMR system (without explaining why it has not done so if it is so easy). DX6163_024, 21 (Jha Rpt.) ¶¶ 48.

E. Subspecialist Recruitment

250. Subspecialists are physicians who receive additional, specialized training after residency, generally in the form of a fellowship. Hocks, Nov. 2 Tr. 212:9-14.

251. Bismarck currently has a need for a number of subspecialists. Currently, patients who need various types of subspecialty care must travel to places like Fargo, Denver or the Twin Cities. JX00008_048, Hocks IH Tr. 187:2-10. Examples include pediatric gastroenterology,

pediatric neurology, pediatric critical care, reproductive endocrinology, and urogynecology. JX00008_048-49, Hocks IH Tr. 188:8-190:6; JX00008_037, Hocks IH Tr. 141:20-142:2; PX04045_027 (MDC Board of Directors Presentation).

252. The transaction will help foster the recruitment of subspecialists that are not currently available in Bismarck. Hocks, Nov. 2 Tr. 212:15-18, 213:11-215:13. Subspecialists are in high demand, and generally look both to the population of an area and the number of physicians practicing in a particular health system; it is easier to recruit subspecialists to an integrated system with a larger number of doctors to refer patients to them. JX00008_037, _048, Hocks IH TR. 142:11-16, 188:17-22; Hocks, Nov. 2 Tr. 213:11-215:13; JX00022_006, Seifert Dep. 18:24-19:11. The enhanced scale of a combined Sanford-MDC thus will facilitate recruitment.

F. Government Testimony Concerning Sanford-MDC Synergies.

253. The Government primarily addresses the transaction's synergies at a high level of generality. Dr. Jha, for example, testified that Sanford and MDC did not need the merger to: (1) add new services because MDC has opened a clinic, (2) add new technology because both have implemented 3D mammography, and (3) achieve a level of clinical integration because already MDC provides high-quality care. Jha, Oct. 31 Tr. 247:12-248:14; 252:7-253:17. These are strawmen that ignore the near term, merger-specific synergies the parties' seasoned professionals have identified.

254. Dr. Jha, for example, does not address Imagenetics at all in either of his two reports. In his testimony, Dr. Jha, agrees that the incorporation of genetics into medicine is beneficial to patients but asserts that there is nothing unique about Imagenetics and that MDC "can do all those things today." Jha, Oct. 31 Tr. 262:1-15. This ignores, *inter alia*, Sanford's new chip, research capability, the tests the Chip can perform the level of investment that went into it and the adaptation of its EMR system, its in-house laboratory capability, the fact that it will be

available to patients for $40 versus the hundreds of dollars that it costs to get it done elsewhere, and the vast disparity between what Sanford has done and the limitations that MDC, which has no genetic counsellors at all, faces. JX00022_014, Seifert Dep. 51:15-22

255. Likewise, Dr. Jha did not dispute the value of Sanford's behavioral health program and asserted it is a "great clinical practice," but again claimed that it could be accomplished without the merger. Jha, Oct. 31 Tr. 262:16-264:3. This disregards the time and expense it took for Sanford to develop its program, the demonstrated success of the program, the fact that MDC currently has no behavioral health therapists at all, and the absence of evidence that it has any intention or ability to replicate this program. JX00011_067, Seifert IH Tr. 263:6-10.

256. With respect to subspecialists, Dr. Jha agrees that it would be valuable to have more subspecialists in Bismarck, but disputes that the merger would make it easier to do so because he claims the ability to recruit them is solely a function of the patient population, which would not be altered by the merger. Jha, Oct. 31 Tr. 249:4-251:6, 289:8-24. The Sanford witness who testified on this issue has recruited hundreds of subspecialists to Sanford clinics. Hocks, Nov. 2 Tr. 233:22-234:1. Dr. Jha, in contrast, has never been responsible for recruiting subspecialists and does not address the reasons given in Mr. Hocks' testimony for why having a larger number of physicians in a practice will facilitate such recruitment. Jha, Oct. 31 Tr. 288:12-289:7.

257. Dr. Jha noted that Sanford already has a maternal fetal medicine ("MFM") specialist, Jha, Oct. 31 Tr. 251:7-24, but ignored the unique factual circumstances surrounding this recruitment. Specifically, Sanford's MFM specialist is a local scholarship student originally planning on becoming, and intended by Sanford to become, an OB/GYN, who decided to become a MFM specialist as a resident. JX00008_038, Hocks IH Tr. 146:21-147:7. Rather than abandon its commitment to her, Sanford honored its scholarship promise and prospective employment offer.

JX00008_038, Hocks IH Tr. 146:21-147:7. This episode does nothing to undermine the parties' well-reasoned and experienced-based conclusion that the transaction will accelerate the recruitment of sub-specialists. All it does is provide another illustration of "promises made, promises kept."

CONCLUSIONS OF LAW

I. The Government Must Meet A Heavy Burden To Obtain The Relief It Seeks.

1. The Eighth Circuit uses "a more stringent standard" for reviewing preliminary injunction applications under the Clayton Act. *FTC v. Freeman Hosp.*, 69 F.3d 260, 267 (8th Cir. 1999). The Government must show that "weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999). "A showing of a fair or tenable chance of success on the merits will not suffice for injunctive relief[,]" because that would be "contrary to congressional intent and reduce[] the judicial function to a mere 'rubber stamp' of the FTC's decisions." *Id*. Thus, to demonstrate the required likelihood of success, "'the FTC must raise questions going to the merits so serious, substantial, difficult and doubtful as to make them fair ground for thorough investigation, study, deliberation, and determination by the FTC in the first instance and ultimately by the Court of Appeals.'" *Id*. (quoting *Freeman*, 69 F.3d at 267).

2. Under this standard, despite numerous attempts, the Government never has obtained a preliminary injunction against a merger in this Circuit. *See Tenet*, 186 F.3d at 1055 (no injunction in hospital merger case); *Freeman*, 69 F.3d at 273 (same); *FTC v. Nat'l Tea Co.*, 603 F.2d 694 (8th Cir. 1979); *U.S. v. Mercy Health Services*, 902 F. Supp. 968, 989 (N.D. Iowa 1995), *dismissed as moot on other grounds, U.S. v. Mercy Health Services*, 107 F.3d 632 (8th Cir. 1997); *U.S. v. Country Lake Foods, Inc.*, 754 F. Supp. 669, 681 (D. Minn. 1990).

3. To demonstrate a likelihood of success on the merits, the Government bears the burden to establish "(1) a relevant market within which (2) the effect of the acquisition in question may be to substantially lessen competition." *Freeman*, 69 F.3d at 268. "By showing that a transaction will lead to undue concentration in the market for a particular product in a particular geographic area, the government establishes a presumption that the transaction will substantially lessen competition." *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990). "The burden of producing evidence to rebut this presumption then shifts to the defendant." *Id*. "If the defendant successfully rebuts the presumption, the burden of producing additional evidence of anticompetitive effect shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times." *Id*. at 983.

II. The Government Has Failed To Prove A Relevant Antitrust Market.

A. The Government Bears the Burden of Establishing a Relevant Market.

4. "The burden is on the government to establish the relevant market" in an action seeking a preliminary injunction pursuant to Section 13b of the FTC Act. *Tenet*, 186 F.3d at 1052-53 & n.12; *see also Freeman*, 69 F.3d at 268 n.12 (holding that it is "essential that the FTC identify a credible relevant market before a preliminary injunction may issue" and rejecting the FTC's argument that it need only "present 'serious, substantial, difficult and doubtful' questions about the relevant market at the preliminary injunction stage").

5. The Eighth Circuit has rejected FTC attempts to enjoin healthcare mergers based solely upon the Government's failure to satisfy its burden as to market definition. *See Tenet*, 186 F.3d at 1052 ("The FTC's failure to prove its relevant geographic market is fatal to its motion for injunctive relief."); *Freeman*, 69 F.3d at 268-72 (affirming denial of FTC motion for preliminary injunction for failure to define a proper relevant market).

6. There is no obligation on defendants to define an alternative, more appropriate market. *See, e.g. Tenet*, 186 F.3d at 1053 n.12 ("Of course, as noted, the burden is on the government to establish the relevant market. Tenet's arguable failure to establish its 65–mile radius as a relevant geographic market has no legal import, except to the extent that its evidence weakens the FTC's case.").

B. Professor Town Demonstrates That The Government Has Failed To Define A Relevant Market.

7. To define a relevant antitrust market—a necessary prerequisite for the rebuttable presumption even to come into play—the Government often uses, as Dr. Sacher purports to have done here, the hypothetical monopolist test articulated in the 2010 U.S. DOJ and FTC Horizontal Merger Guidelines ("Merger Guidelines"). *See, e.g.*, JX00094_011-12, Merger Guidelines § 4.1.1 (describing the hypothetical monopolist test as "requir[ing] that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future seller of those products ('hypothetical monopolist') likely would impose at least a small but significant and non-transitory increase in price ('SSNIP') on at least one product in the market, including at least one product sold by one of the merging firms"). PX6000_030-31 (Sacher Rpt.) ¶¶ 62-63.

8. In applying the hypothetical monopolist test in the healthcare context—*i.e.*, assessing whether post-merger, a provider monopolist likely could impose a SSNIP—it is highly informative to assess whether providers in analogous markets with high levels of concentration are able to impose a SSNIP on customers (*e.g.*, health insurers or payers) relative to markets with lower levels of concentration. Reliance on such evidence is an approach the FTC and DOJ explicitly endorsed in 2006 in a publicly released commentary on the 1992 Merger Guidelines:

> Evidence pertaining more directly to a merger's actual or likely competitive effects also may be useful in determining the relevant market in which effects are likely. Such evidence may identify potential relevant markets and significantly reinforce or undermine other evidence relating to market definition.

U.S. DOJ and FTC Commentary on the Horizontal Merger Guidelines, at 10 (March 2006), https://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf ("*FTC/DOJ Commentary*").

9. The *FTC/DOJ Commentary* provides an example of how this commonsense approach was used to support the market definition for office supply stores in the FTC's successful challenge in 1997 of Staples' proposed acquisition of Office Depot. *Id.* ("The Commission found that in metropolitan areas where Staples faced no office superstore rival, it charged significantly higher prices than in metropolitan areas where it faced competition from Office Depot or the other office supply superstore chain, OfficeMax."); *see also FTC v. Staples, Inc.* 970 F. Supp. 1066, 1075-76 (D.D.C. 1997) (such evidence found to be compelling for purposes of defining the relevant market); *FTC v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1040 (D.C. Cir. 2008) (determining in assessing market definition that the presence of the acquired retailer in local markets depressed Whole Foods's margins significantly).

10. The *FTC/DOJ Commentary* also notes that use of this analysis "may eliminate the need to identify with specificity the appropriate relevant market definition, because, for example, the analysis shows that anticompetitive effects are unlikely in any plausibly defined market." *FTC/DOJ Commentary* at 11 (describing the investigation of a department store merger where there was no difference between pricing of stores in local markets where the store had a 90% share compared to local markets where the store faced a large number of rivals).

11. This analysis is incorporated into the current version of the Merger Guidelines: "The Agencies also look for reliable evidence based on variations among similar markets. . . . The Agencies also may examine how prices in similar markets vary with the number of significant competitors in those markets." JX00094_006, Merger Guidelines § 2.1.2.

12. Professor Town's analysis of actual pricing (*i.e.*, reimbursement rates) in North Dakota addresses this question with respect to BCBS-ND by assessing the pricing that North Dakota providers with concentrations in the relevant service areas that equal or exceed those that the Government claims will result from the transaction obtain from BCBS-ND. The answer is that there is no relationship between physician provider concentration and the BCBS-ND reimbursements received. In other words, firms with a monopolist's share in a "physician services market" comparable to those alleged by the Government here are unable to impose on BCBS-ND any higher reimbursement rates than providers with much lower market shares. FOF Section V.B.5.

13. Conversely, though Dr. Sacher purports to have used the hypothetical monopolist test, he never analyzed ***reimbursement data*** to determine whether a hypothetical monopolist would be able to impose a SSNIP on the payers, including BCBS-ND, that form the basis for the market he proposed. Instead, he improperly applies the hypothetical monopolist test by ignoring the realities of the market in which the hypothetical monopolist would be operating. *See* PDX002 (Sacher Demonstrative) Slides 17-34 (never mentioning, in the market definition demonstratives, the susceptibility of the alleged market to a price increase). As a result, his analysis never assesses whether his theoretical predictions are consistent with actual pricing in North Dakota, and they are not. FOF Section V.D.

C. The Government's Proposed Antitrust Market In This Case Is Inconsistent With Both Section 4.1.4 Of The Merger Guidelines And The FTC's *Evanston* Decision.

14. From the inception of this case, the Government has defined its proposed product markets as services "sold and provided to *commercial payers* and their insured members." Complaint ¶¶ 27, 29, 30, 31 (emphasis added). Excluded from this definition are other payers, in particular governmental payers such as Medicare and Medicaid. The basis for this exclusion—even though

Dr. Sacher agrees that there is no difference between the services provided to commercial versus governmental insurance patients, Sacher, Oct. 31 Tr. 121:9-123:14—is that Medicare and Medicaid, and thus their insureds, are not "*susceptible to price increases*" after the merger because Medicare and Medicaid "do not negotiate reimbursement rates," *Id*. at 123:15-124:2; JX00033_014, Sacher Dep. 51:10-52:15. As recognized by both the Merger Guidelines and the FTC's own decision in *Evanston*, in delineating the market this way, the Government requires the Court to consider the potential impact of the transaction on the specific group of customers in its alleged antitrust market.

15. First, Section 4.1.4 of the Merger Guidelines makes clear that the Government's proposed market is incorrect and, thus, the Government cannot meet its burden. That section states that where the Government alleges what is known as a "price-discrimination market," it must evaluate the ability of a hypothetical monopolist to impose a SSNIP on the targeted customers at the market definition stage. Price-discrimination markets are "defined around those targeted customers, *to whom a hypothetical monopolist would profitably and separately impose at least a SSNIP*." JX00094_015-16, Merger Guidelines § 4.1.4 (emphasis added). That is what the Government has done here by excluding certain customers, Medicare and Medicaid, solely on the basis of the inability to impose a price increase on them and thus defining a market of customers, BCBS-ND, Sanford Health Plan, and Medica, on the proposition that they are susceptible to a price increase.

16. In its reply brief, the Government disputed that Section 4.1.4 was relevant by asserting that it applies only "where there is a realistic prospect of an adverse competitive effect on a group of targeted customers who face distinct competitive options" and here, the Government claims, there would be an adverse competitive effect on all payers. The language "who face

distinct competitive options" appears nowhere in Section 4.1.4. Further, the Government's conclusory assertion that the merger would have an adverse competitive effect on all payers entirely begs the question of whether a hypothetical monopolist "would profitably and separately impose a SSNIP" on the targeted customers.

17. Second, the FTC's rationale in its *Evanston* decision also confirms the inappropriateness of the Government's attempt to sidestep at the market definition stage an analysis of a hypothetical monopolist's ability to impose a SSNIP. That case, *In the Matter of Evanston Northwestern Healthcare Corp.*, 2007 WL 2286195 (FTC Aug. 6, 2007), involved a challenge to a consummated merger.

18. Because *Evanston* was adjudicating a consummated merger, the FTC was able to identify specific price increases that had been imposed on particular commercial payers as a result of the transaction. The FTC noted that the evidence of actual price increases created a basis for defining a market based on unilateral effects to commercial payers. *Evanston*, 2007 WL 2286195 at *51 (citing *Staples*, 970 F. Supp. at 1075-76, 1078). It explained that there is a "fundamental relationship between market definition and competitive effects analysis in unilateral effects cases involving differentiated product markets." *Id.* at *49. It further noted that provider-payer negotiations involve bargaining and that "most economists who have recently studied the issue have concluded that bargaining models are appropriate for hospital markets because bilateral negotiations between MCOs [commercial payers] and hospitals determine prices that often are unique to the particular negotiation." *Id.* at *52 (citing *FTC/DOJ Commentary* 34-36 and economist testimony).

19. The result of each negotiation—assuming there is a negotiation—between providers and payers is different and, as a result, not all commercial payers are necessarily affected in the same

way. For example, in *Evanston*, while most payers experienced significant price increases as a result of the transaction, the Administrative Law Judge found that Blue Cross of Illinois did not because of its bargaining power. *In the Matter of Evanston Nw. Healthcare Corp.*, No. 9315, 2005 WL 2845790, at *138 (FTC October 20, 2005) (BCBS-IL "has the power to limit ENH's price increases" because it "had a very strong bargaining position."); *Evanston*, 2007 WL 2286195 at *52. Therefore, the Commission noted that the market definition it was employing "creates sticky and unsettled issues for merger analysis, most significantly, determining the percentage of a merged firm's revenues that must come from customers who are harmed by the merger for the transaction to violate Section 7." *Evanston*, 2007 WL 2286195 at *52. The FTC avoided the issue in *Evanston* only because payers other than Blue Cross of Illinois had experienced such high increases that the consummated merger resulted in a *significant average price increase across all payers*. *Id*. at *53-54.

20. Here, as Dr. Sacher conceded, the principal targeted customers that constitute "commercial payers" are BCBS-ND, Sanford Health Plan, and Medica. Sacher, Oct. 31 Tr. 125:21-126:21. Given that Sanford is unlikely to raise prices on itself, the Government effectively has identified a market for two customers, and then taken the position that the actual ability of a hypothetical monopolist to impose a SSNIP upon the payer with the vast majority of the market (BCBS-ND) is irrelevant to the market definition inquiry. This is inconsistent with both the Merger Guidelines and *Evanston*. Moreover, the Government has not attempted to define a Medica-only market and with good reason, given that this would likely be "an overly narrow" market. *Evanston*, 2007 WL 2286195, at *52 (quoting *U.S. v. Oracle*, 331 F. Supp. 2d 1098, 1119 (N.D. Cal. 2004) (there is a risk that "'localized competition' analysis [will] devolve into an unstructured submarket-type analysis.").

III. The Transaction Will Not Have A Significant Adverse Effect On Competition.

21. Even if the Government had met its burden to demonstrate a relevant market and established a *prima facie* case based on increased post-merger concentration—which it did not—it cannot establish that the proposed transaction will "substantially lessen competition" in its proposed markets. *Freeman*, 69 F.3d at 268.

22. As a preliminary matter, the Government's *prima facie* case rests on showing that the transaction will increase market concentration. Gov't Opening PI Br. [Dkt. 71-2] at 12-14. Specifically, relying on Section 5.3 of the Merger Guidelines, the Government argues that the presumption of illegality applies because the Herfindahl-Hirschman index ("HHI") exceeds 2,500 and increases more than 200 points. Gov't Opening PI Br. [Dkt. 71-2] at 12. The evidence supporting the presumption is solely the HHI measures provided.

23. To rebut the presumption, Defendants must "discredit[] the evidence underlying the initial presumption." *United States v. Anthem, Inc.*, 855 F.3d 345, 349 (D.C. Cir. 2017). Here, that means Defendants must show only that HHI is an unreliable predictor of competitive effects to shift the burden back to the Government. Professor Town's expert testimony has done this. Specifically, his testimony that there is no relationship between HHI concentration and reimbursement rates or quality remains unrebutted. FOF Section V.B.5. As a result, Defendants have rebutted the presumption such that the Government now has "the burden of producing additional evidence of anticompetitive effect," *Baker Hughes*, 908 F.2d at 983.

24. Moreover, "[t]he Supreme Court has adopted a totality-of-the-circumstances approach to the statute [Section 7 of the Clayton Act], weighing a variety of factors to determine the effects of particular transactions on competition." *Id*. at 984. These factors assess whether "the concentration ratios, which can be unreliable indicators of actual market behavior, [ ] did not

accurately depict the economic characteristics of the [relevant] market." *United States v. Marine Bancorporation*, 418 U.S. 602, 631 (1974).

25. The two aspects of competition at issue in this case are price and quality. Price is typically the determinative focus of Section 7 cases. *See, e.g., ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 571 (6th Cir. 2014) (noting that defendant's CEO "admitted that a merger with ProMedica might '[h]arm the community by forcing higher rates on them'" as evidence that the merger will have competitive harm); *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys.*, Ltd., 778 F.3d 775, 791 (9th Cir. 2015) (affirming the District Court's finding of anticompetitive effects because "reimbursement rates for PCP services likely would increase"). With respect to quality, Defendants are aware of no case, and the Government has cited none, in which a merger was blocked solely on reductions in quality or non-price competition. *See Mercy Health Services*, 902 F. Supp. 986, *dismissed as moot on other grounds*, 107 F.3d 632 (8th Cir. 1997) (rejecting Government's argument that hospital merger would be able to lower quality and declining to enjoin a merger on that basis).

A. The Transaction Will Not Result In Higher Prices.

1. <u>No Evidence Indicates That Sanford And MDC Have A Belief That They Will, Or A Desire To, Increase Prices.</u>

26. A common element of cases in which the Government has successfully blocked a merger is evidence from the parties that they intend to increase prices. For example, in *ProMedica Health System, Inc.*, 749 F.3d 563 (brackets in original), the CEO of one of the merging hospitals stated that "a merger with ProMedica 'ha[d] the greatest potential for higher hospital rates.'" *See*

id. at 571 (citing such statements and explaining that "the Commission's best witnesses were the merging parties themselves").[11]

27. Despite the production of over a million documents and submission to 149 hours of on-the-record questioning through this process, the Government has not identified a single piece of evidence that Sanford or MDC believe the transaction will enable them to raise prices or that they intend to raise prices after the transaction. FOF Section V.A

2. The Evidence Establishes That The Transaction Will Not Enable Defendants To Raise Prices [redacted].

28. The Eighth Circuit has explained that "the evidence shows that large, sophisticated third-party buyers can do [sic] resist price increases, especially where consolidation results in cost savings to the merging entities." *Tenet Health*, 186 F.3d at 1054. The Court reached that conclusion in that case in "spite of [the payers'] testimony to the contrary." *Id*. The Horizontal Merger Guidelines similarly state that "powerful buyers may constrain the ability of the merging parties to raise prices." JX00094_030, Horizontal Merger Guidelines § 8. Finally, the FTC itself concluded in *In the Matter of Evanston Nw. Healthcare Corp.*, No. 9315, 2005 WL 2845790, at *138 (F.T.C. ALJ Oct. 20, 2005), that because one payer, Blue Cross Blue Shield of Illinois, "accounts for approximately twenty percent of ENH's [the merging party's] business," it had "the power to limit ENH's price increases."[12] [redacted]

[redacted]

[11] *See also Saint Alphonsus Med. Ctr.– Nampa, Inc. v. St. Luke's Health System, Ltd.*, Nos. 1:12-CV-00560, 1:13-CV-00116, 2014 WL 407446, *10-11 (D. Idaho Jan. 24, 2014) (identifying similar internal documents); *In the Matter of ProMedica Health System, Inc.*, 2012 WL 1155392 at *34 ("St. Luke's own documents make it clear that one of the chief benefits expected from the Joinder was obtaining the significantly higher rates that the ProMedica hospitals were able to command."); *FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 63-64 (D.D.C. 1998) (pointing to statements of senior executives that the merger would reduce downward pricing pressures).

[12] The Commission ultimately ruled against the consummated merger based on its finding that it had substantially increased prices for the remaining half of the commercial-payer market by such a large

29. [redacted]

30. One "type of evidence[]" useful for assessing a transaction's competitive effects are "direct comparisons based on experience," sometimes called "natural experiments." JX00094_006, Horizontal Merger Guidelines § 2.1.2. For example, in *FTC v. Staples, Inc*., 970 F. Supp. 1066, 1082 (D.D.C. 1997), the Court relied on "pricing practices" in places where "an office superstore chain [was] facing no competition" compared to places where "Staples and Office Depot [the merging parties] compete." *Id.*

31. Use of natural experiments aids antitrust analysis because such analysis is inherently predictive. "Section 7 deals in probabilities not ephemeral possibilities." *Tenet Health*, 186 F.3d at 1051. As the FTC explained in *Staples*:

> In evaluating the legality of a merger, the antitrust laws essentially require a prediction as to whether the deal is likely to lead to less competition and, consequently, higher prices for consumers. Usually, that prediction is by necessity based on inferences derived from market concentration levels. Here, the court need not rely on market share based predictions alone. There is real world direct evidence.

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amount that average net prices were still substantially increased across all payers. *Evanston*, 2007 WL 2286195 at 53-54, 66.

FTC Preliminary Injunction Br., *FTC v. Staples*, Case No. 97-cv-701, at 3-4 (Apr. 10, 1997 D.D.C). There, unlike here, the real world evidence showed that more highly concentrated markets with less competition yielded higher prices. *Id.*

32. [redacted] FOF Section V.B.5. This actual North Dakota evidence [redacted]

3. The Transaction Will Not Result In Increased Prices To Other Payers.

33. With respect to the remaining payers, Sanford Health Plan and [redacted], the transaction will not result in higher prices. For Sanford Health Plan, which is part of the Sanford organization, any price increase essentially would be an internal transfer of money such that it would not serve any interest of the Sanford organization. FOF Section V.D.3.

34. [redacted] Moreover, the Bismarck-Mandan area is a sufficiently small portion of [redacted] covered lives [redacted] that it would not appreciably impact the multistate Sanford-[redacted] relationship that is primarily focused on markets in other states. FOF Section V.C.

35. Further, [redacted], Professor Town's merger simulation analysis simulates a price increase for [redacted] of only [redacted] in the Government's alleged markets if entry is not accounted for, or [redacted] if the likely unduly

pessimistic estimates of Government witness CHI is taken into account. FOF Section V.C. As explained in FOF Section IX, *infra*, this is a small fraction of any of the efficiencies and synergies that will be gained by the transaction. *See also* FOF Section V.C & VIII. *See Tenet Health*, 186 F.3d at 1054 (courts must "consider[] evidence of enhanced efficiency in the context of the competitive effects of the merger"). And even that small number—[redacted]—will be further reduced with entry beyond that estimated by CHI's Mr. Schley. DX6001_62 (Town Rebuttal Rpt.) ¶ 137.

B. The Transaction Will Not Result In Lower Quality.

36. As noted, Defendants are aware of no case—nor has the Government cited one—in which a merger was blocked solely on the basis of reductions in non-price competition. Regardless, the evidence shows the transaction will not harm non-price competition. To the contrary, the transaction will create synergies and efficiencies that expand access to services, create new service lines, save substantial costs, and enhance Sanford and MDC physicians' ability to provide their patients high-quality care. FOF Section IX. Moreover, neither the quality of services provided by physicians nor Sanford's quality-related programs and investments are primarily driven by local competition. FOF Section VI. In fact, analysis of North Dakota healthcare data shows, there is no relationship between provider concentration and quality in North Dakota. FOF Section VI. And even if competition does drive quality, CHI has the incentive, intent, and resources to recruit additional physicians to the Bismarck-Mandan area and the Government has never attempted to explain why Sanford's incentive to compete would be meaningfully reduced under those circumstances. FOF Section VII. This has the dual effect of preserving competitive pressure on Sanford to continue improving its services and of increasing the total number of physicians in the Bismarck-Mandan area.

IV. CHI Will Enter In A Timely And Sufficient Manner.

37. Entry is an important element of the "comprehensive inquiry" of the future competitive conditions in a given market. *Baker Hughes*, 908 F.2d at 988-89 (rejecting DOJ's proposed "quick and effective" test for entry because it would be "channeling what should be an overall analysis of competitiveness into a determination of whether a defendant has shown particular facts."). Courts have noted that the ability of a fringe or small competitor to expand in response to the merger is particularly relevant to the inquiry. *Id*. at 988-89 & n.8; *Country Lake Foods*, 754 F. Supp. at 679; *see also* JX00094_031-32, Merger Guidelines § 9 (entry is part of "the full assessment of competitive effects"). Here, the Government's own witness estimates that CHI (which is far more substantial than a "fringe or small competitor") will be able to compete in the relevant service areas [redacted], and no payer witness asserted that the number of doctors CHI estimates it will be able to recruit in that time will be insufficient for the payer to sell health insurance in the Bismarck-Mandan area or to provide a credible alternative threat.

38. The Government points to perceived difficulties with hiring physicians into Bismarck as a basis for assuming that barriers are high, but courts have rejected such claims in similar circumstances. In *HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104 (S.D. Miss. 1997), one of two hospitals in Vicksburg, Mississippi sued to block the acquisition by its rival hospital of a physician practices with which the plaintiff was allied. In that case, despite actually recruiting new primary care physicians after the acquisition was announced and during the pendency of the litigation, the plaintiff's director of recruitment testified that "negative perceptions and stereotypes about Mississippi exist, which make recruitment to Vicksburg difficult." *Id*. at 1134. The court held that "one witness's impressions about regional perceptions falls short of proving an entry barrier." *Id.* at 1135 (citing *Benjamin Aroostook*

Medical Center, 937 F.Supp. 957, 966 (D. Me. 1996); *see FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1076 (N.D. Ill. 2012) (observing that "the PCP market *is not subject to the same prohibitive barriers to entry that exist in the GAC [hospital] market*, and *the bargaining leverage held by large insurance companies* with respect to physician contracting is different than what would exist in contracting for GAC services if the merger were to take place" and that these and other features made it "less likely that the FTC will prevail on its claim involving the PCP market") (emphasis added).

39. The Government's cite to a recent merger challenge brought by a hospital and the FTC to the proposed acquisition by St. Luke's of the Salzer Medical Group in Idaho does not conflict with this holding. In *St Luke's*, the rival hospital was able to show that it had attempted to hire additional physicians and was unable to do so. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 2014 WL 407446 at *19 (D. Idaho 2014) (entry argument was not raised on appeal). Here the opposite is true, given CHI's successes in expanding even during a self-imposed passive recruiting mode and in light of its significant resources, incentives to expand and its own CEO's estimates of what it will be able to accomplish [redacted].

V. Efficiencies And Synergies Generated By The Transaction Will Improve Services And Counteract Any Competitive Effects.

A. Efficiencies Must Be Weighed Against Potential Anticompetitive Effects.

40. The Eighth Circuit has recognized that efficiencies must be taken into account in assessing the potential competitive effects of a merger. *Tenet*, 186 F.3d at 1054–55 ("We further find that although Tenet's efficiencies defense may have been properly rejected by the district court, the district court should nonetheless have considered evidence of enhanced efficiency *in the context of the competitive effects* of the merger.") (emphasis added). The Merger Guidelines similarly state that "the Agencies consider whether cognizable efficiencies likely would be

sufficient to reverse the merger's potential to harm customers." JX00094_033, Merger Guidelines § 10; *FTC v. University Health, Inc.*, 938 F.2d 1206, 1222 (11th Cir. 1991) ("whether an acquisition would yield significant efficiencies in the relevant market is an important consideration in predicting whether the acquisition would lessen competition").

41. The transaction, as set out in *Stronger Together: Synergy* and quantified by Deloitte, will provide numerous savings and synergies to the merging parties. FOF Section VIII. These savings, particularly given that CHI is no longer a viable partner for MDC, are not obtainable absent the merger. FOF Section VIII. The synergies and efficiencies will enable the merged entity to provide services at lower cost, provide additional services in the Bismarck-Mandan area, expand access to other services, and improve the quality of service available to Western and Central North Dakota. FOF Section VIII.

B. Efficiencies and Synergies Inextricably Linked To The Transaction Must Be Considered.

42. The Merger Guidelines also recognize the relevance of out-of-market efficiencies that are "inextricably linked" to the extent that a remedy in the challenged market would "sacrifice the efficiencies in the other markets." JX00094_033, Merger Guidelines §10 n.14; *FTC/DOJ Commentary* at 57 (considering out-of-market efficiencies is appropriate if "a merger presents large pro-competitive benefits in a large market and a small anticompetitive problem in another, smaller market.").

43. The 340B savings the transaction will provide are inextricably linked, and will be lost should the Government's challenge to the markets it focuses on succeed, because MDC cannot obtain the savings on its own and there are no other 340B-eligible parties with which it could merge to obtain the savings. FOF Section VIII. Further, the 340B savings will be pro-

competitive as the savings will be passed on to customers as well as reinvested by Sanford in providing more and higher quality services. FOF Section VIII.

C. Evidence That, Absent The Transaction, MDC Will Steadily Decline Further Confirms That There Are Not Practical Alternatives To Achieving The Synergies And Efficiencies And That The Transaction Is Fundamentally Pro-Competitive.

44. The Merger Guidelines also recognize that to show that merger efficiencies are not merger specific, the Government must show that "they could be attained by practical alternatives that mitigate competitive concerns, such as divestiture or licensing." Merger Guidelines § 10 n.13.

45. When examining a merger, a court must compare what may happen if the merger occurs with what may happen if the merger does not occur. *FTC v. Nat'l Tea Co.*, 603 F.2d 694, 700 (8th Cir. 1979). MDC's careful assessment of its declining prospects and CHI's abandonment of an MDC acquisition demonstrate that the transaction will enhance and sustain MDC's long-term ability to provide high-quality care, and that the efficiencies and synergies could not be accomplished by MDC as a stand-alone entity or through a different merger. FOF Section II-IV.

VI. The Balance Of The Equities Warrant Denying The Motion.

46. As this Circuit has recognized, "when examining a merger, a court must necessarily compare what may happen if the merger occurs with what may happen if the merger does not occur." *Nat'l Tea Co.*, 603 F.2d at 700. The prospective loss of one of the merging parties "from the relevant market if the merger is enjoined is a relevant factor in this comparison." *Nat'l Tea Co.*, 603 F.2d at 700; *see also id.* at 700 n.8 (recognizing that this argument is distinct from a failing company defense).

47. If the injunction is granted and upheld on appeal, Defendants have advised the FTC (in seeking a stay of the FTC proceeding) that they will abandon the transaction. The parties have filed sworn declarations from Sanford's Chief Legal Officer and MDC's Chief Executive Officer

that for "a variety of reasons, including concerns about issues arising from the delay of the transaction," the parties have agreed that they "will not seek to further litigate the matter in the administrative proceeding" if an injunction is granted and upheld on appeal. DX2017 & DX2018.

48. An injunction will permanently deprive the public of the benefits of the transaction, including those discussed above. *FTC v. Heinz Co.*, 246 F.3d 708, 726 (D.C. Cir. 2001) ("[P]ublic equities include 'beneficial economic effects and procompetitive advantages for consumers.'") (citing *FTC v. Pharmtech Research, Inc.*, 576 F. Supp. 294, 299 (D.D.C.1983)). *See also HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104, 1143-44 (S.D. Miss. 1997) (finding that the acquisition will likely bring new sub-specialists to Vicksburg and weighing that benefit in balancing the equities). The balance of equities thus favors denying the Government's motion.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on November 13, 2017, I electronically filed the foregoing document on all parties via the Court's electronic filing system, which will automatically send e-mail notification of such filing to all attorneys of record in this action.

/s/ James A. Kraehenbuehl
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