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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER, NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC., Plaintiffs, v. ST. LUKE'S HEALTH SYSTEM, LTD, and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	Case No. 1:12-cv-00560-BLW (Lead Case) **DEFENDANTS' CORRECTED PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW**
FEDERAL TRADE COMMISSION; STATE OF IDAHO Plaintiffs, v. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A. Defendants.	Case No. 1:13-cv-00116-BLW

TABLE OF CONTENTS

INTRODUCTION

1. This case arises out of a transaction between St. Luke's Regional Medical Center, Ltd., a subsidiary of regional health care system St. Luke's Health System, Ltd. (together, "St. Luke's), and Saltzer Medical Group, P.C. ("Saltzer"), a physician group practice offering health care services at various locations in Ada and Canyon Counties. As part of the transaction, which closed on December 31, 2012, St. Luke's purchased all of Saltzer's tangible and intangible assets, and Saltzer entered into an agreement to provide professional services exclusively on behalf of St. Luke's for a term of five years (hereafter, the "Saltzer Transaction").

2. Two sets of plaintiffs allege that the Saltzer Transaction violated § 7 of the Clayton Act, 15 U.S.C. § 18, and the analogous Idaho state law, Idaho Code Ann. § 48-106. However, they do so for two entirely different reasons. The Federal Trade Commission ("FTC") and the State of Idaho (hereafter, the "Government Plaintiffs") allege that the Saltzer Transaction will create or enhance market power for adult primary care physician services sold to commercial health insurance companies in a geographic market defined as no larger than the City of Nampa. The Government Plaintiffs contend that the transaction will allow St. Luke's and Saltzer to raise the prices they charge to commercial insurers, who will in turn pass along those price increases to consumers and employers in the form of higher premiums. *See Dkt. 98, (Gov't Pl. Compl.) ¶ 1.*

3. The second set of plaintiffs, Saint Alphonsus Health System, Inc. (along with related entities, referred to hereafter collectively as "Saint Alphonsus") and Treasure Valley Hospital Limited Partnership ("TVH"), are competitors of St. Luke's. (Hereafter, these plaintiffs are referred to as the "Private Plaintiffs"). The Private Plaintiffs concede that they have no standing to challenge the Saltzer Transaction on the ground advanced by the Government Plaintiffs, namely, that the Saltzer Transaction will result in increased prices. *See Dkt. 151 at 4.*

Instead, Private Plaintiffs advance a theory that the transaction between St. Luke's and Saltzer will harm *them* so severely—specifically, by cutting off their access to referrals from Saltzer physicians for inpatient and outpatient hospital services—that it will ultimately harm *competition* in the market for various hospital services in a geographic market defined to include all of Ada and Canyon Counties. Based on these allegations, Private Plaintiffs contend that the transaction violates not only § 7 of the Clayton Act and § 48-106 of the Idaho Code, but also § 1 of the Sherman Act, 15 U.S.C. § 1, and the corresponding Idaho state law, Idaho Code Ann. § 48-104. *Dkt. 63 (Saint Alphonsus/TVH Am. Compl.) ¶¶ 131-52.*

4. St. Luke's and Saltzer deny that the transaction will result in the anticompetitive effects alleged by the plaintiffs. Moreover, they contend, the transaction will have substantial procompetitive benefits in two different markets—the market for delivery of medical care in the two-county area and the market for health insurance in this State. First, in the market for health care services, St. Luke's and Saltzer maintain that their close financial integration (1) accords with the best thinking in health policy on how to control the unsustainable rise in health care costs, (2) is designed to create an integrated delivery system similar to institutions such as the Mayo Clinic which have become role models for providing quality care at lower cost, and (3) furthers both state and federal policies, such as those expressed in the Affordable Care Act. The second market that St. Luke's and Saltzer contend will be made more competitive as a result of the transaction is the market for health insurance. In particular, the Saltzer Transaction facilitates St. Luke's partnership with SelectHealth, a non-profit insurer affiliated with Intermountain Healthcare of Utah, which is bringing an entirely new health insurance product to Idaho.

5. Over four weeks in September and October of 2013, the Court conducted a trial on plaintiffs' claims. After reviewing all of the relevant evidence submitted by both sides, the

Court concludes that the defendants are entitled to judgment in their favor on all of plaintiffs' claims. The specific factual findings and legal conclusions on which the Court's judgment is based are set forth in the remainder of this document.

FINDINGS OF FACT

I. Parties and Summary of Claims

A. The Private Plaintiffs

1. Saint Alphonsus

6. Plaintiff Saint Alphonsus Health System, Inc. is a health system that operates hospitals, outpatient clinics, and other health care facilities in the Treasure Valley of Idaho and eastern Oregon. *Dkt. 63 (Saint Alphonsus/TVH Am. Compl.)* ¶ *13*. In Idaho, Saint Alphonsus owns and operates plaintiff Saint Alphonsus Regional Medical Center, Inc., a 381-bed tertiary care hospital located in Boise, and Saint Alphonsus Medical Center, Nampa, Inc. ("Saint Alphonsus-Nampa"), a 152-bed acute care hospital located in Nampa. *Id.* Saint Alphonsus-Nampa is the only hospital in the City of Nampa. *Transcript at 324:13-21 (J. Crouch); Transcript at 887:20-23 (K. Keeler).* In Oregon, Saint Alphonsus operates Saint Alphonsus Medical Center, Ontario, a 49-bed hospital in Ontario, and Saint Alphonsus Medical Center, Baker City, a 36-bed hospital in Baker City. *See Exhibit 2028.*

7. Saint Alphonsus employs over 200 physicians, who practice in what Saint Alphonsus calls the Saint Alphonsus Medical Group ("SAMG"). [redacted] SAMG currently employs twenty primary care physicians just in Canyon County, at least fourteen of whom practice in Nampa. *Exhibit 1115 at slide 6; Transcript at 712:15-19, 790:19-791:5 (N. Powell).*

8. Saint Alphonsus is owned by Michigan-based Trinity Health, one of the largest Catholic health care systems in the United States. Trinity operates approximately 50 hospitals

across the country. *See Transcript at 855:14-25 (K. Keeler); Transcript at 979:23-981:5 (B. Checketts); Transcript at 1650:7-22 (D. Pate).*

2. Treasure Valley Hospital

9. [redacted]

3. [redacted]

10. [redacted]

B. St. Luke's and Saltzer Medical Group

1. St. Luke's

11. St. Luke's, headquartered in Boise, is Idaho's only locally-owned, locally-governed health care system. *Transcript at 1619:8-21 (D. Pate).* St. Luke's is run by a board of directors, called the System Board, which consists entirely of Idaho community leaders. *Transcript at 1645:3-9 (D. Pate); Transcript at 2756:23-2758:25 (A. Oppenheimer).*

12. St. Luke's is an integrated health care delivery system that comprises hospitals, physician practices, and other health care providers and facilities located throughout southern Idaho and eastern Oregon. *Transcript at 1611:14-23 (D. Pate).*

13. In all, St. Luke's operates eight hospitals in Idaho. In Ada County, St. Luke's operates the St. Luke's Boise Medical Center, a 400-plus bed tertiary medical center in Boise, and the St. Luke's Meridian Medical Center, a 165-plus bed hospital located in Meridian. *See Exhibit 1082 at 3.* St. Luke's also operates St. Luke's Magic Valley Regional Medical Center, a 228-bed hospital in Twin Falls; St. Luke's Wood River, a 25-bed critical-access hospital in Ketchum; St. Luke's Jerome, a 25-bed critical-access hospital located in Jerome; and St. Luke's McCall, a 15-bed critical access hospital located in McCall. *Id.* St. Luke's has also partnered with the Gooding County Hospital District to build a new 15-bed critical access hospital, which opened in 2010, known as the North Canyon Medical Center. *See generally Transcript at 1638:1-20 (D. Pate); Transcript at 1904:15-1907:5, 1919:2-9, 1939:14-16, 1958:5-15 (J. Kee); Transcript at 2063:3-2064:7 (J. Souza); Transcript at 2178:9-20 (B. Fortuin); Transcript at 2230:5-11 (C. Roth).*

14. St. Luke's employs or has entered into professional services agreements with approximately 500 physicians who practice in numerous medical specialties and are geographically dispersed across southern Idaho and eastern Oregon.[1] *Transcript at 1999:19-21*

[1] Under a professional services agreement ("PSA"), a physician practice agrees to provide health care services exclusively on behalf of St. Luke's and St. Luke's is reimbursed for the practice's services under contracts that St. Luke's enters into with payors. *See, e.g., Exhibit 24.* Although physicians practicing under a PSA do not have a direct employment relationship with St. Luke's, the PSA sets forth the compensation that St. Luke's pays the physician practice for services provided by the physicians on its behalf. *Id.* For purposes of this case, a PSA arrangement creates a relationship functionally equivalent to employment to the extent that it provides, at the group level, the same clinical and financial alignment that employment provides at the individual level. Therefore, in the remainder of this document, St. Luke's PSA-based relationships with

(J. Kee); see also Transcript at 1862:23-1863:12 (M. Johnson). Each of the physicians employed or under a professional services agreement ("PSA") with St. Luke's is part of the St. Luke's Clinic. *Transcript at 1863:25-1864:11 (M. Johnson); Transcript at 1879:19-22 (J. Kee).* Prior to the Saltzer Transaction, no more than eight of the St. Luke's Clinic physicians who practiced adult primary care services did so in all of Canyon County. *See Transcript at 2658:10-14 (A. Enthoven).*

15. Prior to the fall of 2011, St. Luke's did not employ any primary care physicians in Nampa. In the fall of 2011, seven physicians affiliated with the Mercy Physicians Group, who were employed by Saint Alphonsus in Nampa, decided to leave Saint Alphonsus and join St. Luke's [redacted] *Transcript at 871:10-872:1 (N. Powell).* Prior to the closing of the Saltzer Transaction, St. Luke's had recruited another primary care physician to join the seven who departed from Saint Alphonsus, for a total of eight St. Luke's primary care physicians practicing in Nampa.

2. Saltzer Medical Group

16. Saltzer Medical Group currently consists of 41 physicians, nearly three-quarters of whom provide adult or pediatric primary care services. *Exhibit 2376.* Specifically, 19 Saltzer physicians practice in the specialties of family medicine and internal medicine, while 10 Saltzer physicians are general pediatricians. Thirty-four of the Saltzer physicians, including 16 of the adult primary care physicians and eight of the pediatricians, practice in Nampa. *See Transcript at 3080:5-17 (W. Savage); Transcript at 2366:22-24, 2368:15-2369:15 (J. Kaiser); Transcript at*

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physicians may be described as "employment."

[2] Although the seven physicians are now employed by St. Luke's, they are referred to in this document for convenience as the "Mercy Physicians Group."

3309:10-11, 3341:2-12 (T. Patterson); Transcript at 3342:15-16 (H. Kunz); Dkt. 269 (M. Djernes Dep.) at 7:14-25; Exhibit 2376.

II. The Need to Transition away from Fragmented, Fee-for-Service Care to Integrated, Value-Based Care

17. The Saltzer Transaction must be placed in the context of the significant structural changes taking place in Idaho, and elsewhere across the country, in the way that health care services are delivered and paid for. These structural changes are aimed at addressing what has become a consensus among health care policy experts, including those presented at trial, on the failings of the present health care delivery and payment system to provide consumers with high value care at the lowest possible cost. This section describes what have been identified as the underlying causes for the current system's failings and the best ideas for addressing those failings.

A. It Is Widely Recognized, and Undisputed Here, That Integrated, Value-Based Care Offers Substantial Benefits Over Fragmented, Fee-for-Service Care.

18. It is universally recognized by health policymakers and experts—including by plaintiffs and their experts here—that the cost and quality of health care in the United States suffer because the health care system is dominated by fragmented care that is compensated on a fee-for-service ("FFS") basis. *Transcript at 2567:5, 2569:1-3, 2570:21-2571:14, 2571:24-2572:3 (A. Enthoven); Transcript at 3568:24-3570:3 (K. Kizer); see also Transcript at 1810:2-15 (W. Deal); Transcript at 2263:14-2264:24 (R. Armstrong).*

19. Fragmentation means that care is provided by disconnected providers who do not or cannot effectively coordinate the care that they provide to any individual patient. It is marked by (1) the lack of real-time sharing of information among providers and limited use of health information technology, (2) the lack of financial alignment among providers to incentivize high-

value care, (3) the lack of agreement among providers about standardized, evidence-based practices to guide care or treatment plans, and (4) a culture of autonomy rather than teamwork. Fragmentation in health care leads to medical errors; both overtreatment and undertreatment of patients; and inefficient use of resources, such that patients are treated by higher-cost providers or in higher-cost care settings when lower-cost providers could provide higher-value care. In sum, fragmentation increases the cost, and lowers the quality, of care. *Transcript at 2563:17-2569:3 (A. Enthoven); Transcript at 3568:24-3569:3(K. Kizer).*

20. The primary way that health care providers are compensated under the current system is on a fee for service basis. *Transcript at 191:23-192:1 (J. Crouch); Transcript at 2251:4-7 (C. Roth); Transcript at 2266:23-25 (R. Armstrong); Transcript at 2572:3-6 (A. Enthoven).* As Jeffrey Crouch, Vice President of Provider Contracting for Blue Cross of Idaho ("BCI"), testified, FFS payment "incentivizes volume" because "the more services [physicians] perform, the more they can bill and the more they're compensated." *Transcript at 191:23-192:6 (J. Crouch); see also Transcript at 1608:9-19, 1628:2-5 (D. Pate); Transcript at 2570:21-24 (A. Enthoven).* Thus, FFS compensation "does not incentivize value." *Transcript at 191:23-192:3 (J. Crouch).* Similarly, plaintiffs' expert, Dr. Kizer, opined that FFS compensation pays for volume, not the quality or necessity of the services provided. *Transcript at 3569:23-3570:3 (K. Kizer).* FFS compensation is broadly recognized to be one of the driving forces behind the high cost of health care in the United States. *Transcript at 191:18-192:1 (J. Crouch); see also Transcript at 2571:22-2572:8 (A. Enthoven); Transcript at 3568:24-3569:3, 3569:18-22 (K. Kizer).*

21. FFS compensation exacerbates the fragmentation of care. For providers compensated on a FFS basis, there is no reward for teamwork or enhancing the value of care for

patients. To the contrary, providers are penalized for providing higher-value care if doing so reduces the demand for their services. For example, when the Duke Medical School identified an improved procedure for treating coronary bypass patients that resulted in lower cost and better results for patients, the system took a significant financial hit in their FFS compensation. *Transcript at 2574:3-20 (A. Enthoven).*

22. Similarly, FFS compensation incentivizes physicians to "hoard" patients—that is, to increase the number of patients that they individually are treating—and to prescribe costly, often wasteful, services that are unsupported by evidence as the best course of treatment. *Transcript at 2573:3-5 (A. Enthoven).* Providers likewise face a disincentive to prescribe lower-cost, non-physician care, such as nutritional counseling, that is poorly compensated, if at all, in the FFS realm. *Transcript at 1632:22-1633:2 (D. Pate).*

23. In fragmented, FFS care, providers are rewarded for doing more, whether or not more leads to better health outcomes. *Transcript at 1608:9-19 (D. Pate).* Providers do not suffer financially for errors, infections, missed diagnoses, or other failures to provide quality care. *Transcript at 2575:6-9 (A. Enthoven)*; *see also Transcript at 1895:16-24 (J. Kee).*

24. In the current U.S. system, marked by fragmentation and FFS compensation, the Institute of Medicine of the National Academy of Sciences estimates that 30 to 40 percent of health spending is waste. *Transcript at 2573:24-2574:2 (A. Enthoven).*

25. In view of the substantial adverse effects of fragmentation and FFS compensation, leading thinkers in health care universally support movement toward integrated care in which providers are compensated based on value, rather than volume. *Transcript at 2563:5-2564:4 (A. Enthoven); Transcript at 3523:9-14, 3523:18-24, 3569:8-13, 3571:8-14 (K. Kizer); see also*

Transcript at 2263:14-2264:11, 2264:25-2265:5 (R. Armstrong); Transcript at 3490:22-3491:20 (D. Dranove).

26. In an integrated system, providers work together to coordinate care. *Transcript at 2585:25-2586:19 (A. Enthoven).* Providers working as a team accept risk for the cost of care and accountability for the quality of care that they provide. *Transcript at 2572:14-21, 2574:21-2575:5 (A. Enthoven).* In this way, incentives are properly aligned between providers and patients, so that providers are fully incentivized to provide higher-value care at lower cost—not to provide higher volume of care without regard to value. *Transcript at 2586:20-2587:8 (A. Enthoven); see also Transcript at 3569:23-3570:3 (K. Kizer).*

27. Defendants' expert, Professor Alain Enthoven, opined that integrated, value-based care provided by organized, integrated delivery systems offers significant advantages over fragmented, FFS care. *E.g., Transcript at 2563:5-8, 2575:16-19, 2602:19-2604:21, 2605:24-2606:23, 2608:23-2610:6 (A. Enthoven).* Professor Enthoven is a retired professor of health economics in the Graduate School of Business at Stanford University and has been working in and studying the health care industry for four decades. *Transcript at 2545:15-22 (A. Enthoven).* Professor Enthoven has written some 85 articles published in leading journals, including several articles relating specifically to the topic of integrated care. *Transcript at 2547:17-2549:9 (A. Enthoven).* Professor Enthoven has also worked with government officials, the Institute of Medicine, the Integrated Healthcare Association, and several other groups on issues related to health policy. *Transcript at 2550:9-2552:20, 2553:18-2555:20, 2560:16-2561:24 (A. Enthoven).* Additionally, Professor Enthoven has, from 1973 to the present, acted as a consultant to Kaiser Permanente, a prominent integrated delivery system in California. *Transcript at 2552:21-2553:12 (A. Enthoven).*

28. In support of his opinion, Professor Enthoven noted that the integrated delivery of care has engendered the strong support of health care policymakers. For example:

a) The Institute of Medicine strongly supports the expansion of integrated delivery systems. *Transcript at 2609:19-20 (A. Enthoven).*

b) The Berkeley Forum, whose participants include several health care industry stakeholders in California, reached a similar conclusion regarding the future of health care in that state, urging the proliferation of risk-based payments and integrated care. *Transcript 2606:1-8, 2608:18-21, 2610: 2-3 (A. Enthoven).* Its conclusion stemmed in significant part from its observed correlation between California's low health care costs per person (*i.e.*, 10 percent below the national average, despite a cost of living that is 30 percent higher than the national average), and the major role played by Kaiser Permanente, a highly integrated delivery system, in providing care to residents in that state (*i.e.*, 40 percent of commercially insured consumers). *Transcript 2606:9-11, 20-23, 2607:23-2608:5, 15-17 (A. Enthoven).*

c) The federal government has also encouraged the expansion of shared-risk, integrated care for Medicare patients through the Affordable Care Act, encouraging providers to offer patients managed care as qualifying Accountable Care Organizations ("ACOs"). *Transcript at 2579:2-11, 2649:2-6 (A. Enthoven).*

d) Key stakeholders in Idaho share that view, as well. Idaho's Department of Health and Welfare favors clinically integrated care based on "outcomes-oriented measure[s] of success." *Transcript at 2263:14-2264:11 (R. Armstrong).* In its view, "more managed care will result in better quality and lower prices" for

patients. *Transcript at 2264:25-2265:5 (R. Armstrong).* The Department is also advocating a shift away from FFS compensation and an increase in risk-based arrangements (*Transcript at 2266:17-25, 2269:1-17 (R. Armstrong)*), as well as a shift from an inpatient focus on treatment to an outpatient one that emphasizes preventative care and community outreach (*Transcript at 2267:5-11 (R. Armstrong)*).

B. The Hallmarks of Integrated Delivery Systems

29. Integrated care exists on a spectrum: care can be more or less integrated, or more or less fragmented. *Transcript at 2575:16-18, 2684:13-2685:2 (A. Enthoven); see also Transcript at 1446:18-23 (D. Dranove); Transcript at 3528:23-3529:11 (K. Kizer).* The more integrated that care is, the better the results for patients. *Transcript at 2563:5-8, 2575:18-19 (A. Enthoven).*

30. There are several key hallmarks of an integrated system.

1. Aligned incentives

31. The primary hallmark of integrated delivery systems is alignment of incentives between providers and patients. *E.g., Transcript at 3573:4-5, 7-10 (K. Kizer).* For physicians, compensation that turns on the value, rather than the volume of care, incentivizes them to provide care that is demonstrated to offer the greatest benefit for patients. *Transcript at 2572:14-2573:2, 2611:20-2612:10 (A. Enthoven); see also Dkt. 366 (S. Brown) at 229:6-9.* While FFS compensation incentivizes providing care that may be of limited or uncertain value (*Transcript at 2572:19-2573:2, 2578:9-20 (A. Enthoven)*), an integrated delivery system with fully aligned incentives rewards physicians for providing evidence-based, patient-centered care. *Transcript at 2572:14-16, 2586:20-2587:17 (A. Enthoven); Transcript at 3558:12-17 (K. Kizer).*

32. From the perspective of the health system, aligned incentives mean that the health system accepts risk and accountability for its patients' care. Thus, in an integrated system that is fully compensated based on risk, the health system accepts a "per member per month" or "capitated" payment: each subscriber pays an upfront fee for total cost of care rather than payment for each service provided. *See, e.g., Transcript at 183:17-25, 184:22-25 (J. Crouch); Transcript at 2576:13-21 (A. Enthoven).* The health system is therefore incentivized to provide the highest-value care: excess health care spending hurts its bottom line, but it retains savings from providing lower-cost care. However, because the system has agreed to treat the subscriber for all health care needs, it is not incentivized to withhold needed care, in part because to do so would potentially result in the patient's need for even more costly care in the future for which the cost would be born by the system. *See Transcript at 1895:19-1896:6 (J. Kee); Transcript at 2578:9-20 (A. Enthoven).*

33. Value-based compensation for physicians and risk-based contracts for health systems also incentivize wellness initiatives and community outreach activities that are either not compensated or inadequately compensated in a FFS setting. The American health care system presently pays physicians to "take care of people when they are sick or injured," not to improve health. *Transcript at 1614:18-1615:2 (D. Pate).* To improve the health of people in the community who are not patients, physicians must access those people in their homes, schools, and businesses before they become sick or injured. *Transcript at 1615:3-8 (D. Pate).* A change in the way that physicians are compensated—away from FFS compensation and toward value-based compensation—makes such outreach possible. *Transcript at 1616:11-14 (D. Pate).*

2. Shared information

34. Clinically, an integrated delivery system achieves better care by sharing information across providers, both primary care physicians and specialists, through a shared

electronic health record. *Transcript at 2584:7-2585:24 (A. Enthoven); Transcript at 3574:12-3575:5 (K. Kizer).* When a patient sees multiple providers for treatment, the electronic health record enables those providers not only to communicate with one another in real time, but also to "have a complete picture of the medical progress of that patient" as they consider their own treatment approach. *Transcript at 1920:18-1923:1 (J. Kee); Transcript at 2126:10-2128:10, 2179:9-16 (B. Fortuin); Transcript at 2336:2-5 (C. Roth); Transcript at 2584:7-2585:24 (A. Enthoven).*

35. When, for example, a patient suffers from complex, co-morbid conditions like diabetes, coronary artery disease, and depression, which require him to see a primary care physician, endocrinologist, cardiologist, and psychiatrist, the physicians can ensure, via the electronic health record, that none of their prescribed medications conflict, that all services that need to be provided are made available, and that nothing falls through the cracks. *Transcript at 2586:5-19 (A. Enthoven); see also Transcript at 1921:3-11 (J. Kee); Transcript at 3574:12-3575:5 (K. Kizer).*

3. Culture of teamwork and shared responsibility

36. Coordinated, seamless patient care depends upon teamwork. In an integrated delivery system, primary care physicians ("PCPs") and specialty physicians work as a team, with PCPs managing patient care and specialty physicians consulting and providing care as needed. *See Transcript at 1831:19-1832:5 (M. Priest); Transcript at 2081:11-21 (J. Souza); Transcript at 2563:24-2564:4, 2585:10-2586:19, 2588:6-14 (A. Enthoven).* Unlike their posture in a fragmented, FFS system, physicians are not economic rivals competing with one another for patients and revenue. *Transcript at 1625:9-14 (D. Pate); cf. Transcript at 2571:4-2572:3, 2573:3-23 (A. Enthoven).*

37. In an integrated delivery system that accepts accountability for patient outcomes, physicians are incentivized to cooperate with one another, sharing best practices and collaborating to achieve the highest-value care for a patient across specialties. *Transcript at 2585:25-2587:8 (A. Enthoven).* They provide one another with clinical decision support, helping one another to provide the best care possible and to continue to improve quality and value where deficiencies exist. *Transcript at 1625:9-14 (D. Pate).*

38. Shared infrastructure, including technological infrastructure, promotes teamwork and easy communication among providers. *E.g., Transcript at 2586:10-19, 2629:4-6 (A. Enthoven).* It also facilitates patient communication with providers, reducing the need for office visits. *See, e.g., Transcript at 2627:10-2628:7 (A. Enthoven).*

4. Agreement among physicians to standardize care with evidence-based practices

39. In an integrated delivery system, physicians commit to developing, standardizing, and putting in place evidence-based practices that are shown to offer the highest value to patients. Through the use of health information technology, the highest-value practices can be identified, based on continually updated evidence, and standardized across the system. *Transcript at 2588:22-2590:1 (A. Enthoven).*

40. Best practices are "hard-wired" through automated practice reminders and order sets. Thus, the electronic health record informs physicians treating an individual patient as to the evidence-based guidelines for the best way to treat the patient's conditions. *Transcript at 2589:7-2590:1 (A. Enthoven).* The result is treatment protocols that are the product of a "continuous learning process" and robust "knowledge management." *Transcript at 2588:22-2590:1 (A. Enthoven).*

5. Population health management

41. Another key feature of integrated delivery systems is a commitment to preventative care and community outreach in order to achieve better health for the overall population. *Transcript at 2591:23-2592:5 (A. Enthoven); Transcript at 1614:18-1615:8, 1638:21-1639:3 (D. Pate).* Integrated delivery systems recognize that "the [health] system benefits if all the people are healthy and don't need medical care" (*Transcript at 2592:22-23 (A. Enthoven)*), so physicians dedicate significant time and resources to health education and outreach not typically compensated in a FFS setting. *Transcript at 2592:14-16 (A. Enthoven); Transcript at 1614:18-1615:2 (D. Pate).*

42. These efforts not only include instruction on diet and exercise (*Transcript at 2592:14-16 (A. Enthoven)*), but also patient outreach and reminders for those patients due for wellness visits and, when appropriate, preventative testing. *Transcript at 2590:8-2591:18, 2592:4-13 (A. Enthoven).*

43. Using an electronic health record, physicians can categorize and track who, for example, is due for a mammogram or suffers from diabetes and does not have their blood sugar under control. *Transcript at 2590:2-2592:13 (A. Enthoven); see also Transcript at 2152:5-2153:6 (B. Fortuin).* In this way, the physicians and their teams are able to monitor patients and avoid preventable, serious episodes that necessitate more costly and invasive interventions. *Id.*

6. Management structure led by physicians

44. For an integrated delivery system to succeed, it is "essential to win the loyalty, commitment, and responsible participation of the [physicians]." *Transcript at 2631:5-7 (A. Enthoven).* Physicians are most responsive to leadership when they "feel they're being led by doctors," who also "understand doctoring" as they do. *Transcript at 1728:10-1729:2 (P. Richards); Transcript at 2631:8-10 (A. Enthoven*).

45. In a physician-led organization, physicians are both the decision-makers in the delivery system and the ones responsible for the results. *Transcript at 2631:1-21 (A. Enthoven).* This structure is the optimal way in which to incentivize a commitment to coordinated, evidence-based, and outcomes-focused care. *See Transcript at 2267:16-20 (R. Armstrong).*

C. Requirements for Systems Delivering Integrated Care

1. Scale

46. An integrated delivery system must be of sufficient scale to support the overhead associated with clinical and financial integration, as well as the cost of the electronic health record. *Transcript at 2600:15-2601:11 (A. Enthoven).*

47. St. Luke's, for example, is able to transition to a value-based physician compensation structure because it can afford Epic, which allows it to "blend[] . . . clinical metrics into the compensation models because [it] will have reliable replicable data that a physician can look at and believe," (*Transcript at 1923:11-15 (J. Kee)*), and the WhiteCloud tools, which enable it to track physicians' performance in terms of adherence to established metrics, quality outcomes, and cost vis-à-vis other physicians and groups in the St. Luke's Clinic. *See Transcript at 1870:4-14 (M. Johnson).* Without the scale and finances to support this infrastructure, a health system could not "identify data elements that would substantiate how [it] would pay . . . quality incentives." *Transcript at 1923:20-22, 2040:19-20 (J. Kee).*

48. [redacted] *Transcript at 2600:15-2601:11 (A. Enthoven); Transcript at 2765:19-2766:1 (A. Oppenheimer).* Indeed, "successful integrated delivery systems are generally fairly large with multiple hundreds of doctors." *Transcript at 2601:10-11 (A. Enthoven).* The number of physicians reflects the correspondingly significant patient population required for a hospital system to accept risk and "ride the ups and downs of . . . that

population." *Dkt. 253 (W. Savage Dep.) at 67:19-21.* That is, risk-based contracts depend upon a significant number of patients in a population to stabilize the per capita health care costs for the population served and to absorb the disproportionate costs of outliers. *Transcript at 2269:18-2270:11 (R. Armstrong).*[3]

49. [redacted] "[I]t takes a much larger organization . . . to accept risk," particularly in terms of "human and capital resources, . . . technology, [and] expertise." *Dkt. 253 (W. Savage Dep.) at 67:13-16.*

2. A Balanced Focus on Primary Care

50. Managing care for a population also requires the proper balance of specialist and primary care providers to serve the population in question. *Transcript at 2601:12-17 (A. Enthoven); Dkt. 371 (K. Seppi Dep.) at 17:3-10.* "Primary care is the access point for . . . patients. And primary care is extremely important in developing a team-based care approach and a patient-centered medical home . . . approach." *Dkt. 371 (K. Seppi Dep.) at 20:2-11; see also Transcript at 2588:6-21, 2601:12-2602:5 (A. Enthoven).*

51. It is likewise important that an integrated delivery system have sufficient regional distribution of primary care providers to ensure convenient access to care based on patient geography. *Transcript at 2602:8-18, 2621:3-8 (A. Enthoven); see also Transcript at 1750:16-1751:4, 1763:17-21 (P. Richards)*; *Dkt. 371 (K. Seppi Dep.) at 20:24-21:2* ("it is very important

[3] For purposes of this opinion, "risk-based arrangements" are distinguished from "gain-sharing" arrangements, in which the provider has the opportunity to earn additional money based on certain criteria, but is not at risk of losing moneys already guaranteed under the contract. In a risk-based arrangement, the provider is at risk of losing money if the costs of services exceed the provider's revenue from the particular payor. *Transcript at 192:17-193:6, 396:22-397:8 (J. Crouch).* Risk-based arrangements provide greater cost-control incentives than gain-sharing arrangements. *Transcript at 396:12-21 (J. Crouch).*

that [an integrated delivery system] [has] a primary care base in all of [its] geographic locations that can act to . . . coordinate and collaborate that care.").

D. Closer Integration—Through Employing or Engaging in Exclusive Agreements with Physicians—Provides Greater Benefits Than Loose Affiliation Among Independent Physicians.

52. Significant reason exists to doubt that clinical integration would happen as well or as quickly without structural financial alignment with a number of providers and physician groups. *See Dkt. 289 (G. Fletcher Dep.) at 63:20-24, 64:1-16.* Providing clinically integrated care and managing the health of a population "takes enough physicians . . . to act as the pilot process" for change. *Dkt. 254 (G. Swanson Dep.) at 116:7-12.* Employed or financially integrated physicians are "secure in their position and they have time to set aside to work . . . on evidence-based practices." *Dkt. 289 (G. Fletcher Dep.) at 64:1-16.* Indeed, a core of employed physicians often "acts as the nidus . . . for the transformative process" required to transition to clinical integration. *Dkt. 254 (G. Swanson Dep.) at 70:9-16; see also Dkt. 371 (K. Seppi Dep.) at 15:17-17:2.* Independent physicians alone likely are unable to generate such change. *Dkt. 254 (G. Swanson Dep.) at 116:3-24.*

53. One successful and well-established integrated delivery system, Geisinger Health System, for example, employs 1,000 physicians, but also works extensively with independent physicians. *Transcript at 2619:12-14 (A. Enthoven).* Geisinger's employed physicians develop evidence-based care protocols, which Geisinger then shares with the independent physicians that affiliate with it through the Geisinger health plan. *Transcript at 2619:20-22 (A. Enthoven).*

54. Defendants' expert Dr. Alain Enthoven testified that while independent physicians are also receptive to the evidence-based protocols, they have been shown to be "slower to innovate and less effective in innovating" (*Transcript at 2620:7-11 (A. Enthoven)*) as a result of their continued reimbursement through fee-for-service business. *Id.* Unlike the

Geisinger-employed physicians, the independent physicians have "diluted incentives" to develop and adhere to the new protocols. *Id.*

55. To spur and advance clinical integration, therefore, a health system depends upon a substantial number of employed physicians to develop and test the necessary protocols and innovations attendant to that transformation. *Transcript at 2641:17-24 (A. Enthoven).* Loose, financially unstructured collaboration among independent physicians is unlikely to generate the magnitude of change required for the adoption of value- and outcome-based medicine. *Dkt. 254 (G. Swanson Dep.) at 116:3-24.*

56. Regardless of the clinical integration that may be achieved without financial integration, financial affiliation with providers strongly supports a health system's ability to (1) shift physician compensation from FFS to a model that compensates for value; and (2) shift contracts with payors from reimbursement for volumes to risk-based—and thus quality-based—agreements. *See, e.g., Transcript at 1744:25-1745:25 (P. Richards).* Looser financial arrangements "almost invariably involve fee-for-service payment," as well as the corresponding perverse financial incentives that are incompatible with improving quality and reducing cost in health care. *Transcript at 2615:13-25 (A. Enthoven).*

57. Consistent with these principles, substantial research demonstrates that health systems that use a higher percentage of employed physicians achieve better, higher-value performance than those that rely more heavily on independent physicians. *Transcript at 2616:1-18 (A. Enthoven); see also Transcript at 1635:20-1637:5, 1704:23-1705:13 (D. Pate).*

E. The Increasing Presence of Integrated Delivery Systems Offers Substantial Benefits in Reducing the Cost and Improving the Quality of Care, and Spurs Health Care Competition.

58. In regions where integrated delivery systems have a strong presence—including Minnesota and Wisconsin, where the Mayo Clinic operates, and California, where Kaiser

Permanente operates—population health care costs are materially below the national average. *Transcript at 2606:9-13 (A. Enthoven)* (health care costs per person in California are substantially below the national average); *see also Transcript at 207:3-6 (J. Crouch)* (health care costs substantially lower in California and Minnesota than in Idaho). Thus, although the formation of fully integrated delivery systems entails creation of firms that have significant market share, the result is not increased prices. *Transcript at 1417:21-1418:18 (D. Dranove)* ("We find no evidence of higher prices. If anything, integration is associated with lower prices . . . ").

59. Formation of integrated delivery systems offers a fundamentally new product: integrated, value-based care. *See Transcript at 2654:12-22 (A. Enthoven)* (distinguishing 21st century medicine from 20th century, FFS medicine); *Transcript at 3523:9-12 (K. Kizer)* (discussing a transition to integrated care as a "sea change" and "revolution"). The availability of such a product from an integrated delivery system has been shown not to inhibit competition, but to spur competition from other providers who would otherwise persist in the more fragmented, FFS paradigm, thus improving the cost and quality of care overall. *E.g., Transcript at 2607:23-2608:9 (A. Enthoven).*

60. That is why Idaho officials, the Berkeley Forum in California, the federal government, and policy experts widely agree that greater integration in health care is an unalloyed good. *See supra at ¶ 28*; *see also Transcript at 3491:2-20 (D. Dranove)*; *Transcript at 3523:9-14, 3523:20-24 (K. Kizer).*

61. In fact, health experts have concluded, in light of the success of Kaiser Permanente and other integrated delivery systems in California, which already has the high-

market-share Kaiser Permanente, that an even *greater* presence of integrated delivery systems is warranted in that state. *Transcript at 2608:18-21, 2610:2-3 (A. Enthoven).*

III. St. Luke's Has Demonstrated Its Commitment to Providing Integrated, Value-Based Care.

A. St. Luke's Mission

62. St. Luke's defines its mission as improving the health of people in its region and, for this purpose, has committed to achieving in Idaho the Triple Aim of health care: better health, better care, and lower costs of care. *Transcript at 1611:14-1612:15, 1613:12-20 (D. Pate); Transcript at 2770:16-19 (A. Oppenheimer)*; *Dkt. 289 (G. Fletcher Dep.) at 113:13-17.* As St. Luke's CEO, Dr. David Pate, explained, St. Luke's goal is to "improv[e] the health of people who are not yet patients; . . . improve[e] and coordinat[e] the care for people who are patients; and . . . lower costs," such that people experience a reduction in their insurance premiums. *Transcript at 1613:12-20 (D. Pate).* St. Luke's hopes to provide the residents of southern Idaho with accountable care, meaning care that is both cost-efficient and high-quality in terms of outcomes. *Transcript at 1624:20-23 (D. Pate).*

63. St. Luke's is pursuing its mission through four key reforms: (1) creating a clinically integrated delivery system that can deliver better care at lower cost; (2) improving community outreach in order to improve health; (3) designing a system that will provide care to everyone regardless of their ability to pay; and (4) building a business model that provides value-based reimbursement to support physicians and hospitals in their efforts to decrease low-value and no-value services that currently are revenue-generating. *Transcript at 1613:24-1614:17 (D. Pate).*

B. St. Luke's Has Already Extensively Invested its Time and Resources to Move Toward Transforming into an Integrated Delivery System that Will Provide Integrated, Value-Based Care.

1. Implementing Epic

64. St. Luke's is in the process of implementing Epic, an electronic health record that tracks, centralizes, and updates a patient's family and medical history and, in turn, improves the continuity and coordination of care the patient receives across multiple providers. *Transcript at 2796:13-2797:23 (M. Chasin).* St. Luke's selected Epic, "generally recognized at or near the top of . . . enterprise-wide patient health records systems" (*Transcript at 1918:25-1919:1 (J. Kee)*) after a year of evaluation and consideration. *Transcript at 1918:16-1919:1 (J. Kee).* St. Luke's presently has 500 providers on the system (*Transcript at 1919:6-9 (J. Kee)*) and has spent $40 million installing the EHR in its ambulatory facilities alone. *Transcript at 1920:14-17 (J. Kee).*

65. One important patient benefit that Epic facilitates is patient engagement. *Transcript at 2798:6-2799:6 (M. Chasin).* Through its patient portal, MyChart, patients enjoy secure email access to their physicians, as well as the ability to track and manage their appointments, view their lab results, and refill their prescriptions. *Id.* Patients, thus, can increase their participation in their own care, *id.*, without increasing the amount of time they need to spend in a physician's office—or incurring the costs of an office visit—to do so. *See, e.g., Transcript at 2627:10-2628:7 (A. Enthoven).*

66. Furthermore, through the Epic EHR, physicians are able to share information across specialties, creating a complete picture of the patients' treatment experiences. *Transcript at 1920:18-1922:1 (J. Kee).* Physicians can view the entire health history of a patient, including all of his lab work and radiological images, all of the contemporaneous notes physicians have made on the patient, all of the tests pending, and all of the preventative care measures outstanding. *Transcript at 2807:9-21 (M. Chasin).*

67. The Epic EHR thus reduces errors resulting from incomplete information, as well as duplicative testing, and thereby improves the quality of a patient's care and reduces overall costs by eliminating unnecessary and erroneous services. *Transcript at 1621:17-1622:19 (D. Pate)*; *Transcript at 1922:2-9 (J. Kee)*. It has substantially improved communication between providers and enhanced coordination of care, both of which result in the provision of higher-value health care. *Transcript at 1920:18-1923:1 (J. Kee)*; *Transcript at 2047:9-2048:21, 2097:7-15 (J. Souza)*; *Transcript at 2796:13-2797:12 (M. Chasin)*; *Dkt. 370 (R. Baressi Dep.) at 115:9-116:7.*

68. St. Luke's substantial investment in Epic is evidence of its commitment to integrated care. *Transcript at 2625:2-11 (A. Enthoven).*

2. Developing the WhiteCloud tools

69. Another major step evidencing St. Luke's commitment to integrated health care is its investment in the WhiteCloud analytical tools. *Transcript at 2628:8-2629:20 (A. Enthoven).* St. Luke's has spent some $15 million implementing WhiteCloud across its health system, which, drawing upon Epic data, produces St. Luke's Clinical Integration Scorecard, the Population Health Management Tool, and Quality Dashboard. *Transcript at 1866:11-1867:4 (M. Johnson); Transcript at 1940:14-1941:3 (J. Kee).*

70. The WhiteCloud tools perform data mining and reporting functions that mine the EHR for protocol compliance and outcomes information and "put it into a format that's actually usable for a physician to begin to modify behavior based on continuous feedback loops and actually seeing the results of their work that they are doing." *Transcript at 1939:22-1940:13 (J. Kee); Transcript at 2134:4-11 (B. Fortuin).*

71. One benefit of the WhiteCloud tools is the capability to generate automated order sets and practice reminders for providers that are highly valuable in providing quality care and

managing population health. *Transcript at 2150:14-2151:23 (B. Fortuin).* Physicians can organize patients into lists or registries to target specific treatments or follow-up (*e.g.*, female patients who have not had a mammogram but who should). *Transcript at 2151:9-15 (B. Fortuin).* These patient registries also enable physicians to quickly identify those members of the population who could benefit from specific wellness initiatives, such as focused diabetes care. *Transcript at 1944:1-5, 1953:18-1956:20 (J. Kee).*

72. WhiteCloud also measures the quality achieved by individual physicians and physician groups according to the evidence-based metrics that St. Luke's has developed. *See Transcript at 2135:9-2136:4, 2146:3-2147:21 (B. Fortuin).* The technology allows St. Luke's to objectively track clinical measures per physician and, consequently, to identify and reduce variance in treatment. *Transcript at 1866:16-1868:7 (M. Johnson); Transcript at 2137:6-2140:7 (B. Fortuin).*

73. Physicians can also compare their individual scores to those of their fellow physicians in their specialty as a form of peer review, without the need for a report to be provided to them. *Transcript at 1867:5-23 (M. Johnson); Transcript at 2136:11-2137:5, 2142:23-2143:23 (B. Fortuin).*

74. Additionally, WhiteCloud allows St. Luke's to compare the frequency of procedures and the cost-per-case of different physicians for a given procedure, which allows the leadership to identify underlying cost and outcome variance and better manage overall costs. *Transcript at 1942:14-1943:4, 1946:4-1948:6, 1950:21-1951:13 (J. Kee); Transcript at 2628:14-20 (A. Enthoven).*

75. WhiteCloud also permits St. Luke's to track its costs for those patients for whom St. Luke's has accepted full risk. The capacity to gauge and monitor these costs dramatically

enhances St. Luke's ability to expand its acceptance of risk for patient care and outcomes going forward. *Transcript at 1866:11-15, 1867:2-4 (M. Johnson).*

3. Physician-led management structure

76. St. Luke's has embraced a physician-led management structure, which further advances its efforts to create an integrated delivery system. *Transcript at 1862:10-17 (M. Priest)*; *Transcript at 2112:2-7 (J. Souza)*; *Transcript at 2625:2-8, 14-16 (A. Enthoven).*

77. St. Luke's System Clinical Leadership Council, for example, is a management body comprising the division medical directors of the St. Luke's Clinic that represent St. Luke's various geographic regions and subspecialties. *Transcript at 1863:5-12 (M. Johnson); Transcript at 2132:15-25 (B. Fortuin).* The Clinical Leadership Council is responsible for communicating key integration decisions and protocols to medical managers in each of St. Luke's individual clinics and, reciprocally, for receiving and evaluating physician concerns as they relate to those protocols and clinical integration overall. *Transcript at 2133:4-24 (B. Fortuin).*

78. Dr. Mark Johnson, for example, divides his time evenly between treating patients as a family medicine provider and serving as Division Medical Director for Family Medicine in Treasure Valley. *Transcript at 1859:20-24 (M. Johnson).* In the latter role, he leads 15 family medicine clinics and 70 family medicine providers in the Treasure Valley. *Transcript at 1862:23-1863:4 (M. Johnson).* As a Division Medical Director, he also sits on St. Luke's System Clinical Leadership Council. *Transcript at 1863:5-12 (M. Johnson).* In short, he is both a practicing physician and integrally involved in executing St. Luke's vision of care across its system. *Id.; Transcript at 1872:15-1873:2 (M. Johnson).*

79. Dr. Brian Fortuin, a practicing internist (*Transcript at 2123:4-7 (B. Fortuin)*) is also a member of St. Luke's System Clinical Leadership Council, as well as the Chair of the

Magic Valley Physician Leadership Council. *Transcript at 2129:2-12 (B. Fortuin)*. In the latter role, he is involved in establishing and reviewing evidence-based protocols, managing the system's IT infrastructure and capabilities, and evaluating physicians' progress toward achieving the Triple Aim. *Transcript at 2129:13-2131:12 (B. Fortuin)*.

80. By making physicians stakeholders in management, as well as practitioners of health care, St. Luke's has put a management structure in place that is likely to facilitate physician commitment and buy-in to St Luke's clinical integration aims. *See Transcript at 2631:1-21 (A. Enthoven)*.

4. Risk-based contracting

81. St. Luke's dedication to integrated care is further evidenced by its ongoing efforts to increase the number of patients for whom it accepts risk—that is, to expand its risk-based contracting. *Transcript at 2631:22-2632:9 (A. Enthoven)*. St. Luke's has stated that its goal is to be ready to accept full-risk—both upside and downside—on all of its contracts by 2015. *Transcript at 1629:14-19 (D. Pate)*. St. Luke's already participates in a full risk-based contract with BCI for its Medicare Advantage product. *Transcript at 398:11-399:9 (J. Crouch)*; *Transcript at 2632:3-6 (A. Enthoven)*; *Dkt. 322 (S. Drake Dep.) at 104:9-24.*

82. On the commercial side, St. Luke's was the first system to embrace the "total cost of care" concept with Regence Blue Shield ("Regence") (*Dkt. 395 (S. Clement Dep.) at 62:22-63:19*),

83. Most notable among St. Luke's accomplishment in terms of risk-based arrangements with commercial payors is its partnership with SelectHealth in Idaho. *Transcript at 2632:7-9 (A. Enthoven); Dkt. 322 (S. Drake Dep.) at 105:24-106:1.* SelectHealth, a subsidiary of Intermountain Healthcare (*Transcript at 1719:9-11 (P. Richards)*) is an insurance carrier that began marketing its products in the Idaho health care insurance market in late 2012. *Transcript at 1725:10-18, 1747:12-21 (P. Richards).* The Idaho insurance product it launched in collaboration with St. Luke's will ultimately be St. Luke's first full risk-based contract with a commercial payor. *Transcript at 2773:2-23 (A. Oppenheimer); see also Transcript at 1630:20-1631:12 (D. Pate).*

84. St. Luke's effort to bring SelectHealth to the Idaho insurance market has injected competition into that market. Patricia Richards, President and CEO of SelectHealth, testified that, as a result of SelectHealth's entry into Idaho, other insurers in the market are "sharpen[ing] their pencil in terms of premiums for customers," and certain customers have decided to stay with their current insurance carrier over SelectHealth only after their current carrier reduced its premiums to compete. *Transcript at 1760:3-20 (P. Richards).*

85. [redacted] St. Luke's efforts, thus far, appear to be working, with PacificSource beginning to market a risk-based model of insurance for its health insurance exchange product (*Dkt. 322 (S. Drake Dep.) at 107:2-9*)[redacted]

86. SelectHealth's entry into the Idaho market has introduced competition, whereby insurance carriers will need to compete for customers by offering superior service, a network of providers that are attractive to purchasers (*e.g.*, employers), and, most importantly, a competitive premium. *E.g., Transcript at 1808:6-22 (W. Deal).*

87. There is evidence that this is already occurring. For example, when Oppenheimer Companies was selecting an insurer for its employee health plan, it ultimately chose Blue Cross over SelectHealth because, in order to compete against SelectHealth and win Oppenheimer Companies' business, Blue Cross significantly lowered its pricing to compete with SelectHealth's offer. *Transcript at 2776:4-2777:10 (A. Oppenheimer).*

5. Transition to value-based compensation

88. St. Luke's has begun changing the way in which its affiliated physicians are compensated to fully align their financial interest with the Triple Aim. St. Luke's investment in Epic and WhiteCloud has given it the means to track data showing the quality of care, which has enabled it to begin engaging with physicians to develop compensation models that incorporate quality metrics. *Transcript at 1923:2-15 (J. Kee).* Thus, with the technological infrastructure described above now in place, St. Luke's has begun transitioning its physicians to value-based compensation. *Transcript at 1923:16-22 (J. Kee).* Three specialties in the health system, cardiology, pulmonary care, and internal medicine, already have begun to transition toward having a significant component of their total compensation based on compliance with quality metrics (*Transcript at 1868:22-1869:8 (M. Johnson); Transcript at 1923:16-19 (J. Kee)*):

a) St. Luke's cardiologists are in the second year of a new compensation system in which each of the cardiologists receives a fixed salary that is approximately 70 percent of their prior income, with the remainder of their income fully at risk

based primarily on quality outcomes. *Transcript at 1829:18-1830:4, 1843:18-21, 1854:15-18 (M. Priest).*

b) St. Luke's pulmonologists have adopted a compensation model under which each physician receives a base salary that accounts for two-thirds of his total pay, and one-third compensation is tied to quality outcomes. *Transcript at 2057:8-14 (J. Souza).*

c) In internal medicine, 20 percent of each physician's compensation is now based on variable compensation tied to earned outcomes. *Transcript at 1923:23-1924:4 (J. Kee).*

d) Additionally, family practice medicine physicians within St. Luke's clinics have begun discussions of how to include a larger quality component in their compensation as well. *Transcript at 1869:9-16 (M. Johnson).* St. Luke's pediatric gastroenterology and endocrinology physicians have begun their transition to quality-based compensation, as well. *Transcript at 2252:17-2253:1 (C. Roth).*

89. St. Luke's goal is to transition all of its specialties to this new compensation structure within two to three years (*Transcript 1924:17-1925:4 (J. Kee)*) and, within three years, to tie 100 percent of a physician's incentive compensation to quality outcomes. *Transcript at 1830:1-4, 1854:15-18 (M. Priest).*

90. St. Luke's demonstrated efforts to move physicians toward compensation structures based on value offers another example of St. Luke's commitment to moving toward providing integrated, value-based care.

6. Use of evidence-based care to benefit population health

91. In recent years, St. Luke's has engaged in a variety of programs and initiatives designed to promote the use of evidence-based, high-value care to improve the health of the regional population that it serves.

a. Initiatives providing high-value, evidence-based care

i. COPAR initiative

92. St. Luke's has invested in its "Care of Patients at Risk," or COPAR, program. It is well recognized that the sickest 5 percent of patients give rise to more than 50 percent of the costs of patient care. *Transcript at 2634:12-14 (A. Enthoven)*. St. Luke's COPAR program is designed to coordinate and manage care for these individuals. *Transcript at 1927:24-1928:3 (J. Kee)*. The program uses health data to predictively model those patients at risk of moving into a high-cost disease state, requiring expensive care and increasing the likelihood of adverse results. *Transcript at 1926:24-1927:8 (J. Kee)*. The nurse care coordinators working with the program offer intensive care to these patients on an outpatient basis in an attempt to maintain the patients' health and avoid the need for higher-cost care. *Transcript at 1927:9-1928:3 (J. Kee)*.

93. COPAR aims both to improve the quality of care for these patients and to reduce the cost of care. COPAR nurses are each assigned to 125 to 150 patients and provide very specific coordination of those patients' care with the intent of keeping their quality of life as good as it can be, and keeping them in a low-cost setting. *Transcript at 1929:1-7 (J. Kee)*. Nurses assist them with basic health requirements (such as refilling prescriptions), as well as helping to coordinate the patients' family and social support, in order to maintain the patients' health and quality of life, to allow them to stay in their homes, and to avoid the need for costly intervention. *Transcript at 1928:17-1929:16, 1930:5-15 (J. Kee)*.

94. The COPAR initiative is directly contradictory to the interests of providers in a FFS setting. *Transcript at 2635:10-19 (A. Enthoven).* When patients come to the emergency room or seek intensive care under FFS compensation, that increases physicians' and hospitals' revenue. *Transcript 1929:24-1930:2 (J. Kee).* St. Luke's investment in COPAR, which attempts to *decrease* patients' use of treatment that is highly reimbursed under a FFS system, demonstrates its commitment to movement toward higher-value, outcomes-based care. *Transcript 1929:24-1930:4 (J. Kee).*

ii. YEAH!

95. St. Luke's presently runs a community outreach program called "Youth Engaged in Activities for Health," or "YEAH!". *Transcript at 1616:15-19 (D. Pate).* YEAH! targets children ages 5 to 16 that are in the 95th or greater percentile of their expected body weight. *Transcript at 1616:20-22 (D. Pate).* The program, among other tactics, connects these children and their families with a nutritionist who takes them to a grocery store and teaches them how to read labels and make healthy choices. *Transcript at 1616:24-1617:3 (D. Pate).* The children also meet with social workers and nurses and are involved in physical activities. *Id.* The goal of YEAH! is to intervene before these children develop diabetes or other diseases associated with obesity and to teach them how to lead healthier lifestyles. *Transcript at 1615:11-1616:19 (D. Pate).*

96. St. Luke's does not make money on its YEAH! program. *Transcript at 1617:23-1618:3 (D. Pate).* It funds this program, as well as its smoking cessation efforts and its high school sports concussion programs (*Transcript at 1618:7-1619:7 (D. Pate)*), with some grants, but largely as a charitable investment in the community without reimbursement. *Transcript at 1617:24-1618:3 (D. Pate).*

iii. Humphreys Diabetes Center

97. St. Luke's has made a serious investment in treating and preventing diabetes. St. Luke's has deployed a team of 16 diabetes educators into clinics throughout Treasure and Magic Valleys to work with both physicians and patients to help to coordinate diabetes care. *Transcript at 1932:2-1933:6 (J. Kee).* Diabetic patients are monitored in a system-wide diabetes registry. *Transcript 1953:24-1954:2 (J. Kee).* And primary care physicians in St. Luke's system are given tools to track their individual patients' outcomes on measures relevant to diabetes care, such as hemoglobin A1c, through the WhiteCloud data analytics tools. *Transcript 2137:23-2138:16 (B. Fortuin).*

98. These investments in diabetes education and prevention are not consistent with increasing FFS reimbursement, but advance St. Luke's mission of improving population health and achieving the Triple Aim. *Transcript at 1933:24-1934:4 (J. Kee).*

b. Improvements in evidence-based care achieved by previously independent physicians now affiliated with St. Luke's

99. As demonstrated below, affiliation with St. Luke's directly enabled previously independent physicians to offer higher-value care to patients.

i. Idaho Cardiology Associates

100. Idaho Cardiology Associates ("ICA") is a formerly independent physician practice that affiliated with St. Luke's in October 2007. *Transcript at 1825:21-1826:3, 1826:20-24 (M. Priest).* The ICA cardiologists, working in conjunction with other physicians at St. Luke's Idaho Cardiology, have developed a congestive heart failure clinic to promote better health in the community by closely managing the population of high-risk congestive heart failure patients. *Transcript at 1834:5-1835:8 (M. Priest).* The congestive heart failure clinic is staffed with five mid-level providers (physician assistants and nurse practitioners) and two "nurse

navigators" who make recurring home visits to monitor at-risk patients. *Transcript at 1834:15-1835:4 (M. Priest).* The clinic is not profitable. *Transcript at 1835:12 (M. Priest).* According to Dr. Priest, "were [ICA] a private practice group, there would have been no way [it] could have afforded to do this." *Transcript at 1835:12-14 (M. Priest).*

101. The congestive heart failure clinic is sustainable only because St. Luke's has the financial resources to perform the following: (1) pay travel costs to unite clinic providers every month to help identify high-risk patients; (2) incentivize and sufficiently compensate Dr. Chai, the clinic's director, to shift his focus from a lucrative private practice to run the clinic full-time; and (3) support five mid-level providers who are "completely devoted to the management of patients with congestive heart failure." *Transcript at 1834:15-1836:4 (M. Priest).*

102. Since affiliating with St. Luke's, ICA has also worked to implement protocols to reduce the crucial "door-to-balloon time" for heart attack patients. *Transcript at 1855:24-1856:15 (M. Priest).* A shorter door-to-balloon time is better for the health of the patient. *Transcript at 1856:23-25 (M. Priest).* St. Luke's was unable to convince an independent group of practitioners to adopt the protocols aimed at reducing door-to-balloon times, and in cases involving those independent practitioners, the door-to-balloon time was 20-40 minutes longer than it was for the St. Luke's employed physicians who followed the protocols. *Transcript at 1856:16-23 (M. Priest).* The cardiologists employed by St. Luke's have been able to reduce the door-to-balloon time to an average of approximately 48 minutes using the above-mentioned protocols, compared to a national standard of 90 minutes. *Transcript at 1856:8-9, 1857:6-13 (M. Priest).*

ii. Idaho Pulmonary Associates

103. St. Luke's acquired the assets of Idaho Pulmonary Associates (now "SLIPA") in 2010. Subsequent to affiliation with St. Luke's, the IPA physicians have participated in and

benefited from a number of internal innovations that the group could not have achieved as an independent practice. *Transcript at 2059:10-15, 2062:4-2063:2 (J. Souza).*

104. One such innovation is the establishment of the eICU system, a coordination of "hardware, software, and people" that allows intensivists to constantly monitor critically ill patients remotely from a central location. *Transcript at 2059:20-2061:23 (J. Souza).* The eICU system serves "like air traffic control" for intensivists, allowing for the elimination of redundant intermediary steps in treating patients for time-sensitive issues. *Transcript at 2060:20-2061:11 (J. Souza).* Implementation of the eICU system has caused patient length of stay and mortality rate to decrease. *Transcript at 2065:19-22 (J. Souza).* St. Luke's program is the first successful implementation of an eICU in Idaho. *Transcript at 2103:20-25 (J. Souza).* Although IPA considered supporting a system like eICU prior to the affiliation with St. Luke's, the financial requirements—having trained physician and nursing staff working around the clock—and loss of FFS revenue associated with its use caused the group to oppose its implementation. *Transcript at 2061:20-2062:8, 2063:1-2 (J. Souza).*

105. The lung nodule clinic is another example of a program that improved quality while reducing cost that was initiated by St. Luke's following the affiliation of IPA physicians. *See generally Transcript at 2079:6-2082:2 (J. Souza).* Prior to affiliation, reviewing "lung nodules" or "lung spots" as indicated in a CAT scan was a significant source of revenue for IPA because it was reimbursed on a FFS basis by commercial payors. However, according to Dr. Souza, it was a relatively "low-value service to the patient." *Transcript at 2079:6-2080:24 (J. Souza).* Subsequent to affiliation with St. Luke's, IPA physicians were encouraged to create and initiate innovations that could improve quality and lower the cost of care. *Transcript at 2081:1-10 (J. Souza).* As part of St. Luke's, the IPA physicians identified evaluation of lung nodules as

an opportunity to add value, so they created the lung nodule clinic, which has resulted in a 75 percent decrease in patients needing follow up care with a pulmonologist. *Transcript at 2079:6-2082:2 (J. Souza).* Dr. Souza testified that IPA could not and would not have created the clinic on its own because it could not have afforded to sacrifice the "six figures" in lost FFS revenue. *Transcript at 2082:3-6 (J. Souza).*

106. Subsequent to affiliation, the IPA physicians have also played a major role in reducing costs and improving care in connection with treatment for sleep apnea, creating new "pathways" to encourage eligible patients to seek out-of-center sleep tests or "split studies," rather than traditional sleep center studies. Choosing to have one of these alternative studies results in fewer hospital visits and greatly reduced commercial payor reimbursements. *Transcript at 2082:11-2084:2 (J. Souza).* The sleep apnea quality improvements have resulted in clinical benefits for St. Luke's patients and financial benefits to the payors through reduced reimbursements, in large part due to the greater flexibility of the doctors who, according to Dr. Souza, are now "immune to the financial impact . . . and set free to find the waste in the system[.]" *Transcript at 2082:11-2084:12 (J. Souza).* According to Dr. Souza, IPA could not have initiated the sleep apnea quality improvements on its own because to do so would have resulted in an unsustainable loss of approximately $650,000 in FFS revenue. *Transcript at 2083:25-2084:2 (J. Souza).*

107. As part of St. Luke's, the IPA physicians have also worked together with other St. Luke's physicians to develop quality initiatives to reduce group C sepsis—a condition resulting in a high mortality rate. Those internal, "team-based care" initiatives have resulted in annual improvement in perfect care rates for group C sepsis patients. *Transcript at 2077:13-2079:4 (J. Souza).* This is true despite the fact that IPA did not meet its target on this measure for last year.

Transcript at 2107:6-2108:2 (J. Souza). In fact, Dr. Souza testified that St. Luke's and IPA have intentionally set "very aggressive" group C Sepsis targets that are "difficult to achieve," in order to encourage physicians to "continuously improve." *Transcript at 2119:21-2120:24 (J. Souza).*

IV. The Changing Market Dynamics in the Treasure Valley

108. The structural changes taking place nationwide, and in Idaho through the efforts of St. Luke's, have not gone unnoticed by Saint Alphonsus, nor by payors and employers putting together physician networks. Indeed, as has taken place in other markets in which integrated delivery systems have formed (*see supra* at Section III), participants in the market for health care services in southern Idaho have reacted to St. Luke's efforts by accelerating the development of their own systems to compete more effectively with St. Luke's.

A. Competition in the Treasure Valley Between the Saint Alphonsus and St. Luke's Health Systems

109. The evidence and testimony presented in this case make clear that the Boise area is characterized by two large health care delivery systems: St. Luke's Health System and Saint Alphonsus Health System. Competition between these two integrated systems is intense.

110. [redacted]

111. Likewise, Arthur "Skip" Oppenheimer, a member of the St. Luke's Health System Board, testified that "there is heavy, serious competition between Saint Al's and St. Luke's,

which has an impact on the ability for anybody to raise prices, Saint Al's or St. Luke's, beyond some level." *Transcript at 2769:2-9, 2786:8-15 (A. Oppenheimer).*

112. St. Luke's CEO, Dr. David Pate, testified that "Saint Alphonsus is a very strong competitor. And I like that because, frankly, they push us to be better and I think we push them to be better." *Transcript at 1650:10-12 (D. Pate).*

1. Saint Alphonsus has followed St. Luke's in transitioning from volume to value and increased its directed contracting efforts to compete vigorously against St. Luke's.

113. [redacted]

114. Both Saint Alphonsus and St. Luke's recognize that preparing for the new health care environment requires developing new arrangements with payors, the need to work closely with a base of employed physicians, and the need also to work with independent physicians. *Transcript at 2896:11-2897:23 (D. Argue); Exhibit 2526.*

115. [redacted]

116. [redacted]

117. [redacted]

118. [redacted]

2. Both systems have increased their employment or PSA relationships with physicians to prepare for upcoming health care changes.

119. Over the last several years, physicians have increasingly sought to become employed by, or closely affiliated with, health systems in response to the changing health care environment. It is becoming increasingly difficult for independent practices to recruit physicians to this marketplace because new physicians increasingly want that closer affiliation with health systems, rather than working in independent practices. *Transcript at 2049:12-15 (J. Souza); Transcript at 2391:4-15 (J. Kaiser).*

120. [redacted]

121. Sally Jeffcoat, Saint Alphonsus's CEO, wrote in 2011, "It is my opinion that many of the employment moves have happened because physician groups were motivated to prepare for health reform, contractually protecting anticipated income reductions (proposed by Medicare) through multi-year contracts" and "also by the desire to partner with hospitals to implement the infrastructure (IT, care coordination, standardization) required for ACOs and to meet meaningful use requirements." *Exhibit 2232 at 1.*

122. Saint Alphonsus made a proposal to affiliate with Saltzer physicians and informed Saltzer that "a more formal alignment would accelerate these possibilities [of increasing the collaboration and partnership between the entities] and facilitate development of a solid integrated model of health care delivery." *Exhibit 2227 at 2.* In proposing a PSA arrangement similar to the St. Luke's PSA proposal to Saltzer, Saint Alphonsus described one the benefits of that arrangement as the "[a]bility for Saltzer and SAHS to develop a strong physician integration

partnership." *Id. at 11.* Although Saint Alphonsus offered alternative arrangements to Saltzer, Saint Alphonsus identified the fully integrated model as providing the greatest benefits. *Id. at 6-11.*

123. This evidence undermines Saint Alphonsus's position at trial that there are no benefits to be achieved from employing physicians that cannot be achieved through looser affiliations. Saint Alphonsus's actions and statements acknowledge that there are clinical benefits to close affiliation with physicians through employment or PSA arrangements.

124. [redacted]

B. Payors and Employers in the Treasure Valley Have Also Recognized the Need to Transition from Broader to Narrower Networks, and Have Accelerated Those Efforts in Response to SelectHealth's Entry in the Market.

125. In the Treasure Valley and nationally, the development and use of narrow network products has been growing. *Transcript at 2902:21-24 (D. Argue); Exhibit 2230; Exhibit 2526.*

126. In return for being the exclusive provider in a narrow network, or for financial incentives that encourage enrollees to use one in-network provider versus other in-network providers, the exclusive or preferred provider will offer a reduced rate to the payor. The reduced rates result in lower costs to the health plan, and in turn, lower premiums and out-of-pocket costs for enrollees. *Transcript at 2903:6-16 (D. Argue); see Dkt. 373 (G. Sonnenberg Dep.) at 32:22-33:12.* The reason the exclusive or preferred provider is willing to offer a discount is because of the expectation that a more limited network (or incentives to use the provider) will result in channeling of patient volume to the provider. *Transcript at 2903:3-5 (D. Argue); Exhibit 2536.*

127. Tiered networks offer both narrow and broad networks to enrollees, and the enrollee can choose whether to select a provider in the narrow or the broad network at the point of service. The cost to the enrollee will depend on which tier provider he or she visits. *Transcript at 2903:21-2904:3 (D. Argue).*

128. Health plans use narrow networks and tiered networks to influence which providers patients choose. *Transcript at 2904:7-9 (D. Argue).*

129. [redacted]

130. [redacted]

131. IPN has been having discussions about tiered products where Saint Alphonsus would be at a preferred tier and IPN (and St. Luke's) would only be in network at a secondary tier. *Transcript at 485:4-12 (L. Duer).* Paul's Market, which has employees in Nampa, has entered into such an arrangement with IPN. *Id.* Various other networks in Idaho have also succeeded in excluding St. Luke's from the network, including the Saint Alphonsus Health Alliance, First Choice, and Micron. *Transcript at 484:17-485:12 (L. Duer).*

132. [redacted]

V. The Saltzer-St. Luke's Affiliation

A. The Terms of the Professional Services Agreement Between Saltzer and St. Luke's

133. On December 31, 2012, Saltzer and St. Luke's executed a Professional Services Agreement. *Exhibit 24*. [redacted]

134. [redacted]

135. [redacted]

136. The PSA also provides, at Section 2.2(a), that "all Saltzer physicians may have privileges at any hospital and may refer patients to any practitioner or facility regardless of its affiliation with St. Luke's." *Exhibit 24 at 2.2(a).* The parties to the PSA uniformly interpret that provision to mean that Saltzer physicians have complete freedom to refer patients wherever they choose. *Transcript at 773:10-20 (N. Powell); Transcript at 1958:16-1960:2 (J. Kee); Transcript at 2241:9-2242:1 (C. Roth); Transcript at 2387:13-24 (J. Kaiser).*

137. Saltzer physicians currently have a guaranteed salary with additional compensation based on RVUs. *Transcript at 3321:3-6 (T. Patterson).* A plan to implement quality-based incentives was referenced in the PSA, but specific quality incentives were not built into the contract at the outset because, according to Dr. Patterson, "it takes time to develop what the outcome measures would be, and so it wasn't something that could be established at the time." *Transcript at 3327:4-10 (T. Patterson).* However, compensation for the Saltzer physicians is expected to include quality-based incentives in the future. *Transcript at 3326:19-3327:3 (T. Patterson).* Indeed, Saltzer and St. Luke's have amended their initial PSA to include an addendum that provides for up to 20 percent of Saltzer's compensation being put at risk or otherwise tied to quality-based incentives. *Exhibit 2624; Transcript at 3327:11-17 (T. Patterson).*

138. The compensation for Saltzer physicians was set in accordance with what St. Luke's pays its physicians in the same specialties across the Treasure Valley in order to have equity in compensation across the St. Luke's organization. *Transcript at 2249:19-2250:7 (C.*

Roth). As per its practice when making new hires, St. Luke's hired an independent third party to evaluate the compensation arrangements with the Saltzer physicians. *Transcript at 2250:8-16 (C. Roth)*. That third party found that the Saltzer compensation was within the limits of fair market value. *Exhibit 1977 at 10* ("Given the analysis, Grant Thornton believes that the proposed compensation program for the family practice physicians is within fair market value standards and reasonable."). [redacted]

139. Compensation for the Saltzer physicians, as for all physicians at St. Luke's, is "payor blind," meaning the Saltzer physicians are paid the same amount to treat a patient regardless of whether or not that patient is on commercial insurance, Medicare, Medicaid or uninsured. *Transcript at 3322:25-3323:10 (T. Patterson); Transcript at 2250:1-7 (C. Roth); Transcript at 788:11-17 (N. Powell); see also Exhibit 24 at § 1.5* ("Saltzer agrees to participate in St. Luke's programs to provide charity care… Saltzer Physicians shall not discriminate against patients based on their ability to pay.").

140. Compensation for the Saltzer physicians is *not* tied in any way to where they make referrals, nor is it tied to the volume or revenue generated by Saltzer physicians for ancillary services, such as laboratory or imaging services. *Transcript at 3327:18-3328:3 (T. Patterson); Transcript at 3081:23-3082:4 (W. Savage); Dkt. 270 (R. Page Dep.) at 106:23-107:1.*

B. Saltzer's Decision to Affiliate With St. Luke's Was the Result of a Lengthy and Well-Considered Analysis of the Future of Health Care and the Benefits to be Achieved Through Such an Affiliation.

1. Background on Saltzer's consideration of a closer affiliation with a larger health care system and its prior unsuccessful efforts to coordinate care under less formal affiliations

141. For years before the transaction with St. Luke's, physician leadership at Saltzer was acutely aware of the changing landscape of health care in regard to the increasing importance of integrated services in reducing cost and providing better overall care. *Transcript at 2371:16-2372:7 (J. Kaiser); see also Transcript at 808:2-7 (N. Powell).*

142. Saltzer physicians were concerned that the traditional fee-for-service reimbursement model was no longer sustainable and that they needed to explore transitioning to a value-based compensation model. *Transcript at 3344:18-24 (H. Kunz); see also Dkt. 253 (W. Savage Dep.) at 65:25-66:21.*

143. Saltzer believed that it needed to upgrade its medical record system and health information technology to keep pace with the industry, but could not afford to do so without partnering with a larger system. *Transcript at 3344:5-17 (H. Kunz).*

144. Prior to making the decision to join St. Luke's, Saltzer made attempts to coordinate care with other health systems under less-formal affiliations. For example, Saltzer worked with the Mercy Medical Center (the former name of what is now Saint Alphonsus-Nampa) in an attempt to coordinate limited services. None of those projects came to fruition due to an unwillingness to participate on the part of Mercy's out-of-state parent, Catholic Health Initiatives ("CHI"). *Transcript at 2372:8-14, 2374:8-15 (J. Kaiser).* After Saltzer's negative experience with Mercy and CHI, Saltzer determined that in order to work effectively towards a solution it would need a local partner in the Idaho community. *Transcript at 2374:8-16 (J. Kaiser).*

145. In December of 2008, Saltzer and St. Luke's executed a memorandum of understanding ("MOU") establishing an informal partnership to begin more deliberate and focused efforts around a series of joint initiatives aimed at improving access to high quality medical care, enhancing coordination of medical services, and streamlining the health care delivery model in Ada and Canyon Counties. *Transcript at 2225:18-25, 2226:22-2227:13 (C. Roth); Exhibit 2196.* The MOU also outlined five core areas of improvement sought to be achieved by the informal alignment. *Transcript at 2227:18-23 (C. Roth).*

146. Although the parties made some progress in the five areas (*Transcript at 2228:2-15 (C. Roth)*), and Saltzer physicians such as Dr. Kaiser testified that the relationship succeeded in getting the parties "finally talking about" integration, the parties did not get "a whole lot of things accomplished" (*Transcript at 2373:8-11 (J. Kaiser)*), and what limited success was achieved often took years to develop. *Transcript at 2227:24-2228:15 (C. Roth).*

147. Saltzer also participated in a looser affiliation called the Treasure Valley Health Network, a partnership among Saltzer, Saint Alphonsus-Nampa, and Terry Reilly Clinic. That partnership, however, did not result in any sharing of data or management of patients, nor did it otherwise serve as a vehicle to improve the coordination of health care services. *Transcript at 2376:23-2378:15 (J. Kaiser).*

2. Saltzer's negotiations with St. Luke's regarding a closer affiliation

148. Saltzer hired a consulting firm, the Coker Group ("Coker"), to advise on its decision to affiliate with a larger health system. *Dkt. 271 (M. Reiboldt Dep.) at 15:2-16:19.* Coker advised Saltzer that it needed to find a major partner or risk breaking apart or potentially "implod[ing]." *Id. at 77:5-20.*

149. In 2009, Saltzer initiated discussions with St. Luke's regarding a closer affiliation. *Transcript at 2228:20-2229:13 (C. Roth); Transcript at 3345:9-10 (H. Kunz); Transcript at 3081:17-22 (W. Savage).*

150. Negotiations between Saltzer and St. Luke's progressed over approximately three years (*Transcript at 2237:18-22 (C. Roth)*) and "evolved significantly" during that time. *Transcript at 1712:8-11 (D. Pate).*

151. One issue that delayed the negotiations between the parties was that a number of the Saltzer surgeons maintained ownership interests in Treasure Valley Hospital. St. Luke's expressed concern during negotiations that these ownership interests would have a tendency to serve as obstacles to the sort of clinical, strategic, and financial alignment that St. Luke's sought with Saltzer. *Transcript at 2243:21-2244:25 (C. Roth).*

152. Another basis for St. Luke's concern with respect to the surgeons' ownership in TVH was their prior relationship with another surgical center in Nampa. *Transcript at 2244:11-25 (C. Roth).* Before TVH opened, the surgeons did the majority of their outpatient surgeries at a surgery center called Ambucare, which was located in Nampa. *Dkt. 394 (N. Powell Dep.) at 329:3-10.* After the surgeons were given the opportunity to invest in TVH, however, they moved all of their surgeries to TVH in Boise, and the Ambucare surgery center in Nampa was forced to close. *Dkt. 394 (N. Powell Dep.) at 329:21-330:11.*

153. Nevertheless, St. Luke's did not insist that the Saltzer physicians with ownership interests in TVH sell those interests. *Transcript at 2245:1-6 (C. Roth).* Rather, St. Luke's made both an exclusive offer and a nonexclusive offer to the Saltzer physicians. *Transcript at 771:23-772:3 (N. Powell).* The exclusive offer required the Saltzer surgeons who had ownership interests in the Treasure Valley Hospital to sell those interests; the nonexclusive offer allowed

those Saltzer surgeons with ownership interests in the Treasure Valley Hospital to retain their ownership. *Transcript at 772:4-11 (N. Powell).* In recognition of the fact that those physicians would be allowed to retain a personal investment in a competing surgery center, and as a reflection of the fact that they were expected under such an arrangement not to dedicate the same time and energy to improving the system at St. Luke's as were the other Saltzer physicians without such outside ownership interests, the nonexclusive offers contained lower compensation than the exclusive offers and restricted the surgeons from holding certain administrative positions at St. Luke's. *Transcript at 2245:7-24 (C. Roth).*

154. Drs. Andrew Curran and Steven Williams, formerly Saltzer surgeons, now at Saint Alphonsus, testified that no one from St. Luke's ever told them that the surgeons had to pull out of Saint Alphonsus-Nampa, that they could no longer perform surgeries at TVH, or that they could not make referrals where they wanted; rather, St. Luke's was only concerned with the surgeons' *ownership* in TVH. *Dkt. 393 (A. Curran Dep.) at 106:17-107:6; Dkt. 396 (S. Williams Dep.) at 111:10-13, 112:3-10; see also Transcript at 2245:25-2246:7 (C. Roth).* Nevertheless, in October 2012, the Saltzer surgeons resigned from Saltzer and entered into PSAs with Saint Alphonsus effective in November. *Exhibit 2022.*

3. Saltzer's decision not to affiliate with Saint Alphonsus

155. In late 2011, in the midst of Saltzer's negotiations with St. Luke's, the Saltzer surgeons advocated to obtain a proposal for affiliation from Saint Alphonsus. *Transcript at 2239:24-2240:5 (C. Roth); Dkt. 394 (N. Powell Dep.) at 327:13-17; Exhibit 2010.*

156. Saltzer had a "longstanding history of distrust" of Saint Alphonsus. *Transcript at 152:6-11 (M. Reiboldt).* Dr. Williams testified that the former CEO of Saint Alphonsus told Saltzer during an earlier attempt to affiliate with Saltzer that if Saltzer did not affiliate with Saint Alphonsus, Saint Alphonsus was going to drive Saltzer out of business. According to Dr.

Williams, this caused many Saltzer physicians (including himself) to express serious concerns about working with Saint Alphonsus. *Transcript at 2511:17-24 (S. Williams).*

157. In January 2012, Saint Alphonsus made an offer to affiliate with Saltzer. Despite the fact that the financial terms of that offer were "virtually identical" to those offered by St. Luke's (*Transcript at 3348:1-6 (H. Kunz); see also Transcript at 767:24-768:3 (N. Powell)*), Saltzer rejected the Saint Alphonsus offer for at least several reasons.

158. Initially, Saltzer did not believe that Saint Alphonsus shared its vision of moving towards a value-based care model. *Transcript at 3348:7-14 (H. Kunz).*

159. Saltzer also felt that St. Luke's was generally more receptive to Saltzer's input as a "valued partner" in the negotiations than was Saint Alphonsus. *Transcript at 3348:15-18, 3350:13-21 (H. Kunz).* Indeed, plaintiffs have repeatedly cited a letter from Dr. Randell Page of Saltzer to his partners in which one of the reasons Dr. Page lists for advocating in favor of affiliating with St. Luke's is that St. Luke's "responded to every one of our concerns. They are offering a wonderful opportunity to control and co-develop-services in Canyon County." *Exhibit 1366.* While plaintiffs want this Court to read that letter as suggesting that the affiliation between Saltzer and St. Luke's would somehow permit Saltzer to kick out all other providers from Canyon County and "control" the entire market, this Court accepts Dr. Page's more reasonable explanation that he meant that "Saltzer would be in a position to have input into our own future in the decision-making process" as St. Luke's developed services in Canyon County. *Transcript at 2865:23-2866:8 (R. Page).*

160. Additionally, the initial Saint Alphonsus offer contained an onerous non-compete clause that would have limited the ability of the physicians to practice medicine within a 90-mile

radius if they decided to leave Saltzer/Saint Alphonsus. *Transcript at 3348:19-23, 3350:7-12 (H. Kunz).*

4. Saltzer's objectives in affiliating with St. Luke's

161. [redacted]

162. The documents and testimony presented in this case substantiate these goals, as well as a number of additional goals that Saltzer had in affiliating with St. Luke's, as summarized in part below.

a. Improving accessibility and quality of care for all patients

163. Saltzer's primary motivation for affiliating with St. Luke's was to provide the best possible health care to the community. *Transcript at 3313:5-10 (T. Patterson); Transcript at 3346:2-6 (H. Kunz).* Saltzer believed that becoming "tightly aligned" with St. Luke's increased the likelihood that St. Luke's would invest the time, resources, and risk to bring much-needed additional services and facilities to Canyon County. *Dkt. 270 (R. Page Dep.) at 130:22-131:12.*

164. It was also important to Saltzer that an affiliation with St. Luke's would increase access to medical care for the significant population of Medicaid and Medicare patients in

Canyon County by enabling Saltzer to move away from providing fee-for-service care as an independent group, which required many Saltzer physicians to manage their patient populations to limit the number of Medicaid or uninsured patients they could accept. *Transcript at 787:5-8 (N. Powell); Transcript at 3323:17-21 (T. Patterson); see also Dkt. 253 (W. Savage Dep.) at 65:25-66:21, 67:8-68:8.*

b. Permitting Saltzer physicians to practice integrated care within a health care system

165. Saltzer physicians also testified regarding the importance to them that the affiliation with St. Luke's provides the Saltzer physicians with the ability to be "involved in all aspects of care rather than being fragmented as part of an outside system that works in concert with the health system but not integrated with the health system." *Transcript at 3315:10-22 (T. Patterson).*

166. The Saltzer physicians spoke with physicians in the St. Luke's Clinic and were very impressed with the way that physicians in the Magic Valley, for example, moved from practicing in silos of health care to an integrated health care delivery system using a team-based approach. *Transcript at 2376:10-22 (J. Kaiser).*

c. Establishing a St. Luke's hospital in Nampa

167. During their negotiations, St. Luke's and Saltzer also discussed building a new hospital facility in Canyon County. *Transcript at 2233:21-24, 2235:15-16 (C. Roth).* St. Luke's had purchased property in Caldwell years earlier for the purpose of building health care facilities there at some "undetermined" time in the future. *Transcript at 2234:1-5 (C. Roth).* However, Nancy Powell testified that she and the Saltzer physicians pushed St. Luke's to open its Canyon County facility in Nampa instead, as part of an affiliation. *Transcript at 812:11-16 (N. Powell); see also Transcript at 2235:5-16 (C. Roth).*

168. As a result of the discussion with the Saltzer physicians, St. Luke's purchased property in Nampa and established emergency and outpatient services there. St. Luke's plans to establish a hospital there in the future, although no timeline has been set at this point for its construction. *Dkt. 320 (J. Stright Dep.) at 216:14-19; Transcript at 2235:17-25 (C. Roth).*

d. Transitioning to value-based delivery of care and compensation and risk-based contracts

169. Saltzer leadership shared in St. Luke's overarching goal of transitioning from the traditional fee-for-service compensation model to a value-based compensation model, focused on the outcome and quality of services, and emphasizing population management of disease, preventative care, and educational initiatives. *Transcript at 3312:15-16, 3317:15-20 (T. Patterson).*

170. Although a part of the discussion, according to Dr. Kaiser, compensation was never "the prime driver" in seeking closer affiliation with St. Luke's. *Transcript at 2384:21-2385:7 (J. Kaiser).* Dr. Kaiser testified that Saltzer wanted to receive "fair compensation" from St. Luke's when compared with national benchmarking data and what St. Luke's pays the other physicians in the St. Luke's system. *Transcript at 2385:21-2386:2 (J. Kaiser).*

171. With respect to payor contracts, Saltzer tried for years without success to get payors to agree to contracts containing quality incentives and commercial contracts with shared savings. *Transcript at 2853:13-17 (R. Page).* Saltzer hoped that it would be able to enter those types of contracts as part of St. Luke's, and that was very important to Saltzer physicians in pursuing the PSA with St. Luke's. *Transcript at 2853:13-2854:5 (R. Page).*

172. Additionally, affiliating with St. Luke's allows Saltzer to participate in insurance contracts with downside risk, which – as an independent group – Saltzer's President, Dr. Kaiser, and its CEO, Bill Savage, testified Saltzer did not have sufficient resources or reserves to do.

Transcript at 2374:22-2375:15 (J. Kaiser); Dkt. 253 (W. Savage Dep.) at 67:8-68:8. Indeed, Nancy Powell, Saltzer's former CFO, now Chief Administrative Officer at SAMG, testified that it would be far too risky for an independent group of Saltzer's size to take on any contracts with downside risk. *Transcript at 826:20-827:3 (N. Powell).*

173. Saltzer leadership believed that a closer affiliation was necessary to permit Saltzer to transition to value-based compensation, and did not view a joint venture or looser affiliation with St. Luke's as sufficient. *Transcript at 3318:14-22, 3345:21-3346:1 (T. Patterson).*

e. Maintaining autonomy over referrals and other medical decisions

174. It was also very important to the Saltzer physicians that they be permitted to retain the freedom to admit and refer patients wherever they chose. *Transcript at 3325:16-3326:6 (T. Patterson); Transcript at 3351:7-13, 3352:22-3353:2 (H. Kunz); Transcript at 2241:9-11 (C. Roth).*

175. In the midst of negotiations, a Saltzer physician, Michael Djernes, expressed his concern that affiliation would result in a loss of autonomy for Saltzer regarding referrals. *Dkt. 269 (M. Djernes Dep.) at 31:1-3.* According to Dr. Patterson, however, referrals "quickly became a nonissue" when St. Luke's made it clear that it would not seek to influence Saltzer's referrals or admission practices in any way. *Transcript at 3326:7-12 (T. Patterson).* St. Luke's never indicated to Saltzer during negotiations that it sought to or would in any way direct how the Saltzer physicians made referrals. *Transcript at 3351:14-20, 3352:22-3353:7 (H. Kunz).*

176. It was "well understood" that Saltzer physicians who were taking care of patients at Saint Alphonsus-Nampa were going to continue to do so, and "that was totally acceptable and understood by St. Luke's throughout the transaction." *Transcript at 2387:4-24 (J. Kaiser); see also Transcript at 1649:18-1650:4 (D. Pate).* According to St. Luke's CEO, Dr. David Pate: "as

a physician, I would find it completely objectionable for us to direct where our physicians are supposed to refer business." *Transcript at 1649:2-12 (D. Pate).*

177. The PSA contains an "exclusivity" provision that prohibits the Saltzer physicians from becoming employed by or financially affiliated with other health systems or hospitals during the term of the PSA. However, the PSA makes clear that "[a]ll Saltzer physicians may have privileges at any hospital and may refer patients to any practitioner or facility regardless of its affiliation with St. Luke's." *Exhibit 24 at Section 2.2(a); see also Transcript at 2242:2-2243:11 (C. Roth).*

f. Permitting Saltzer physicians to more easily participate in community outreach efforts

178. As an independent practice, Saltzer physicians were not compensated to take time out of their practice to do community outreach or perform other services that bettered the health of the community but that are not adequately compensated, if compensated at all, under the existing FFS system. *Transcript at 3312:22-25 (T. Patterson).* Thus, many Saltzer physicians could not pursue out-of-office opportunities due to constraints of time and money. *See Transcript at 3337:6-14 (T. Patterson).*

179. The fact that the Saltzer Transaction provides the Saltzer physicians with a guaranteed salary allows them more freedom to focus on community outreach programs because their pay will not be negatively impacted by engaging in such activities, even though they do not generate fee-for-service revenue. *Transcript at 3321:3-20 (T. Patterson).* As part of the St. Luke's system, Saltzer physicians not only are compensated for their work outside the hospital or clinic, "it's just part of the culture; it's expected" and "encouraged." *Transcript at 3312:25-3313:4, 3320:3-3321:2 (T. Patterson).*

g. Allowing Saltzer to obtain and benefit from technological upgrades

180. Prior to affiliating with St. Luke's, Saltzer physicians were concerned that they needed to upgrade the practice's health information technology—including its electronic medical records system (eClinicalWorks)—to meet new challenges in the health care industry, but they recognized that Saltzer could not afford to absorb the cost of doing so on its own. *Transcript at 3344:5-17 (H. Kunz).*

181. Saltzer physicians knew that St. Luke's had a "robust platform for health information technology" based on the Epic system and were excited about the benefits to be obtained from making use of that technology. *Transcript at 3345:16-20 (H. Kunz).*

182. When Saltzer was shopping for an electronic medical records ("EMR") system, it tried to get a demonstration of the Epic system, but Epic "wouldn't talk to us because we had less than a hundred physicians." *Transcript at 743:16-19, 789:5-8 (N. Powell).*

183. Saltzer physicians view eClinicalWorks as a "plug-and-play electronic medical record" that was purchased based on its affordability and lacks many of the key features of the Epic system. *Transcript at 3316:5-15 (T. Patterson).*

h. Improving Saltzer's ability to recruit and retain physicians

184. As an independent group, Saltzer had difficulty recruiting and retaining new physicians, a difficulty Saltzer feared was part of a trend that would worsen in the future. *Transcript at 3084:23-3085:7 (W. Savage); Transcript at 3344:25-3345:6 (H. Kunz); Dkt. 271 (M. Reiboldt Dep.) at 113:21-114:4, 114:24-115:6.*

185. A key anticipated benefit of the Saltzer Transaction was that St. Luke's and Saltzer "would work together to build a provider network in western Ada and Canyon County," meaning "St. Luke's would help [Saltzer] recruit." *Dkt. 270 (R. Page Dep.) at 74:1-4.*

186. Potential Saltzer recruits routinely express an interest in being part of a larger health care system and are increasingly less interested in joining an independent practice. *Transcript at 3088:19-3089:4 (W. Savage); Transcript at 3312:10-14, 3317:5-11 (T. Patterson); Transcript at 3345:5-6 (H. Kunz).* Affiliation with St. Luke's makes it easier for Saltzer to recruit and retain new physicians. *Transcript at 3345:23-3346:1 (H. Kunz); Dkt. 271 (M. Reiboldt Dep.) at 113:21-114:23.*

187. Saltzer could not afford, in many instances, to assume the risk of guaranteeing salaries for physicians who could not generate sufficient income in their first several years of practice. *See Transcript at 786:25-787:4 (N. Powell); see also Transcript at 3099:20-3100:2 (W. Savage).* St. Luke's has a greater ability to offer guaranteed salaries to attract and retain qualified physicians. *Transcript at 786:20-24 (N. Powell); Dkt. 271 (M. Reiboldt Dep.) at 113:21-114:23.*

188. Affiliation with St. Luke's was anticipated particularly to improve Saltzer's ability to recruit specialists, something that historically was difficult for Saltzer. *Transcript at 3084:23-3085:7 (W. Savage).* For example, since affiliating, St. Luke's has provided financial assistance in the recruitment of at least one new specialist—an otolaryngologist—for whom Saltzer "couldn't have even funded his guarantee let alone his comp[ensation]." *Transcript at 3099:20-3100:2 (W. Savage).*

i. Creating efficiencies and reducing the cost of medical care by reducing overhead

189. St. Luke's and Saltzer agreed early in their negotiations that reducing the cost of health care was an important goal in an affiliation. *Transcript at 2500:8-10, 2501:9-18, 2502:16-20 (S. Williams).*

190. The economies of scale and other efficiencies resulting from the transaction, including those resulting from treating patients within a larger health system, in addition to savings from group purchasing, and how those efficiencies would lead to a reduction in the cost of care for Saltzer patients, was the subject of even the early meetings between Saltzer and St. Luke's regarding the benefits to be achieved from the affiliation. *Transcript at 2503:10-2505:5 (S. Williams).*

j. Considerations that did not play a role

191. Establishing a stronger bargaining position with respect to third-party payors had "[a]bsolutely nothing" to do with Saltzer's decision to affiliate with St. Luke's; and was never a part of the discussions or negotiations between Saltzer and St. Luke's. *Dkt. 253 (W. Savage Dep.) at 68:9-15, 216:14-20; Transcript at 2853:9-12 (R. Page).*

192. The claimed ability to raise prices to commercial insurance payors also was not a factor in Saltzer's determination to enter into an agreement with St. Luke's. *Transcript at 2384:13-20 (J. Kaiser).* Indeed, the parties never even discussed whether the affiliation would result in increased reimbursement from commercial payors. *Transcript at 2384:13-20 (J. Kaiser); Transcript at 3346:7-14 (H. Kunz).* According to Bill Savage, "[c]ommercial payors weren't part of our negotiations" at all. *Dkt. 253 (W. Savage Dep.) at 216:14-20.*

C. St. Luke's Desired to Align With Saltzer In Order to Pursue the Triple Aim for Patients in Canyon County.

193. For its part, St. Luke's wanted to align with Saltzer because St. Luke's leadership believes that integration with Saltzer through the PSA is critical to enable St. Luke's to achieve its Triple Aim of providing higher-quality, better-coordinated, and more-affordable health care services to the population of Canyon County. *Transcript at 1638:1-1639:8, 1640:8-12, 1641:19-22 (D. Pate); Transcript at 2229:22-25, 2230:5-21 (C. Roth).* Throughout its negotiations with

Saltzer, St. Luke's routinely stressed that its overarching goals in connection with a possible affiliation were to provide "better health, better care, and lower costs." *Transcript at 3346:11-14 (H. Kunz).*

194. At the time that St. Luke's and Saltzer began discussions about a closer affiliation, St. Luke's did not employ any physicians practicing in Nampa. *Transcript at 2658:10-14 (A. Enthoven).* Even years later at the time of the closing of the Saltzer Transaction, St. Luke's had few employed or closely affiliated physicians in Canyon County, despite the fact that approximately 22 percent of St. Luke's patients were traveling from Canyon County to receive care at St. Luke's facilities. *Transcript at 2766:19-2767:7 (A. Oppenheimer).* St. Luke's believes it is essential to have a nucleus of employed or closely affiliated physicians in the region in order to achieve the benefits of accountable, coordinated, and integrated care. *Dkt. 254 (G. Swanson Dep.) at 69:19-71:9, 113:25-114:25, 116:3-24.* Thus, it was important to St. Luke's that Saltzer's physicians had a presence in Nampa and Caldwell in Canyon County as well as in Meridian. *Transcript at 2230:16-19 (C. Roth).*

195. St. Luke's was interested in pursuing an affiliation with Saltzer specifically due to the strong pre-existing relationship with Saltzer, reflected in part in the entities' prior efforts to coordinate care and work together for their patients. Prior to affiliating, St. Luke's and Saltzer physicians enjoyed close professional relationships in the community, working at the same facilities and sometimes caring for the same patients. *Transcript at 2225:12-17, 2229:17-21 (C. Roth).*

196. In the early meetings between St. Luke's and Saltzer, Nancy Powell's notes reflect that Gary Fletcher, the Chief Operating Officer of the St. Luke's Health System, explained a number of St. Luke's motivations in pursuing the requested affiliation with Saltzer:

(1) St. Luke's was interested in pursuing a closer affiliation with Saltzer because one of St. Luke's goals was to partner with physicians, and St. Luke's wanted physician partners with long-term sustainable relationships in order to form an integrated delivery system that was aligned with physicians (*Transcript at 809:13-810:16; 811:15-19 (N. Powell); Exhibit 1369 at 1, 3*); (2) St. Luke's sought to increase access for patients in Canyon County (*Transcript at 810:17-811:2 (N. Powell); Exhibit 1369 at 1*); and (3) St. Luke's wanted to provide continuity of high-level and quality care to patients in Canyon County. *Transcript at 811:3-14 (N. Powell); Exhibit 1369 at 3.*

197. St. Luke's was also interested in Saltzer because Saltzer was strategically aligned with St. Luke's views of health care delivery. *Transcript at 2767:8-12 (A. Oppenheimer); Dkt. 387 (Cross Examination Clip from N. Powell Dep.) at 210:1-7, played at Transcript at 813:2.* The Saltzer physicians shared St. Luke's vision of moving away from the fee-for-service payment system and offering a new, procompetitive and value-based health care delivery system in the western Treasure Valley. *Transcript at 1644:11-23 (D. Pate); Transcript at 2767:13-22 (A. Oppenheimer).* The Saltzer physicians also shared St. Luke's goals of improving the health of the people in the community, as well as streamlining and coordinating that care, and they wanted to work with St. Luke's specifically towards those goals. *Transcript at 2229:22-2230:4 (C. Roth).*

198. St. Luke's representatives informed Saltzer at the first meeting between the organizations that one of St. Luke's goals in affiliating with Saltzer was reducing the costs of health care and that vertical integration of health care providers was expected to lead to decreases in the costs of health care. *Transcript at 2502:2-20, 2505:13-16 (S. Williams).*

199. Dr. Williams (the former Saltzer surgeon now affiliated with Saint Alphonsus), testified that a large part of the very first meeting between St. Luke's and Saltzer was centered on the costs of health care. *Transcript at 2499:23-2500:15 (S. Williams).* Dr. Williams testified that Dr. David Pate of St. Luke's discussed the advent of accountable care organizations, and the fact that in the ACO model, the cheapest care that could be provided at good quality was the care that was going to be preferred by any ACO. *Transcript at 2499:16-22, 2500:16-2502:1 (S. Williams).*

200. St. Luke's also told Saltzer that St. Luke's expected to realize economies of scale from treating patients within a single integrated system, and presented specific examples of those savings to Saltzer during the early meetings. *Transcript at 2503:14-2505:5 (S. Williams).*

201. St. Luke's told Saltzer that if Saltzer and St. Luke's could combine forces, they could continue to provide high quality care and do so at a lower cost. *Transcript at 2505:13-16 (S. Williams).*

202. A desire to gain "market power" played no role whatsoever in St. Luke's decision to affiliate with Saltzer. *Transcript at 2253:19-22 (C. Roth).* The St. Luke's Health System Board of Directors did not consider the effect of the transaction on St. Luke's market share in arriving at the decision to affiliate with Saltzer. *Transcript at 1639:9-13 (D. Pate).*

203. Almost by definition, affiliating with Saltzer would expand St. Luke's market share in Canyon County, where St. Luke's had little presence prior to the Saltzer Transaction. However, Ed Castledine, another St. Luke's executive who was involved in the early stages of the negotiations with Saltzer, testified that the focus was on clinical alignment in order to improve patient care, not market share. *Dkt. 262 (E. Castledine Dep.) at 122:25-123:6; see also id. at 121:8-20.* St. Luke's considered it a "good idea" to be able to work with the Saltzer

physicians in Nampa, not because they were "dominant," but because the "opportunity" to "engage at a . . . really significant level with that number of providers would allow us to improve care on a pretty large scale, as opposed to, say, a small orthopedic practice or [an] independent small family practice[.]" *Dkt. 262 (E. Castledine Dep.) at 120:20-25, 121:4-122:4.*

204. St. Luke's did not affiliate with Saltzer to affect the referral patterns of Saltzer physicians, to be able to negotiate higher rates with payors, or otherwise to drive up prices for health care services. *Transcript at 1640:4-7, 1644:24-1646:12 (D. Pate); Transcript at 2241:5-8, 2253:23-2254:1 (C. Roth); Transcript at 2764:13-18, 2768:2-7 (A. Oppenheimer); see also Transcript at 809:4-8 (N. Powell); Transcript at 3121:14-19 (W. Savage).*

205. While good intentions will not save an otherwise unlawful transaction under the antitrust laws, the Court finds that plaintiffs have not proven that a purpose of the Saltzer Transaction was to allow Saltzer or St. Luke's to raise prices to commercial payors or engage in anticompetitive conduct.

VI. The Government Plaintiffs' Claims That the Saltzer Transaction Will Have Anticompetitive Effects in the Market for Adult PCP Services in Nampa Sold to Commercial Payors.

206. The Government Plaintiffs allege that the transaction will have anticompetitive effects in the market for adult primary care physician services in Nampa sold to commercial health plans. *Dkt. 98 (Gov't Plaintiffs' Compl.) at ¶ 27; Transcript at 1312:22-1313:4, 1314:22-1315:1 (D. Dranove).* This claim is based solely on the horizontal overlap between Saltzer PCPs in Nampa and the seven former Mercy Physicians Group PCPs who left Saint Alphonsus in the fall of 2011 to work for St. Luke's in Nampa.[4] *Transcript at 12:12-14 (FTC Opening Statement); Transcript at 2194:10-23, 2195:8-20 (A. Crownson); Transcript at 2310:2-4 (C.*

[4] The overlap also includes the one PCP recruited to join the former Mercy Physicians Group PCPs, for a total of eight PCPs already affiliated with St. Luke's at the time of the Saltzer Transaction.

Roth). In effect, it is because of the fact that St. Luke's employs the seven former Mercy Physicians Group PCPs in Nampa that the Government Plaintiffs contend the Saltzer Transaction should be unwound.

207. The Court is not bound by the Horizontal Merger Guidelines promulgated by the FTC and the Department of Justice. *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120 (N.D. Cal. 2001); *see also Transcript at 1337:16-18 (D. Dranove).* As the Merger Guidelines expressly acknowledge, "merger analysis does not consist of uniform application of a single methodology." *Merger Guidelines § 1.* However, the parties' economic experts both testified that the Merger Guidelines provide at least a useful framework for evaluating the Government Plaintiffs' claim. Accordingly, in the following sections evaluating the Government Plaintiffs' claims, the Court references the Merger Guidelines where appropriate.

A. Background Principles

1. Market Definition and Competitive Effects

208. Market definition—the process of defining the product and geographic markets in which a transaction is alleged to have anticompetitive effects—aids in identifying likely competitors and alternatives for consumers (patients, health plans, and employers). *Transcript at 2887:17-21 (D. Argue).* However, as the Merger Guidelines expressly state, market definition is "not an end in itself"; rather, market definition "is useful to the extent it illuminates the merger's likely competitive effects." *Merger Guidelines § 4, p. 7.* Thus, the process of market definition and the analysis of competitive effects each inform the other. *Merger Guidelines § 4, p. 7; see also Transcript at 2893:4-9 (D. Argue).*

2. Critical Loss Analysis

209. The antitrust laws at issue in this case are concerned with the creation or aggregation of market power, which would allow providers to raise prices above competitive

levels. Ultimately, then, an important question the Court must answer is whether the Saltzer Transaction gives the combined St. Luke's and Saltzer the ability to raise prices above competitive levels by some small but significant amount without losing so many patients that the attempted price increase becomes unprofitable. *Transcript at 2910:19-2911:1 (D. Argue).* If an attempted price increase would ultimately be unprofitable, then prices would return to competitive levels. This would indicate a lack of market power. *Transcript at 2917:11-16 (D. Argue).*

210. One tool that has been used in antitrust cases both to help define markets and assess competitive effects is Critical Loss analysis. *Transcript at 2912:5-9 (D. Argue).* Critical Loss analysis seeks to determine whether, if St. Luke's and Saltzer raised prices by a small but significant amount, they would lose enough revenue that the attempted price increase would be unprofitable. *Transcript at 2910:19-2911:5 (D. Argue).* Critical Loss analysis has been established for decades and is discussed in the Merger Guidelines as a tool to be used in analyzing transactions. *Merger Guidelines § 4.1.3; FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1128 (N.D. Cal. 2001); *see also Transcript at 2913:16-23 (D. Argue).*

211. Critical Loss analysis is concerned with "marginal customers," or those customers that would change their behavior as a result of a small but significant price increase. In other words, it need not be the case that most (or even many) customers would change their behavior in response to an attempted increase in price. What are important are the actions of those customers who would consider changing their behavior in response to an attempted price increase—and whether they in fact would change their behavior. *Transcript at 2911:11-25 (D. Argue).*

212. Critical Loss analysis involves a two-step process. The first step is calculating the critical loss—the "break-even point" that provides an "objective yardstick" for determining how much revenue would have to be lost to make an attempted price increase unprofitable. *Transcript at 2912:10-15, 2918:10-11 (D. Argue)*; *see also Merger Guidelines § 4.1.3.* The critical loss is calculated using the defendants' revenues and costs. *Transcript at 2912:20-2913:1 (D. Argue).* The second step involves determining whether the "actual loss" —the volume of revenue that the defendant would lose if it attempted a price increase—is likely to exceed the critical loss. *Transcript at 2913:2-9, 2922:2-20 (D. Argue).* If it would, then the attempted price increase would not be profitable, indicating that the defendant lacks market power.

213. An attempt by Saltzer and St. Luke's to raise prices for adult PCPs in Nampa could lead to a reduction in revenue in any number of different ways, each of which is relevant to the Critical Loss analysis. *Transcript at 2923:23-2925:9 (D. Argue).* For example:

a) If the price increase results in an increase in patients' out-of-pocket costs, some patients may decide to switch to non-St. Luke's/Saltzer PCPs, leading to a reduction in revenues from patient care. *Transcript at 2924:5-9 (D. Argue).*

b) A price increase that causes a health plan's costs to increase will be passed on to employers and employees in the form of higher premiums. *Transcript at 2924:22-2925:1 (D. Argue); Transcript at 1309:12-19 (D. Dranove).* As premiums increase, some employers will limit or drop coverage, resulting in a decrease in the volume of commercially-insured patients and associated revenues to St. Luke's and Saltzer. *See Transcript at 2924:14-21 (D. Argue).*

c) Relatedly, premium increases will likely cause some individuals to drop their commercial insurance coverage. *Transcript at 2925:2-9 (D. Argue).* A reduction in commercially-insured patients is another way that a price increase could result in loss of revenue to St. Luke's and Saltzer. *Transcript at 2925:2-9 (D. Argue).*[5]

d) A combined St. Luke's-Saltzer could also lose patient volume from commercial health plans and employers taking steps to exclude St. Luke's and Saltzer from a network, or incentivizing enrollees to use less expensive providers. *Transcript at 2924:14-21 (D. Argue).*

214. The defendants' economic expert, Dr. David Argue, analyzed revenue and cost data from St. Luke's primary care practices in Nampa and calculated that for a 5 percent increase, the critical loss is 8.8 percent. *Transcript at 2912:23-2913:1, 2916:18-22 (D. Argue).* In other words, if St. Luke's and Saltzer tried to raise the prices of adult PCP services by 5 percent and they lost as little as 8.8 percent of their revenues from those services as a result of the actions of patients, employers, and/or payors, the attempted price increase would be unprofitable. *Transcript at 2917:3-10 (D. Argue); Exhibit 2570.* If a price increase is unprofitable, the combined St. Luke's-Saltzer would be unable to sustain such an increase and the price would return to competitive levels. This would indicate a lack of market power. *Transcript at 2917:11-16 (D. Argue).*

215. Dr. Argue conducted further analysis to demonstrate that the average patient of a St. Luke's primary care physician in Nampa generates about five times as much revenue from complementary services (*e.g.*, laboratory work, imaging, inpatient or outpatient procedures) as

[5] While some individuals who lose commercial insurance may ultimately obtain insurance through government programs, like Medicaid, provider reimbursement under those programs is less favorable than commercial reimbursement. *Exhibit 2634; Transcript at 350:8-351:5 (J. Crouch).*

from revenues for the professional services of the PCP. In other words, if a price increase causes patients to switch from St. Luke's physicians to non-St. Luke's physicians, that results not just in lost revenue from the PCP visit, but lost downstream revenue from other services that patients of St. Luke's PCPs typically have done at St. Luke's. *Transcript at 2919:14-2920:21 (D. Argue).*

216. When the loss of these additional revenues is taken into account, the Critical Loss figure is reduced to approximately 1.5 percent. That is, if St. Luke's attempted to raise prices by 5 percent, the loss of only 1.5 percent of patients, and their resulting revenue from both PCP professional services *and* the complementary services that the average St. Luke's patient obtains from St. Luke's, would render the attempted price increase unprofitable. *Transcript at 2921:4-8, 2921:21-2922:1 (D. Argue).*

217. The Government Plaintiffs' economic expert, Professor David Dranove, criticized Dr. Argue's calculation of the critical loss, arguing that Dr. Argue characterized too much of the cost of physician compensation as a fixed, rather than a variable, cost. *Transcript at 3440:3-11 (D. Dranove).* However, Dr. Argue's calculation of fixed costs was based on an analysis of other compensation agreements that, like the Saltzer agreement, provide for both a minimum guaranteed salary and the prospect of some additional compensation based on productivity. *Transcript at 2912:20-2913:1, 3071:16-3072:3 (D. Argue); Transcript at 3484:3-16, 3486:13-3487:25 (D. Dranove).* Plaintiffs have not demonstrated that it is inappropriate to consider the loss of revenue from complementary services in determining the critical loss. Accordingly, the Court finds that Dr. Argue's methodology and calculations are reliable, and adopts the 1.5 percent critical loss figure calculated by Dr. Argue.

218. The next step in the analysis is to determine whether, if St. Luke's attempted to increase prices by 5 percent, the actual loss would exceed the 1.5 percent critical loss.

Transcript at 2922:2-20, 3031:2-8 (D. Argue). To answer that question, Dr. Argue considered patient origin data, the proximity of primary care physicians to home and work, the experience of employers with tiered networks, price sensitivity of enrollees and patients, and the willingness of patients to change physicians. *Transcript at 2926:3-12 (D. Argue).* After considering that evidence, Dr. Argue concluded that "there is a great likelihood that that Critical Loss would be exceeded by an actual loss." *Transcript at 3031:6-7 (D. Argue).* For the reasons set forth below, the Court finds that conclusion to be reasonable.

B. Nampa Is Too Narrow a Geographic Market for Adult PCP Services.

219. Defendants do not dispute, and the Court therefore finds, that adult primary care physician services sold to commercial health plans is a relevant product market. The providers in this market include physicians who practice in internal medicine, general medicine, and family practice medicine specialties. *See Transcript at 1313:1-21 (D. Dranove).*

220. The "geographic market" consists of the collection of adult PCPs that act as competitive constraints on one another. *Transcript at 2932:23-2933:2 (D. Argue).* Defendants contend that the relevant geographic market for adult PCP services is not limited to providers in Nampa. *Transcript at 2933:11-16 (D. Argue).* While defendants' expert, Dr. Argue, does not precisely define the outer bounds of the geographic market, he contends that it includes providers in Nampa, Caldwell, Meridian, and west Boise. *Transcript at 2949:3-2950:3 (D. Argue).* Dr. Argue further contends that whether the market is that broad or as narrow as plaintiffs define it, the Saltzer Transaction is not likely to result in anticompetitive effects. *Transcript at 2951:9-25 (D. Argue).*

221. For the reasons set forth below, the Court finds that the geographic market for adult PCP services sold to commercial payo*rs is not limited to Nampa.* The Court agrees that the evidence supports Dr. Argue's conclusion that the market includes providers in Caldwell,

Meridian, and west Boise. However, the Court further finds that regardless of whether the market is as narrow as Nampa (as plaintiffs argue) or includes providers in other communities (as defendants argue), the transaction is not likely to result in anticompetitive effects.

1. A significant number of Nampa residents leave Nampa for primary care.

222. A patient's decision as to which primary care physician he or she visits is based on a variety of factors, including: (1) the patient's past relationship with the PCP; (2) recommendations; (3) perception of quality; (4) location; (5) out-of-pocket cost; and (6) whether or not the provider is in-network. *Transcript at 2934:7-16 (D. Argue).*

223. Both Professor Dranove and Dr. Argue examined patient origin data provided by payors. Patient origin data show the existing geographic distribution of patient visits based on these factors. *Transcript at 2934:7-16 (D. Argue).*

224. The patient origin data show that there is a substantial volume of travel in and out of Nampa for adult PCP services. Approximately 40 percent of Nampa residents currently leave Nampa for adult PCP services. In one of the three zip codes (83687) that comprise plaintiffs' proposed geographic market, over half of the adult PCP services provided to those Nampa residents are provided by PCPs outside of Nampa. *Transcript at 2935:14-23 (D. Argue); Exhibit 2398.*

225. Over half of patients who live in the zip codes along I-84 travel outside the community to receive primary care physician services. I-84 provides an easy route for patients to travel to Caldwell, Meridian, and Boise to receive care. *Transcript at 2941:20-2942:8 (D. Argue); Exhibit 1784.*

226. Dr. Argue also demonstrated that the 75 percent service areas for Meridian and Caldwell primary care physicians—*i.e.,* the zip codes that account for 75 percent of those

physicians' patient visits—fully encompass the service area for Nampa primary care physicians. *Transcript at 2938:20-2939:11(D. Argue); Exhibit 2416.* The service areas are the zip codes that represent the most important sources of patients for the providers. *Transcript at 2938:18-2939:11 (D. Argue).* Approximately one-third of the patients of the Nampa primary care physicians come from communities other than Nampa. *Transcript at 2935:18-2936:6 (D. Argue); Exhibit 2398.*

227. Professor Dranove argues that because patients pay the same price for PCP services regardless of which provider they choose, the fact that a substantial number of patients currently travel into and out of Nampa for PCP services is not reflective of price differences or whether more patients would travel in response to an increase in the price of PCP services. *Transcript at 1303:3-20, 1360:16-17 (D. Dranove).* However, data on existing travel patterns are relevant in that they demonstrate that consumers are generally willing to obtain adult primary care services that are close to where they live *or* close to where they work. *Transcript at 464:16-465:1 (L. Duer); Transcript at 711:13-712:14, 804:13-17 (N. Powell); Transcript at 1763:4-16, 1787:2-5 (P. Richards).*

228. These data show that providers in communities outside of Nampa act as competitive constraints on Nampa providers, and vice versa. *See Transcript at 2949:8-15 (D. Argue).* The data are also important because they suggest that primary care physicians outside of Nampa are acceptable alternatives to Nampa primary care physicians from the perspective of a significant percentage of consumers. *Transcript at 2936:3-13 (D. Argue).*

2. More patients would travel in response to a price increase.

229. If, in response to an increase in price, enough patients who currently choose Nampa providers would switch to providers outside of Nampa—or patients who live outside of Nampa but currently see Nampa providers would choose to stay "close to home" and see

providers in their home communities—such that the price increase would be unprofitable, Nampa is not a properly defined geographic market. *Transcript at 2949:8-2950:3 (D. Argue).* Whether enough patients would "switch" to result in a loss of revenue in excess of the critical loss depends in part on how sensitive patients are to changes in price.[6]

230. Dr. Argue testified that some patients are sensitive to changes in out-of-pocket costs, and that additional patients may travel if prices were to increase. *Transcript at 2934:20-2935:13 (D. Argue).* Professor Dranove does not contend that patients are *completely* price insensitive, *i.e.*, that no patients will switch in response to increases in the price of physician services. Rather, he contends that patients are largely price insensitive. *Transcript at 1406:10-12 (D. Dranove).* But Professor Dranove conducted no study of patient sensitivity to price changes. *Transcript at 1406:7-9 (D. Dranove).*

231. Evidence from this market suggests that patients are sensitive to price increases. Jeffrey Crouch of BCI testified that approximately 10 percent of BCI's membership is "highly sensitive to pricing and . . . will research prices online" and will become aware of price differences. *Transcript at 366: 9-16 (J. Crouch).* Dr. Steven Williams, an investor in TVH and a former Saltzer surgeon, testified that cost is usually a factor in patients' decision to use TVH over other facilities. *Transcript at 2484:3-23 (S. Williams); Exhibit 2558.*

232. In addition, there is an example in this market of patients not only changing providers, but traveling from Nampa to other communities, in response to price increases for primary care services. In 2008, Micron switched from the Blue Cross PPO plan—in which Saint

[6] As noted above, in addition to lost revenue from patients choosing lower-cost providers, St. Luke's could also lose revenue if employers or employees drop commercial insurance coverage because of premium increases resulting from increased provider costs.

Alphonsus, St. Luke's, and Saltzer were all participating providers—to a new "narrow network" plan. *Transcript at 594:14-595:2 (P. Otte).*

233. The narrow network plan contained four tiers of providers and provided financial incentives for Micron employees to use certain providers. *Transcript at 557:18-558:2 (P. Otte); Exhibit 2001.*

a) The first, least expensive tier includes providers at the Micron Family Health Center, located on Micron's Boise campus. *Exhibit 2001; see also Transcript at 558:12-24 (P. Otte).* At the on-site clinic, members pay a $10 flat-fee charge, no matter the service provided. *Transcript at 558:12-559:3 (P. Otte).*

b) The second tier is the Micron Health Partners Network ("MHPN"). *Transcript at 557:23-24 (P. Otte); Exhibit 2001.* [redacted] The co-payment for primary care services provided by MHPN providers is *10 percent. Transcript at 560:22-561:1 (P. Otte).*

c) The third tier is the broader PPO network. *Transcript at 557:25 (P. Otte).* Members have a co-payment ranging from 15 to 18 percent for providers in the PPO tier. *Transcript at 561:1-2 (P. Otte).* The PPO tier excludes St. Luke's and until 2011, excluded Saltzer as well. *Transcript at 558:6-9, 594:6-13 (P. Otte).*

d) The last tier is for out-of-network providers, such as St. Luke's. *Transcript at 557:25-558:1, 558:10-11 (P. Otte).* Members who see an out-of-network provider have a 40 percent co-payment. *Transcript at 561:3-4 (P. Otte).*

234. After these price incentives were implemented, there was a dramatic shift of Micron employees in Nampa from Saltzer PCPs (who were not in the MHPN) to MHPN providers. Jackie Butterbaugh of Imagine Health, which put together the MHPN network, testified that Micron employees in Nampa traveled to Caldwell and Boise for adult and pediatric primary care services. *Dkt. 318 (J. Butterbaugh Dep.) at 80:16-25.* This testimony was corroborated by Dr. Harold Kunz of Saltzer, who testified that when the new Micron plan went into effect, virtually all 60 of the Micron patients he was seeing switched to other providers, primarily in Meridian and Boise. *Transcript at 3362:23-3363:9 (H. Kunz).*

235. [redacted]

236. [redacted]

237. Dr. Dranove testified that the Micron example cannot be generalized to other employers because the Micron Family Health Center in Boise may explain why so many Micron employees were willing to travel outside of Nampa. *Transcript at 1357:18-25 (D. Dranove).* However, the Family Health Center has been available to Micron employees since before the MHPN plan was implemented in 2008. *Transcript at 596:12-15 (P. Otte).* Yet it was not until the financial incentives in the new Micron health plan were implemented that Micron employees in Nampa switched to seeing new providers.

238. Plaintiffs have also asserted that the financial hardships that Micron faced at the time that it established its health plan as a unique factor leading to the success of the narrow network. *Transcript at 1357:7-25 (D. Dranove); Transcript at 1492:7-18 (D. Haas-Wilson).* However, by 2010, Micron had "started to make a fair amount of money." Micron made $1.8 billion in 2010, and began acquiring competitors in 2011 and 2012. *Transcript at 584:2-10 (P. Otte).* Micron has chosen to maintain its health plan notwithstanding its financial improvement. *Transcript at 2908:13-14 (D. Argue).* Furthermore, as Dr. Argue testified, the cost-cutting stresses that Micron faced are not materially different than the incentives that all employers face to cut costs. *Transcript at 2907:17-23 (D. Argue).*

239. [redacted] In absolute dollar terms, however, the price differences for services in the various tiers are relatively small. Pat Otte of Micron explained this, using as an example a standard $200 charge for a visit to a PCP. Micron would typically negotiate a discounted rate of 35 percent off of that charge, with co-payments based on the discounted charge. If a Micron employee went to the Family Health Center, he or

she would pay a flat $10 fee. If he or she went to a provider in the MHPN tier, he would pay $13—calculated as 10 percent of the discounted amount for the PCP visit ($200 - $70 (*i.e.*, the 35 percent discount) = $130 * 10%). *Transcript at 560:22-561:2, 617:20-618:11 (P. Otte).*

240. Moreover, as Dr. Argue testified, employers and plans have the ability to adjust co-payments and allowable amounts to magnify the disincentives to choose more costly providers. Dr. Argue provided an illustrative example using the $200 charge for PCP services referenced by Mr. Otte. If the health plan negotiates a 20 percent discount and pays 80 percent of the balance, the patient would be responsible for $32 (or 20 percent) of the net charge ($200 - $40 (*i.e.*, the 20 percent discount) = $160. $160 * 20% = $32). *See Transcript at 2966:17-24 (D. Argue).* If St. Luke's were to increase prices by 5 percent, the plan would then be responsible for reimbursing $134.40, and the patient would pay $33.60 as a copayment, an increase of "only" $1.60. The health plan, however, would experience an increase of $6.40 per service. *Transcript at 2967:2-17 (D. Argue).*

241. Even if a patient might not be sensitive to a 5 percent price increase in his co-payment, health plans are sensitive to such price changes and can seek to address them in a variety of ways, including creating a separate tier or network in which a non-St. Luke's provider is the exclusive or preferred provider. *Transcript at 2967:18-2968:7 (D. Argue).* In exchange for the increased volume, the health plan can negotiate a lower allowable amount.

242. For illustrative purposes, assume that the new allowable amount is 70 percent of charges. Those savings will then be passed on to the enrollee in the form of a lower copayment, for example, 10 percent. *Transcript at 2968:5-12 (D. Argue).* Under this new network design, a $200 charge will cost the health plan $126, and will cost the enrollee $14. *See Transcript at 2968:12-19 (D. Argue).* Under this illustrative scenario, the price difference imposed by the

provider is still the same 5 percent increase. However, now the difference to the patient between receiving a service at St. Luke's and receiving the same service at the exclusive provider in the narrow tier is over $19. *See Transcript at 2968:12-19 (D. Argue).* Through this type of mechanism, health plans can increase patient sensitivity to price changes and drive volume to lower-priced networks. *Transcript at 2969:1-7 (D. Argue).*

243. This illustrative example is not purely hypothetical. The Micron plan is a real-world example of one such plan, and, as noted above, the use of narrow network products has been increasing and is expected to continue increasing in the future. *Supra* at Section IV(B).

244. If St. Luke's were to attempt to increase prices by a small but significant amount, it would likely lose more than 1.5 percent of patients (*i.e.*, the Critical Loss benchmark) to other providers, defeating the attempted price increase. This supports the conclusion that St. Luke's and Saltzer would not have "market power" in plaintiffs' proposed geographic market of Nampa, meaning that the geographic market is broader than Nampa. *Transcript at 2912:5-7, 2943:9-11, 2949:3-2951:4 (D. Argue).*

3. Evidence relating to provider contracting and marketing demonstrates that Nampa is not a properly defined geographic market.

245. [redacted]

246. If Nampa is a proper market for primary care physician services, then one should see evidence that providers with a large market share in Nampa—*e.g.*, Saltzer—are able to exercise market power by obtaining higher rates. *Transcript at 2946:24-2947:3 (D. Argue).*

[redacted] However, the evidence does not show that providers with high market shares in Nampa have been able to exercise market power in negotiations with payors.

247. For example, Saltzer accounts for 89 percent of the pediatricians in Nampa. *Transcript at 2947:3-6 (D. Argue).* In its negotiations with Blue Cross, Saltzer made several threats to terminate its contract if Blue Cross did not include gain-sharing provisions. However, Blue Cross never acquiesced. This indicates that Blue Cross believed that its enrollees had acceptable outside options to Saltzer pediatricians—*i.e.*, that pediatricians in communities outside of Nampa were acceptable alternatives for Nampa residents. *Transcript at 725:1-3, 794:9-19 (N. Powell); Transcript at 2947:6-12 (D. Argue).*

248. For its part, Saltzer never followed through on any of its threats because it determined that it could not "walk away from 22 percent of [its] business." *Transcript at 794:25-795:3 (N. Powell).* The reason that Saltzer believed walking away from Blue Cross would result in a loss of business is that if Saltzer went out-of-network with Blue Cross, its Blue Cross patients would go to other doctors for care rather than paying higher out-of-pocket costs. *Transcript at 794:25-795:15 (N. Powell).*

249. Dr. Williams of Saltzer testified that Saltzer's fees from insurers had been eroding over a number of years, which he attributed to Saltzer's lack of power at the bargaining table with commercial payors. *Transcript at 2506:4-11 (S. Williams).* If Nampa is a distinct geographic market for adult PCP services, then Saltzer, which before the St. Luke's transaction

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[7] [redacted]

had a market share of over 65 percent (*Exhibit 1789*), should have been able to extract higher payments from Blue Cross, according to the plaintiffs' theory of competitive harm. *Transcript at 2946:18-2947:12 (D. Argue).* But it was not able to do so.

250. [redacted]

251. In sum, the evidence concerning payor negotiations does not support plaintiffs' claim that Nampa is a relevant geographic market. If Nampa were the relevant market, then Saltzer, with its significant market share in both adult and pediatric primary care in that market, should have been able to extract higher reimbursement for its services because payors had no viable "outside options" for services in the proposed Nampa market. But Saltzer was not able to extract such concessions.

4. Other evidence relating to market definition

252. Plaintiffs point to internal St. Luke's documents that refer to a "Nampa market" in discussing the Saltzer Transaction as evidence that Nampa is a properly defined geographic market for purposes of their antitrust claims. *See Exhibit 1115; Transcript at 1319:8-21 (D. Dranove).* However, these documents do not purport to reflect an antitrust analysis of market definition. Moreover, there is other ordinary course-type evidence that supports a broader view of the market.

253. For example, Saltzer considered its market to be broader than Nampa, and to include all of Canyon County. Nancy Powell testified that Saltzer wanted any exclusivity agreement with St. Luke's to cover all of Canyon County because that is what Saltzer viewed as

the market for its services. *Dkt. 387 (Cross Examination Clip from N. Powell Dep.) at 214:23-215:17, played at Transcript at 802:10.*

254. Primary Health Medical Group anticipated that by opening a new clinic in Nampa it would be able to serve patients "that live in South Nampa and the outlying areas of Canyon County." *Transcript at 1204:23-1205:16 (D. Peterman).*

255. Skip Oppenheimer, a member of the board of St. Luke's Health System, testified that the Treasure Valley has "grown together" and that the St. Luke's Health System board does not consider Nampa a "discrete market." *Transcript at 2781:14-16, 2782:11-20 (A. Oppenheimer).*

256. [redacted] All of Canyon and Ada Counties fall within 90 miles of Saint Alphonsus Regional Medical Center. The proposal for such an expansive restriction is inconsistent with the plaintiffs' position that Nampa is a discrete geographic market for adult PCP services.

5. Analysis of market concentration

257. The Merger Guidelines state that market "concentration is often one useful indicator of likely competitive effects of a merger." *Merger Guidelines § 5.3.* The antitrust agencies use the Herfindahl-Hirschman Index ("HHI") to measure concentration and changes in concentration levels. *Merger Guidelines § 5.3.* HHIs are calculated by summing the squares of the individual firms' market shares. *Merger Guidelines § 5.3.*

258. Both Dr. Dranove and Dr. Argue agree that concentration levels are not intended to constitute rigid barriers distinguishing procompetitive mergers from anticompetitive mergers, but rather are one data point that should be considered as part of the overall analysis of the likely competitive effects of the Saltzer Transaction. *Transcript at 1337:9-22 (D. Dranove); Transcript at 2890:1-15 (D. Argue).* The Merger Guidelines themselves state that HHIs do not "provide a rigid screen to separate competitively benign mergers from anticompetitive ones," but rather function to identify mergers which are unlikely to raise competitive concerns and others for which a closer examination of the competitive factors may be warranted. *Merger Guidelines § 5.3.*

259. As Dr. Argue explained, market shares and measures of market concentration, such as HHIs, are poor measures of competitiveness in certain market conditions, especially those markets with confidential bilateral bargaining over price. *See Transcript at 2953:18-25 (D. Argue).* When there are two attractive alternative providers, such as Saint Alphonsus and St. Luke's, that vigorously compete for contracts with health plans, payors will get competitive prices regardless of concentration levels. *Transcript at 2953:18-25 (D. Argue).* This system-to-system competition "gives the payors leverage in these negotiations." *Transcript at 2953:18-25 (D. Argue).*

260. Dr. Argue provided an example as to why high concentration levels are not necessarily indicative of market power, and can fail accurately to reflect the presence of robust competition in a market. Although Micron is not a separate market, it provides an example of how competition between two major health systems ensures that payors receive competitive prices notwithstanding high concentration levels. *Transcript at 3074:12-3075:1 (D. Argue).*

a) [redacted] These shares are equivalent to an HHI of 6250, which is "highly concentrated" based on the Merger Guidelines standards. *Transcript at 2953:7-11 (D. Argue).*

b) [redacted] These current shares are equivalent to an HHI of 8200, for a change in HHI of 1950. This would indicate that the Micron "market" is even more highly concentrated than it was prior to 2008. *Transcript at 2953:10-11 (D. Argue).*

c) Notwithstanding the high concentration levels, there is no evidence that Micron faced supracompetitive prices from either system at either time. To the contrary, Micron was able to "take these two systems, play them off against each other in a manner that allowed Micron to get good, competitive pricing." *Transcript at 2953:11-15 (D. Argue).*

261. According to plaintiffs, if the geographic market were limited to Nampa, the pre-transaction HHI for the adult primary care services market would be 4612, the post-transaction HHI would be 6219, and the change in HHI would be 1607. Under the Merger Guidelines, the transaction would "be presumed [by the FTC] to be likely to enhance market power. The presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power." *Merger Guidelines § 5.3; Transcript at 1336:24-1337:15, 1339:25-1340:15 (D. Dranove).*

262. If the market includes Nampa, Caldwell, Meridian, and western Boise, the pre-transaction HHI for the adult primary care services market is 1,448 and the post-transaction HHI is 2,180. The change in HHI is 732. *Transcript at 2952:6-9 (D. Argue).* According to the Merger Guidelines, the post-transaction HHI results in a "moderately concentrated" market. Under the Merger Guidelines, the Saltzer Transaction would therefore "potentially raise significant competitive concerns and often warrant scrutiny." *Merger Guidelines § 5.3.*

263. Regardless of how the market is defined, the Court must ultimately evaluate the other facts in the case to determine market dynamics and whether those dynamics may offset any concerns about market concentration. *Transcript at 2952:9-20 (D. Argue).*

C. The Transaction is Not Likely to Result in Anticompetitive Effects.

264. The Court concludes that regardless of whether the market is as narrow as Nampa or includes surrounding communities, the Saltzer Transaction is not likely to result in anticompetitive effects for the reasons set forth below.

1. Changes in "bargaining leverage" are not informative of market power.

265. The Government Plaintiffs' theory of anticompetitive effects is as follows: the Saltzer Transaction will increase St. Luke's bargaining leverage—its "clout"—in negotiations with payors, and increased clout for St. Luke's makes it more likely that St. Luke's can obtain price increases or other favorable contract terms. *Transcript at 34:7-13 (FTC Opening Statement)* ("[I]f clout is reduced, as we believe it will be here, on the part of those that seek to buy services from St. Luke's . . . then prices will rise."); *Transcript at 1373:16-22 (D. Dranove).*

[redacted]

266. According to Professor Dranove, in negotiations between providers and health plans, the strength of the parties' positions each are based in part on what their alternative is—their "outside option" —if they are unable to reach an agreement. *Transcript at 1304:1-1305:4 (D. Dranove); see also Transcript at 2900:19-2901:3 (D. Argue).* Stated differently, each party must consider its "best alternative to a negotiated agreement" or "BATNA." *Transcript at 1300:8-12 (D. Dranove).*

267. Bargaining strength is zero-sum; that is, any improvement in one party's bargaining leverage reduces the other party's leverage, and vice-versa. *Transcript at 1397:18-24 (D. Dranove).* While a plan's enrollment and a provider's number of physicians or facilities contribute to bargaining power, other factors such as reputation, quality, and location all affect the relative bargaining position of the parties. *Transcript at 2901:4-17 (D. Argue).* Professor Dranove contends that what is important is how the Saltzer Transaction will affect St. Luke's bargaining strength *relative* to BCI's bargaining strength. *Transcript at 1307:6-22, 1397:5-17, 1437:23-25 (D. Dranove).*

268. However, Dr. Argue testified that *absolute* bargaining strength is at least as important as relative bargaining strength. *Transcript at 2900:10-2901:17, 2957:7-2958:18 (D. Argue).* If, notwithstanding an increase in its relative bargaining strength vis-à-vis a payor, St. Luke's still cannot risk being excluded from the health plan's network, then the transaction will not create anticompetitive effects. *Transcript at 2957:7-2958:18 (D. Argue).*

269. Plaintiffs have not demonstrated that the Saltzer Transaction would enable St. Luke's to terminate its contracts with any payors. [redacted]

[redacted] BCI maintains a dominant market share in nearly all core product lines, excluding only certain Medicare and Medicaid products. *Transcript at 326:16-22 (J. Crouch); 461:8-13, 479:7-9 (L. Duer)* (describing BCI as the "800-pound gorilla in th[e] market[.]"); *Exhibit 2632;* [redacted] Dr. Pate testified that "Blue Cross is so dominant that they are a must-have for us. We couldn't just walk away from their business." *Transcript at 1646:18-20 (D. Pate).*

270. Micron provides a ready example of what happens to St. Luke's revenues when it fails to reach agreement with a payor. [redacted]

271. A shift of a much smaller magnitude away from St. Luke's in response to it walking away from Blue Cross would be sufficient to make a price increase "completely untenable for St. Luke's." *Transcript at 2959:11-22 (D. Argue).* Saint Alphonsus would pick up that lost patient volume. The Saint Alphonsus Health Alliance, for example, can be marketed without St. Luke's and Saltzer providers, and would attract enough patients away from St. Luke's and Saltzer to exceed the critical loss. *Transcript at 2959:2-10 (D. Argue); see also Transcript at 795:4-15 (N. Powell).*

272. The more fundamental problem with plaintiffs' "bargaining leverage" theory is that, according to Professor Dranove, *any* merger of competing providers enhances the

providers' bargaining leverage—regardless of whether the merger creates or enhances *market power*—which is the touchstone of an antitrust analysis. *Transcript at 1397:25-1398:3, 1398:17-19 (D. Dranove).* Thus, Professor Dranove testified, in his view *any* merger of providers harms consumers. *Transcript at 1402:23-1403:1 (D. Dranove).*

273. Changes in the relative bargaining strength of parties to a negotiation do not, however, indicate whether the transaction is anticompetitive. *Transcript at 2957:7-11 (D. Argue).* Nor do price increases. Prices increase for any variety of reasons, but the antitrust laws are concerned only with *market power*, which facilitates the raising of prices to *above competitive* (or "supracompetitive") levels. *See Transcript at 1398:25-1399:3 (D. Dranove).*

274. Professor Dranove was not able to provide any objective benchmark from which to determine when an increase in bargaining strength creates market power, and thus becomes relevant for an antitrust analysis. *Transcript at 1398:20-24, 1399:4-1400:8 (D. Dranove); Transcript at 2957:18-2958:3 (D. Argue).* Ultimately, Professor Dranove testified that whether a change in bargaining leverage is likely to result in anticompetitive effects rests on other evidence, including changes in concentration levels. *Transcript at 3429:10-22 (D. Dranove).*

2. Plaintiffs have presented no evidence that changes in bargaining leverage lead to increased prices.

275. If changes in bargaining leverage invariably lead to increased prices, one would expect to see evidence of such price increases based on St. Luke's prior acquisitions of physician practices. However, plaintiffs have not presented any such evidence.

a. The Magic Valley

276. The testimony of Scott Clement of Regence Blue Shield provides an example of the disconnect between the bargaining leverage theory and the evidence. Plaintiffs claim that the employment of a significant percentage of providers by the Magic Valley Medical Center (which

was eventually acquired by St. Luke's) enabled the providers to obtain more favorable reimbursement rates. But Mr. Clement, who negotiated reimbursement rates with St. Luke's on behalf of Regence, testified that, from his perspective, St. Luke's acquisitions in the Magic Valley did not have a discernible effect in his negotiations with St. Luke's: "I can't say there was a discernible difference in how those negotiations went that I would attribute to the fact of those acquisitions. I don't think that changed things significantly." *Dkt. 395 (S. Clement Dep.) at 118:23-119:1, 119:4-10.* Plaintiffs have presented no evidence that St. Luke's was able to use increased bargaining leverage in the Magic Valley arising out of its employment of primary care physicians to obtain reimbursement increases—let alone *above market* reimbursement increases.

277. Likewise, with respect to Idaho Physicians Network (IPN), St. Luke's apparently was not able to leverage its employment of a significant number of primary care physicians into increased prices. Like BCI and Regence, IPN has a uniform fee schedule that applies to physicians in Twin Falls. St. Luke's physicians in the Magic Valley were, for years, paid on a fee schedule that was *less* than the standard IPN fee schedule for physician services [redacted]

278. The evidence that plaintiffs presented concerning St. Luke's negotiations with Blue Cross in the Magic Valley does not lead the Court to find that increased bargaining leverage is likely to lead to supracompetitive price increases. The following is a summary of the evidence presented concerning negotiations with Blue Cross in the Magic Valley:

a) [redacted]

[redacted]

b) [redacted]

c) [redacted]

d) [redacted]

e) [redacted]

[redacted]

279. This evidence does not demonstrate that St. Luke's was able to extract above-market pricing—particularly when considered alongside the testimony of Scott Clement to the effect that St. Luke's acquisitions had no noticeable impact on St. Luke's bargaining leverage with Regence. [redacted] does not lead the Court to conclude that the parties' ultimate agreement reflects an exercise of market power—or that the Saltzer Transaction is likely to result in an increase in prices.

280. Moreover, the Court finds the Magic Valley is not an appropriate analogy for the markets at issue in this case. As Dr. Argue testified, very few patients leave Twin Falls to go to Jerome or other smaller, outlying communities for primary care services. In contrast, a significant amount of the adult and pediatric primary care physician services received by residents of Nampa is provided by physicians located outside Nampa, in comparable or larger cities such as Meridian or Boise. *Transcript at 2975:11-2976:4 (D. Argue).*

b. Plaintiffs have failed to prove that any increase in physician fees is likely.

281. Further undermining the claim that the Saltzer Transaction will create or enhance market power in the market for adult PCP services is the fact that payors have, by and large, succeeded in unilaterally imposing uniform fees for physician services. [redacted]

282. [redacted] Likewise, St. Luke's physicians in the Treasure Valley receive the same physician fees as all other Regence providers in the Treasure Valley for their professional services. *Dkt. 252 (S. Clement Dep.) at 44:19-22, 46:6-10.*

283. While Saltzer physicians negotiated higher reimbursement from Regence for participating in the Regence PPO, that does not demonstrate that Saltzer had market power. The testimony indicates that Saltzer was able to resist a decrease in reimbursement for participation in Regence's PPO network primarily for two reasons. First, it was clear to the parties that Saltzer was not likely to experience any increase in volume in exchange for the requested discount since the PPO network was as broad as the Traditional network that provided for higher reimbursement. *Dkt. 252 (S. Clement Dep.) at 18:20-23, 19:10-14, 42:24-43:7, 181:18-182:12.* Second, Regence felt like it needed to have Saltzer in the network because its larger competitor, Blue Cross, had Saltzer in the network. *Dkt. 252 (S. Clement Dep.) at 43:12-22, 72:16-23.*

284. As with the Magic Valley evidence summarized in the previous section, the Court cannot conclude that the fact that Saltzer or St. Luke's was able to negotiate better reimbursement from one payor— but not others—reflects an exercise of bargaining leverage or above-market pricing. As Dr. Argue testified, if the provider's leverage (its market power) arises out of the fact that a payor lacks an attractive "outside option" —*i.e.*, because there are not sufficient alternative providers in a market—then the provider cannot have market power as to one payor but not another. *Transcript at 2972:8-2973:1, 2973:16-20 (D. Argue).* It would therefore be "illogical" to conclude that the fact that Saltzer negotiated higher rates with Regence reflects that Saltzer has market power, when another payor, Blue Cross, successfully resisted Saltzer's efforts to negotiate higher reimbursement. *Transcript at 2973:7-15 (D. Argue).*

285. Because St. Luke's PCPs are paid by Regence the statewide fee schedule rates, once Saltzer physicians transition from Saltzer's Regence fee schedule to St. Luke's reimbursement, the amount that Regence pays for the professional services of Saltzer PCPs will actually *decrease*. *Dkt. 252 (S. Clement Dep.) at 46:16-24.*

286. [redacted]

287. Plaintiffs emphasize an e-mail from Dr. Randell Page of Saltzer to other Saltzer employees complaining about BCI's decision to stop paying for services billed with "consultation" codes, in which Dr. Page stated, "If our negotiations w/Luke's go to fruition, this

will be something we could try to get back, ie consult codes, as there would be the clout of the entire network." *Exhibit 1361.* This email is not inconsistent with the Court's conclusions regarding bargaining leverage. As Dr. Page testified, he was expressing his hope that if Saltzer affiliated with St. Luke's, St. Luke's would raise the issue of consultation codes to prevent the reduction in reimbursement. *Dkt. 270 (R. Page Dep.) at 57:7-18, 58:1-16, 58:18-59:3; Transcript at 2851:11-2852:7 (R. Page).* Dr. Page further explained that no one from St. Luke's ever expressed a belief that Saltzer would be able to bill for consult codes again as a result of the affiliation, and Saltzer has not been able to start billing Blue Cross again for those codes since joining St. Luke's. *Transcript at 2851:15-2852:7 (R. Page).* Dr. Page also testified that no one from St. Luke's ever mentioned Saltzer gaining "the clout of St. Luke's network in payor negotiations" or being able to increase reimbursement rates as a result of the affiliation.[8]

288. In sum, plaintiffs have failed to prove that St. Luke's or Saltzer has been able to exercise bargaining leverage (or market power) to obtain above-market pricing for physician services, or that the Saltzer Transaction is likely to enable them to do so.

c. Plaintiffs have not proven that prior transactions otherwise resulted in supracompetitive pricing.

289. Professor Dranove argued that even if St. Luke's and Saltzer are unable to extract higher reimbursements for services in the market for adult PCP services—the market in which the transaction is alleged to create or enhance market power—they could leverage their purported market power to obtain increased reimbursement for other services. *Transcript at 1346:24-1347:11, 1393:16-21 (D. Dranove).*

[8] To the extent that this exchange is relevant at all, it provides another example of how Saltzer, despite its purported market power in plaintiffs' proposed Nampa market, was unable to resist reductions in reimbursement by BCI.

290. Dr. Argue disagrees, testifying that the argument that an increase in market power in physician services will allow St. Luke's to extract increased prices in other services is inconsistent with plaintiffs' antitrust theory. *Transcript at 2960:19-2961:3 (D. Argue); Transcript at 3444:3-5 (D. Dranove).* For example, if St. Luke's tried to exercise its supposed market power in physician services by raising the price of other services—which presumably are already priced at profit-maximizing levels—St. Luke's would lose business. *Transcript at 2961:15-20 (D. Argue).* Even if the price increase were scattered among various services such that a patient may not recognize it, the health plans will notice the increase and would simply "take advantage of the alternatives that are in the other markets." *Transcript at 2961:21-2962:5 (D. Argue).*

291. Plaintiffs have not presented any evidence relating to any of St. Luke's prior acquisitions that would substantiate the theory that St. Luke's was able to extract market power for physicians' services through increased reimbursement for other services.

292. Plaintiffs' experts conceded that they have not attempted to demonstrate that any reimbursement rates that St. Luke's has negotiated have resulted in supracompetitive pricing. *Transcript at 1387:7-9, 3471:16-24 (D. Dranove); Transcript at 1578:7-10 (D. Haas-Wilson).* Nor does other evidence in the record support such a conclusion.

293. The Court does not find to be significant the analysis done by Professor Hass-Wilson showing that, for 21 procedure codes common to TVH, Saint Alphonsus, and St. Luke's, St. Luke's allowed outpatient payments are higher on average than those of TVH or Saint Alphonsus. *Transcript at 1525:15-1526:3 (D. Haas-Wilson).* Those twenty-one codes are not a representative sample of the total number of procedure codes billed by St. Luke's. *Transcript at 2984:10-2985:16 (D. Argue).*

294. Dr. Argue has examined the history of contract negotiations between St. Luke's and BCI and concluded that the evidence does not suggest that St. Luke's has been able to extract above-competitive pricing from Blue Cross:

a) [redacted]

b) [redacted]

c) [redacted]

295. This history of negotiations demonstrates a consistent, back-and-forth pattern—one that Blue Cross expects—in which the parties anticipate closing the gap between initial offers and meeting in the middle. *Transcript at 2977:9 -2978:4 (D. Argue).*

296. [redacted]

297. [redacted]

298. Second, the reports themselves are, at best, ambiguous as to what they show concerning St. Luke's reimbursement from BCI relative to other hospitals. [redacted]

299. [redacted]

300. Linda Duer of IPN likewise testified that Saint Alphonsus charges more, and offers lower discounts off of those higher charges, than St. Luke's. *Transcript at 492:8-10 (L. Duer).* [redacted] Accordingly, the Court cannot conclude that St. Luke's reimbursements are higher than Saint Alphonsus's, let alone that any such price differential reflects market power.

d. Plaintiffs have not proven that the Saltzer Transaction is otherwise likely to result in supracompetitive pricing.

301. The 2012 negotiations between St. Luke's and BCI are significant for the additional reason that they took place at a time when the parties expressly contemplated that Saltzer was going to be joining St. Luke's. To appreciate the significance of this fact, however,

the Court first turns to certain evidence that plaintiffs presented regarding a previous dispute between BCI and St. Luke's.

302. [redacted]

303. [redacted]

[redacted]

[redacted]

304. [redacted] Any modeling done by Blue Cross for the contract accounted for the affiliation of Saltzer with St. Luke's. *Transcript at 2978:5-16 (D. Argue); Exhibit 2; Exhibit 2617.* Yet the price increase agreed to for the years 2013-2014 is similar to past years, and plaintiffs have presented no evidence that the negotiated price increase is above competitive levels. *Transcript at 2978:17-24 (D. Argue).*[10]

3. Plaintiffs' other evidence of likely anticompetitive effects does not demonstrate that the Saltzer Transaction is likely to be anticompetitive.

a. Evidence does not support Plaintiffs' argument that St. Luke's has engaged in a plan to "pay more, charge more."

305. Plaintiffs argue that the evidence shows that St. Luke's and Saltzer agreed through their transaction to a plan whereby St. Luke's would pay above-market compensation to the Saltzer physicians and recoup that increase by increasing the reimbursements that commercial payors compensated St. Luke's for the Saltzer physicians' services. For this argument, plaintiffs rely primarily on two sets of documents:

10 [redacted]

a) Opinions rendered by outside consultant Grant Thornton on whether the productivity-based compensation that could be paid to the Saltzer physicians under the agreement with St. Luke's was consistent with "fair market value" (hereafter, the "fair market value opinions"); and

b) Financial modeling undertaken by outside consultant Peter LaFleur showing the impact on total reimbursement for Saltzer's services assuming that commercial insurers agreed to reimburse for Saltzer's services under St Luke's commercial agreements.

306. Before turning to address the documents cited by plaintiffs, it is important first to explain what is meant by "provider-basing" and its relevance (or lack thereof) to this case.

i. "Provider-basing" Saltzer may generate additional revenue for Saltzer's services but has nothing to do with commercial payors.

307. Under regulations promulgated by the Centers for Medicare and Medicaid Services ("CMS"), which administers the Medicare and Medicaid programs, certain health care services provided to Medicare beneficiaries are reimbursed at a higher rate when performed in certain hospital-owned facilities than when performed in independent physician offices or clinics. *See* 42 C.F.R. § 413.65. A provider obtaining such increased reimbursement engages in what is known as "provider-based billing."

308. The increase in reimbursement from CMS reflects the costs and obligations that must be taken on to comply with the regulations. A provider-based facility operated by a hospital is required to, *inter alia*, comply with accreditation standards ensuring quality and safety of services, satisfy federal requirements for handicapped accessibility and other